



Five Key Ingredients in the Integrated Care Recipe

Integrated models of healthcare seek to reduce care fragmentation by coordinating care, improving communication between providers, and tracking clinical outcomes. Primary care and behavioral health integration initiatives now have the benefit of a large body of research (now over 80 studies strong) as well as a growing wealth of field experience. These collective resources all support integrated care as one strategy in controlling healthcare costs, improving clinical outcomes, and improving the care experience for patients/consumers. Integrated care also helps to extend behavioral healthcare to many persons without access to convenient and affordable behavioral health services.

Successful integrated care implementation requires a deliberate, thoughtful, and structured implementation plan with new clinical roles, new partnerships, new procedures, new tools, and often a new funding model.

Over the last decade, the Advancing Integrated Mental Health Solutions Center at the University of Washington has partnered with many organizations in their efforts to implement integrated healthcare. Here are five key lessons from our most successful partnerships:

- 1 Leadership buy-in and high-level project promotion is important from the very start.
- 2 Focus on the business case and organizational partnerships early.
- 3 Use of structured quality improvement methodologies is critical to support the multiple layers of change required for success.
- 4 Every community is unique and requires careful adaptation of models used by others to meet their own unique needs. "Cookie cutter" implementations are often bound for failure.
- 5 Start small. Consider a pilot project or a limited target population to start with. A successful integrated care project is often quite "infectious" as people see its benefits.

Integrated models of care require clinical duties and roles that are typically new to providers such as performing medication reconciliation, using a care registry, systematically tracking care referrals and outcomes, and facilitating communication between providers. These new duties and roles must be carefully thought through in team-building exercises, and rolled out with adequate clinician training and support.

Implementing integrated care also requires new partnerships — between health plans, primary care service providers, mental health service providers, substance use treatment providers, and other community partners. Bringing all of these partners to the table in a productive manner is often a challenge, as they have different missions and cultures.

Obviously, no program can be sustained without appropriate financial support and careful development of a viable plan is critical. Although it is important to maximize the service revenue, our experience is that attempting to fund integrated models of care solely via more efficient billing or increased productivity is usually insufficient. Other strategies that capitalize on the medical cost offsets are often necessary such as blended funding, layered payments methods, and pay-for-performance methodologies that "reward" programs based on pre-determined outcome benchmarks.

All of this comes at a time of unprecedented changes in healthcare world. Providers are increasingly challenged with "change fatigue" brought on by a changing funding and regulatory environment combined with rapidly increased expectations for care outcomes.

It may seem like a tremendous effort is required to transform into an integrated care provider, but it's certainly worth the effort. It has been a great opportunity for the AIMS Center to be part of the improved clinical outcomes and improved sense of purpose and meaning that can arise out of successful integrated care.

What's next? Partnering programs are extending principles of integration to new populations, such as new mothers and children, older adults, uninsured, school students, and veterans and their families. Other programs are working to expand the scope of integration projects to include persons with severe mental disorders, diabetes, and cardiovascular conditions. Still others are including new clinician types into integrated care teams such as substance use providers, and peer clinicians. 2014 promises to bring not only intense change, but also multiple opportunities to bring effective mental healthcare to greater numbers of people.

MARC AVERY

Clinical Associate Professor and Associate Director for Clinical Services, AIMS Center and the Division of Integrated Care and Public Health, University of Washington School of Medicine