



Ohio Colleges of Medicine
Government Resource Center



Identifying a common core of integrated healthcare program requirements

Implications for workforce development

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All Ohio Institute on Community Psychiatry, March 2015

Goals:

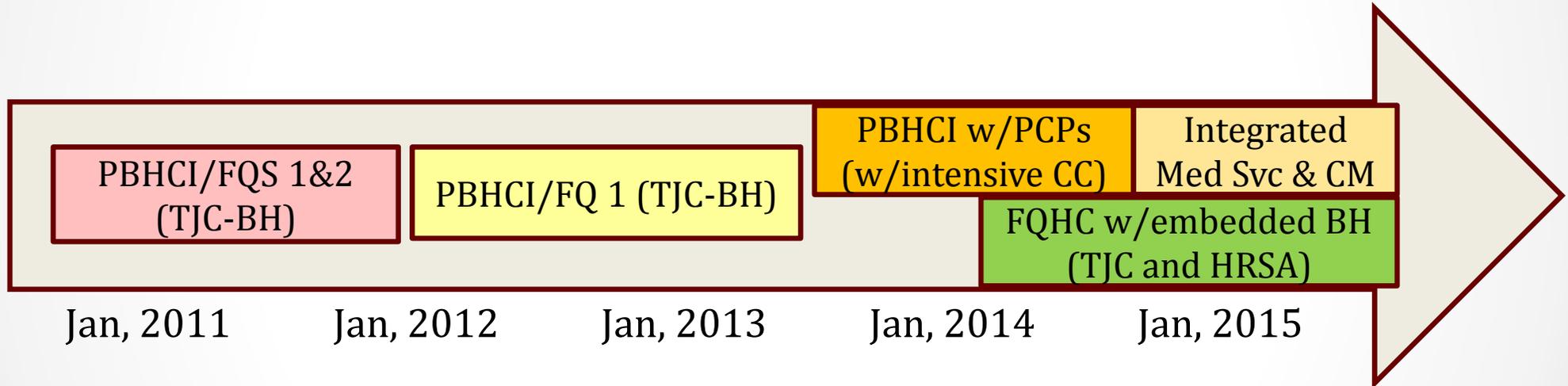
- Identify and define core elements of IHC based on three broad frameworks: (1) CMS Health Home service model; (2) Chronic Care Model; and (3) Four Principles of Effective Care.
- Identify similarities and differences in the expression of each core element across eight integrated BH/PC models conceptualized by funding and accrediting bodies.
- Discuss workforce implications for a selected core elements of IHC Models:
 - From the perspective of expert panelists
 - From the perspective of workshop participants

Introductions

John Kern, M.D.
Chief Medical Officer

Regional Mental Health Center, Inc.

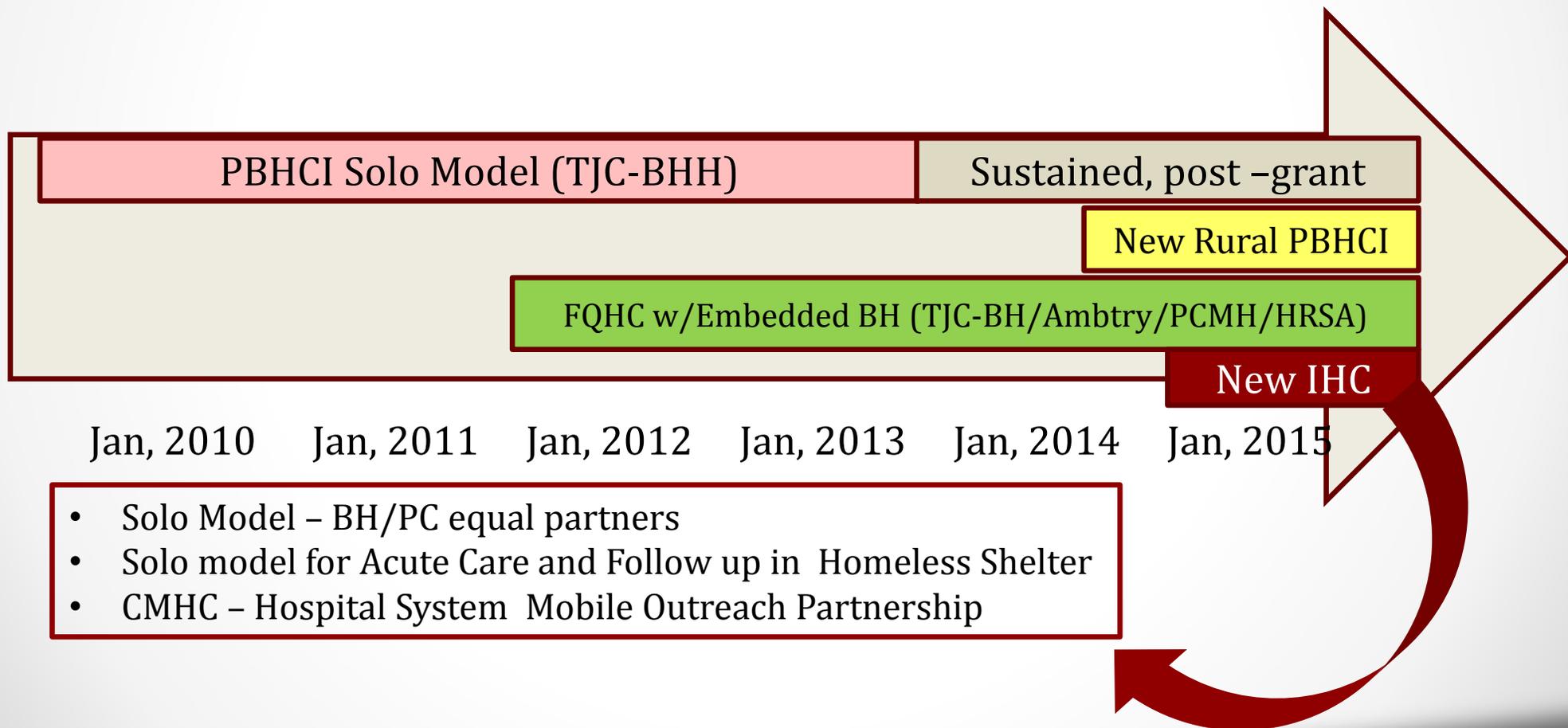
Merrillville, Indiana



Sandy Stephenson, MSW
Director of Integrated Healthcare Services

Southeast Inc.

Columbus, New Philadelphia, and St. Clairsville, Ohio



Participants

What type of organization are you primarily affiliated with?

- a. Provider organization that offers some type of integrated healthcare program
- b. Provider organization that plans to offer some type of integrated healthcare program
- c. Provider organization (BH, PC or other)
- d. University
- e. Local or state health and human service agency
- f. Managed care/ and or insurance organization
- h. Other

Origin of Panel Concept:

- Real-world experiences of panelists;
- Review of literature, regulatory, and credentialing requirements; and
- Reactions we received to an earlier iteration of our analysis

Core Elements of Integrated Care in BH Settings

PCMH Core Elements: Lessons Learned

- Standards in PCMH recognition tools vary widely in emphasis^{1,2}
- Measures often address core elements that are easier to assess³
- Lack of research indicating which standards are most closely related to improved performance, patient outcomes, and cost⁴
- Organization of recognition tools vary so comparison process takes time and effort^{1,3}

¹Burton, Devers, Berenson (2010). ²Stange, Nutting, Miller et al. (2010). ³Stange, Miller, Nutting (2010),

⁴Alexander & Druss (2012)

Initial Working Set of Core Elements of BHH

- Considered three frameworks^{1?}
 - CMS Health Home Service Requirements
 - Chronic Care Model (CCM), essential elements for high-quality chronic disease care
 - Four Principles of Effective Care (AIMS Center, University of Washington, 2011)
- Used an inductive process ²

¹Alexander & Druss (May, 2012); ²Crane & Panzano, 2014

Initial Set Elaborated with Program Standards

Documents reviewed ⁵

- CARF Health Home
- CARF Integrated Behavioral Health and Primary Care
- Ohio Health Home Certification Criteria
- The Joint Commission, Behavioral Health Home Certification
- The Joint Commission, Primary Care Medical Home
- SAMHSA Primary Behavioral Health Integration Projects
- Federally Qualified Health Centers - HRSA
- NCQA PCMH 2014

Systematic but preliminary analysis

Elaborated Set of Core Elements

- Patient and Family Centered Care
- Culturally Appropriate Care
- Comprehensive Care Plan
- Use of continuing care strategies to include
 - Care Management
 - Care Coordination
 - Transitional Care
- Self-Management Support
- Team-based care
- Full Array of Services (e.g., PC, MH, SA, Prevention, Health Promotion),
- Quality Improvement Processes
- Evidence Based Practice/Clinical Guidelines
- Outcomes measurement
- Health Info Technology & EHR Meaningful Use
- Enhanced Access to care
- Miscellaneous Organization Level Requirements

More Detailed Review re: Person Centered Care

CARF IBHPC	CARF HH	OHH	TJC HH Cert	TJC PCMH	PBHCI Program	FQHC - HRSA	NCQA
10b &c, 11, 13b&c, 15d	2e, 7c4, 7c5, 7e, 12b, 13, 15a9, 16b, 18c, 18d, 18e, 18f,	C1a, C1b, C1c, C1e, C5e, C5g, C5h, C5i, C5j, I	CTS.02.02.01-6, CTS.03.01.01-(12,13), CTS.03.01.03-(17,20,22), CTS.04.01.01-7, CTS.04.01.03-27, CTS.04.02.25-(2,4), CTS.06.01.05-(1,4), CTS.06.01.07-(1,2) RI.01.02.01-(31,32,33), RI.01.04.01-6, RI.01.04.03-(1,2,3,4,5,6) RI.01.05.01-(4,5,8,10,11)	RI.01.02.01: EP31, EP32 RI.01.04.03: EP1, EP2, EP3 RI.01.04.03: EP1, EP2, EP3, EP4, EP5, EP6 RC.02.01.01 : EP28	1. I. Purpose, 1, pg. 6: / 2. I. Purpose pg. 7: / 3. Expectations, pg 8: / 4. Expectations, pg. 8: / 5. 2.1 Required Services / 6. 2.1 Required Services: Preventive and Health Promotion Services / 7. Appendix M: Suggest Year 1 (of 4) implementation goals	Subpart C: §51c.303 Project elements, (j), (k) §51c.304 Governing board, (b), (b1) Site Visit Guide, Program Requirement #18: Board Composition	Elements 1C1-1C4, 1D2, 1E2, 1E3, 3C2, 3C3, 3C5, 3D3, 6B1

30,000 Foot View

Core Elements	CARF IBHPC	CARF -HH	OHH	TJC HH Cert	TJCP CMH	PBHCI Pgm	FQHC App	NCQA
Patient and Family Centered Care	✓	✓	✓	✓	✓	✓	✓	✓
Culturally Appropriate Care		✓	✓	✓	✓			✓
Comprehensive Care Plan	✓	✓	✓	✓	✓	✓	✓	✓
Continuing Care Strategies (Care Mgmt., Coordination, Transitional Care)	✓	✓	✓	✓	✓	✓	✓	✓
Self-Management Support	✓	✓	✓	✓	✓	✓	✓	✓
Team-based Care	✓	✓	✓	✓	✓	✓	✓	✓
Full Array of Services (e.g., PH, MH, Health Promotion, LTC)		✓		✓	✓	✓	✓	✓
Quality Improvement Processes	✓	✓	✓	✓	✓	✓	✓	✓
Evidence Based Practice			✓	✓	✓	✓	✓	✓
Outcomes measurement		✓	✓	✓	✓	✓	✓	✓
Health Info Technology/ Meaningful Use		✓	✓	✓	✓	✓	✓	✓
Enhanced Access to care	✓	✓	✓	✓	✓	✓	✓	✓

Initial Observations

- A ✓ ≠ ✓
 - The way that each element is operationalized differs under each model.
 - Assessment methods vary in term of ‘level’ of measurement (e.g., policy versus patient experience)¹
- The documents reviewed include implied expectations that might get overlooked
 - It’s important to make implied expectations explicit
 - PBHCI and the Chronic Care Model (e.g., PACIC domains)
- All core elements have workforce implications

¹Crane & Panzano, 2014

Workforce Domains*

- **Shaping Workforce Training**
- **Informing Job Descriptions**
- **Employee Recruitment**
- **A Guide to Orientation**
- **Performance Assessment**
- **Shaping Existing & Future Competency**

*Core Competencies of Integrated Care (Hoge, Morris, et al., 2014)

Two Core Elements and Workforce:

Self Management

Self Management

- A set of tasks that individuals must undertake to live well with one or more chronic conditions. It is what the person with a chronic disease does to manage their own illness, not what the health service provider does.⁶

Self Management Support

- What others do to assist individuals with chronic illness develop and strengthen their self-management skills.⁶
- Education and supportive interventions, regular assessment of progress/problems, goal-setting; problem-solving support
- Peers are an important source of self-management support

Self Management Programs

Sub-Feature	CARF HH	CARF IBHPC	OHH	TJC HH Cert	TJC PCMH	PBHCI SAMHSA	FQHC App	NCQA
Provide education/training in CDSM to consumers	✓	✓ *	✓ **	✓ ***	✓	✓		✓
Provide education/training in CDSM to family/significant others <i>as allowable by law</i>	✓	✓	✓			✓		✓
Assign responsibility to consumers for participating in self-management activities					✓			
Specifies content to be addressed by SM. programming (e.g., strategies to access care)	✓ (4)	✓ (3)	✓ (2)					
Engage consumer in monitoring progress toward SM goals			✓					✓*** *
Engage significant others in monitoring clients progress with SM goals			✓					

* Specified focus on self-efficacy; **specify building monitoring skills; *** involve PCP and team in SM education and training programming **** Provide tools to consumers to record/track progress

Workforce Question

Q1: What SM models have you found to be effective for clients you serve, or for families/significant others of those clients?

Q2: Which of the following WORKFORCE-related issues presents the biggest obstacle to offering and/or sustaining evidence-based self management programs/practices at your organization?

- a. Capacity (availability of staff, staff skills/knowledge, staff turnover)
- b. Lack of support from agency leadership
- c. The ability of staff to engage clients (and/or family members) in programming
- d. Staff attitudes regarding self management
- e. Other workforce factors

Self Management Support

Sub-Feature	CARF HH	CARF IBHPC	OHH	TJC HH Cert	TJC PCMH	PBHCI Pgm	FQHC App	NCQA
Assess outcomes of SM activities on an ongoing basis (e.g., clients' ability to self manage chronic conditions)	✓	✓	✓	✓	✓			
Provide resources to support SM planning	✓	✓						
Specify staff responsibilities re: supporting and monitoring clients' implementation of their SM plan	✓*	✓		✓***	✓**			✓***
Incorporate clients SM goals for physical and behavioral health in care plan				✓	✓			✓****
Connect consumers with peer support for self-management			✓					✓
Connect significant others with peer support for self-management			✓					
Use EHR to identify patient-specific educational needs								✓*** **
Use EHR to issue reminders for preventive and chronic care								✓*** **

* Have written policies in place re staff SM support responsibilities; **Coordinate delivery of consumer and family/SO SM supports; *** Train staff and assign responsibility to team members to support client and family SM activities; **** share SM plan with significant others; ***** deliver educational information to at least 10% of patients in need of it

Workforce Question(s)

Q1: How do you define “self-management support”?

Q2: How do you train staff to train patients to train themselves?

Q3: How do you measure the extent to which self management support activities provided by staff:

- help clients become more skilled at self management behaviors?
- help clients achieve core outcomes in their self management plans?
- cross the line and deter clients from building SM skills?

Team-Based Care

Team-based Care

Services provided by a group of professionals that may include a nurse care coordinator, nutritionist, behavioral health professional, social worker or any professionals deemed appropriate by the State such as:

- peer support specialist, medical specialists; dietitians; chiropractors; licensed complementary and alternative medicine practitioners; pharmacists; physician assistants
-

Team should be inter-disciplinary and inter-professional

Team may operate in a variety of ways (e.g., face-to-face, virtual)

Team may be based at a hospital, CMC, CMHC, rural clinic, academic health center or any entity deemed appropriate by the State

⁷Adapted from ACA definitions of team in Sections 2703 and 3502

Team¹-based Care: Structure

Sub-Feature	CARF HH	CARF IBHPC	OH H	TJC HH	TJC PCMH	PBHCI	FQHC ¹ App	NCQA
The team has a designated caseload				✓	✓			
Members from complementary disciplines	✓	✓			✓			
Required disciplines or positions are specified (e.g., nurse care manager, embedded PCP, care coordinator)	✓	✓	✓					
A leader for the team is designated			✓	✓				✓
Job descriptions are developed for all clinical and non-clinical team members								✓
Team members are cross - trained	✓	✓		✓		✓		
The team psychiatrist or psychologist is available during all hours of operation	✓ ¹	✓ ¹						
Required services	See Full Array of Services							

¹ Term “team” does not appear in FQHC regulations;

² Can be provided via consultation

Team-based Care: Process

Sub-Feature	CARF HH	CARF IBHPC	OHH	TJC HH Cert	TJC PCMH	PBHCI Pgm	FQHC	NCQA
Service delivered in integrated way	✓	✓	✓ ¹					
Patient-centered approaches used	See Person-Centered Care							
Warm handoffs are provided to clients	✓							
All team members review care plans	✓			✓				
Coverage plans for absent disciplines or team members are specified	✓	✓						
Team members follow written procedures for collaborating with external providers	✓	✓	✓	✓				
A structured approach is used to foster communication among team members (e.g. written procedures, team meetings, HIT)	✓	✓			✓			✓
Care Management., Care Coordination, Transitional Care	SEE Continuing Care Strategies							

¹ Integrated delivery may involve different approaches (face to face, video conferencing, telephone)

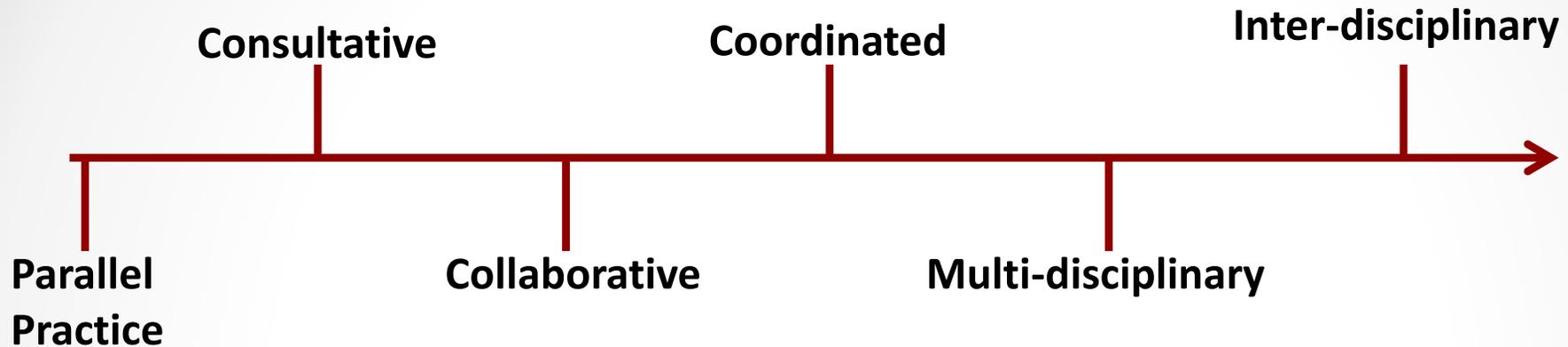
Six Levels of Collaboration⁸

COORDINATED		CO-LOCATED		INTEGRATED	
Level 1: Minimal Collaboration	Level 2: Basic Collaboration (at distance)	Level 3: Basic Collaboration (on-site)	Level 4: Close Collaboration (on-site; some system integration)	Level 5: Close Collaboration (approaching integrated practice)	Level 6: Full Collaboration (transformed/merged/IHC practice)

Differentiated in extent to which team members share:

- spaces, systems, communication, and mental-model of “team”
- clinical delivery practice models, treatment plans
- exposure to PC/BH treatment experience by patients (disjointed → seamless)
- vision and organizational support by leadership
- resources/funding sources

Team-based Care Continuum⁹



Increases in terms of:

- whole person emphasis, determinants of health considered
- structural complexity
- communication, # of participants, synergy, importance of consensus
- complexity and diversity of outcomes considered

Decreases in terms of:

- hierarchy and clearly-defined, rigid roles
- practitioner autonomy
- adherence to bio-medical model

Workforce Question(s)

Q1: How do you define “team” in an integrated health care environment? What are the staffing implications of your definition?

Q2: How do you divide all the tasks required for a team to deliver or achieve patient-centered, integrated care?

Q3: How do you teach providers who are used to being everything to everybody to work in a team?

Q4: What are your practice expectations for the Team and Team-Based Care?

Next steps for the core element analysis

- Complete analysis in partnership with HRSA/SAMHSA Center for Integrated Health Care Solutions (CIHS) and other interested partners
- Identify potential applications
- Seek sponsorship to produce a white paper
- Share findings with other audiences

Questions?

References

- ¹ Burton R, Devers K, Berenson R: Patient-centered medical home recognition tools: a comparison of ten surveys' content and operational details. The Urban Institute, Health Policy Center, 2010.
- ² Stange K, Miller W, Nutting P, Crabtree B, Stewart E, Jaén C: Context for understanding the national demonstration project and the patient-centered medical home. *Annals of Family Medicine* 8:S2-S8, 2010.
- ³ Stange K, Nutting P, Miller W, Jaén C, Crabtree B, Flocke S, Gill J: Defining and measuring the patient-centered medical home. *J Gen Intern Med* 25: 601-612, 2010.
- ⁴ Alexander L, Druss B: Behavioral health homes for people with mental health & substance use conditions: the core clinical features. SAMHSA-HRSA Center for Integrated Health Solutions, 2012.

5 Recognition Tools

Commission on Accreditation of Rehabilitation Facilities Standards Manual, *Health Home supplement to the 2013 Behavioral Health Standards Manual (released July 1, 2013)*

Commission on Accreditation of Rehabilitation Facilities Standards Manual, *Integrated Behavioral Health and Primary Care supplement to the 2013 Behavioral Health Standards Manual (released July 1, 2013)*

Ohio Health Home Service Standards for Persons with SPMI, *Ohio Administrative Code 5122-29-33 (effective July 1, 2014)*

Joint Commission Behavioral Health Home Certification Standards, *for organizations accredited under the Behavioral Health Care Accreditation Program (effective January 1, 2014)*

Joint Commission Primary Care Medical Home Certification *for organizations accredited under the Ambulatory Care Accreditation Program (version 2011)*

SAMHSA PBHCI RFA: (PPHF-2012), Catalogue of Federal Domestic Assistance (CFDA) No.: 93.243, Applications due 6/8/2012.

Federally Qualified Health Centers:

- Electronic code of Federal Regulations (e-CFR Data current as of July 8, 2014), Title 42: Public Health, Part 51c – Grants for community health services.
- Health Center Program Site Visit Guide for HRSA Health Center Program Grantees and Look-A-likes; January 2014/Fiscal Year 2014

The National Committee for Quality Assurance Patient-Centered Medical Home 2011 Standards and Guidelines *(released Jan. 31, 2011)*

References

- ⁶ Self-management support in behavioral health: Organizational Assessment Tool, Resources for Plans and Providers of Integrated Care, RAND Corporation for Agency for Healthcare Research on Quality, July, 2014.
- ⁷ Patient Protection and Affordable Care Act, Public Law 111-148, March 23, 2010.
- ⁸ Health, B., Wise, Romero, P., and Reynolds, K.A. A review and proposed standard framework for levels of integrated healthcare, Washington, DC, SAMHSA-HRSA Center for Integrated Health Solutions, March, 2013.
- ⁹ Boon, H., Verhoef, M, O'Hara, D. and Findlay, B. (2004). From parallel practice to integrative health care: a conceptual framework, BMC Health Services Research, 4:15, pages 1-5; open access at <http://www.biomedcentral.com/1472-6963/4/15>