Implementing Integrated and Co-located Care

Tuesday, March 31, 2015

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http://www.integration.samhsa.gov/mai-coc-grantees-online-community/webinars

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Clients in HIV Care: A Case for Effective Integration/Co-location

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MAI-CoC HIV Lead
The MayaTech Corporation

HIV Care Continuum

Primary Care Continuum of HIV Treatment – a Silo

SOURCE: Pence et al., 2012.
The Trouble With Silos and HIV

It is rare for people living with HIV to need only HIV services... mental health issues, substance use and other concerns/conditions interact with one another

- Approximately 50% meet diagnostic criteria for anxiety or depression
- 25%-45% have a substance use disorder
- 25% are infected with Hepatitis C

- HIV care can be its own silo, where clients’ other health and sociocultural needs may not be adequately addressed

“HIV IS QUINTESSENTIALLY A BIO-Psycho-social ILLNESS” EUGENE FARBER PH.D.

Integration/Co-location for Clients in HIV Care

Holistic approach provided by an interdisciplinary, culturally sensitive team

Allows for flexible, integrated care for a person whose “unified diagnosis” is comprised of intertwined conditions

Incorporates strategies to reduce HIV stigma/disparities and increase culturally grounded adaptive coping
Integration/Co-location for Clients in HIV Care

Begin treatment “where the client is”, not where clinicians expect him or her to be
Recovery vs. Medical model
Match intervention not only to diagnosis but to the client’s readiness to accept treatment
Provide an “open-door” service and care system that engages and re-engages individuals into sustained quality care

Integration/Co-location for Clients in HIV Care

Organization/Clinic
Strengthen and blend organizational linkages
- Established protocols for shared records, collaboration and consultation, and integrated data management
Expand access and remove barriers
- Space and service delivery protocols for integrated/co-located staff
- Removing administrative, financial, logistical barriers

Integration/Co-location for Clients in HIV Care

Providers
Trained in integrated risk assessments, screening and brief intervention methods.
Skilled in communicating with providers/teams from different disciplines
Understand how to communicate, support and provide care for
- clients with intertwined conditions
- clients with unique cultural/social contexts and expectations
Integration/Co-location for Clients in HIV Care

Prevention
Deliver health education messages and social marketing
Use screening, HIV testing & behavioral counseling
  - Assess change readiness
  - Reduce risky behaviors
  - Promote treatment adherence
  - Link to more intensive prevention interventions
Offer prevention services to other potentially exposed individuals

Beyond the Silo
There are complex concerns/conditions that affect clients living with HIV, and addressing them in a holistic manner is an essential component of HIV care
Integrating services across biomedical, behavioral, and social spheres can reduce health disparities and improve both HIV outcomes and overall health and wellness
Integration is not always quick or easy, but the barriers to integration can be overcome with leadership/vision, shared values, ongoing communication, and widespread staff/client engagement

CIHS Framework for Levels of Integrated Healthcare
Laura Galbreath, M.P.P.
Director, SAMHSA-HRSA Center for Integrated Health Solutions (CIHS)
National Council for Behavioral Health
The care a patient experiences as a result of a team of PC & BH clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.*

Lexicon for Behavioral Health and Primary Care Integration, AHRQ

Behavioral health care can include mental health care, substance abuse care, & health behavior change.

The Difference Between Integration and Collaboration

- **Collaboration** describes how resources (namely, the healthcare professionals) are brought together.

- **Integration** describes how services are delivered and practices are organized and managed.

Make sure everyone is on the same page...

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Coordinated Care

Level 1 — Minimal Collaboration
- Behavioral health and primary care providers work at separate facilities and have separate systems.
- Providers communicate rarely about cases.
- When communication occurs, it is usually based on a particular provider’s need for specific information about a mutual patient.

Level 2 — Basic Collaboration at a Distance
- Behavioral health and primary care providers maintain separate facilities and separate systems.
- Providers view each other as resources and communicate periodically about shared patients.
- These communications are typically driven by specific issues.
- Behavioral health is most often viewed as specialty care.

Co-Located Care

Level 3 — Basic Collaboration Onsite
- Behavioral health and primary care providers co-located in the same facility, but may or may not share the same practice space.
- Providers still use separate systems, but communication becomes more regular due to closer proximity, especially by phone or email, with an occasional meeting to discuss shared patients.
- Providers may feel like they are part of a larger team, but the team and how it operates are not clearly defined, leaving most decisions about patient care to be done independently by individual providers.

Level 4 — Close Collaboration with Some System Integration
- There is the beginning of integration in care through some shared systems.
- In an embedded practice, the primary care front desk schedules all appointments and the behavioral health provider has access and enters notes in the medical record.
- Often, complex patients with multiple healthcare issues drive the need for consultation, which is done through personal communication.
- As professionals have more opportunity to share patients, they have a better basic understanding of each other’s roles.
Integrated Care

Level 5 — Close Collaboration Approaching an Integrated Practice
- The providers begin to function as a true team, with frequent personal communication.
- The team actively seeks system solutions as they recognize barriers to care integration for a broader range of patients.
- Providers understand the different roles team members need to play and they have started to change their practice and the structure of care to better achieve patient goals.

Level 6 — Full Collaboration in a Transformed/Merged Practice
- The highest level of integration involves the greatest amount of practice change.
- Fuller collaboration between providers has allowed antecedent system cultures (whether from two separate systems or from one evolving system) to blur into a single transformed or merged practice.
- Providers and patients view the operation as a single health system treating the whole person. The principle of treating the whole person is applied to all patients, not just targeted groups.

Using the Framework

The Integrated Practice Assessment Tool, or IPAT, is an actionable tool that can guide assessment and planning.
- Where are you now?
- Where would you like to be at the end of the grant?

Five Ingredients in the Integration Recipe

Leadership buy-in and high-level project promotion is important from the very start.
- Focus on the business case and organizational partnerships early.
- Use of structured quality improvement methodologies is critical to support the multiple layers of change required for success.
- Every community is unique and requires careful adaptation of models used by others to meet their own unique needs.
- Start small. Consider a pilot project is often quite “energizing” as people see its benefits.
A Standard Framework for Levels of Integrated Healthcare

A shared understanding when we’re talking about integration is critical for meaningful dialogue and staff engagement in service redesign.

Lessons Learned in 2014-14PBHCI:

- Leadership
  - Executive buy-in and engagement
  - Setting staff expectations and training
  - Continuous quality improvement
- Clinical
  - Clinical registries / population management
  - Consumer/patient flow
  - Clinical guidelines and evidence-base practices
- Operations
  - Nurturing the PC/BH relationships / conflict management
  - Clarity in policy and procedures
  - EHRs and care coordination

Lessons Learned cont.

- Wellness
  - Activating individuals to support self management
  - Embedding wellness across the organization
  - Evidence-based interventions
- Financing
  - Billing and coding
  - Community partnerships
  - Sustainability strategies
- Workforce
  - Training for ALL staff
  - Importance of recruitment & retention
Adam Bryant...

Passionately curious – alert and engaged
Battle hardened confidence – ownership and perseverance
Team smarts – understands people
Simple mind set – connect the dots for new opportunities
Fearless – surprising career moves building new skills

Project FUSE: Facilitating United Service Efforts
Moneta Sinclair, Ed.D.
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POSITIVE IMPACT
FOUNDED 1993 IN ATLANTA TO PROVIDE MENTAL HEALTH SERVICES FOR PEOPLE AFFECTED BY HIV.

By 2015, each year the agency provided:
- HIV prevention services and HIV/STI testing to over 4000.
- IMPACT, licensed substance abuse treatment program, to 75.
- Behavioral Health services in 4 HIV primary care settings.
- Comprehensive behavioral health services (individual, couples, group and psychiatry) to 600.
- Training 250 behavioral health professionals.

POSITIVE IMPACT HEALTH CENTERS
POSITIVE IMPACT AND AID GWINNETT/RIC CRAWFORD CLINIC MERGED MARCH 2015.

Services at both locations include:
- HIV Specialty Care.
- Mental Health and Substance Abuse Services.
- HIV prevention and testing.
- HIV case management and advocacy.

AID GWINNETT/RIC CRAWFORD CLINIC
FOUNDED IN 1990 TO PROVIDE HIV CARE TO PLWHA IN NORTH METRO ATLANTA.

By 2015, each year the agency provided:
- HIV prevention services and HIV/STI testing to over 1500.
- HIV Specialty Care to 800 in two locations.
- Case management and patient advocacy to all patients.
- Wrap around services including transportation and housing support.
A project to bring together behavioral health, prevention and primary care.

**WHO?**
**POPULATIONS OF FOCUS**

- African American and Latino men and women, gay and bisexual men, transgendered individuals, and substance abusers.
- Veterans and their families will also be served.

**WHAT?**
**GOAL AREAS**

- Co-locating HIV primary care and behavioral health.
- Behavioral health services (mental health/co-occurring substance abuse).
- Substance abuse treatment navigation services
- Substance abuse prevention/HIV prevention: CLEAR.
- Substance abuse treatment: IOP, CCP, and CHANGE.
- HIV/Hepatitis testing, Hepatitis vaccination
- Wrap-around recovery support and retention.
**Recruitment Method**

**Identifying and Recruiting Target Population**

*Hepatitis Vaccine*

**Outreach at Various Community Sites**

*Establish Referral Sources/Co-located Agency Staff*

**Behavioral Health & Primary Care Services**

*N = 900*

**Who:** Other Positive Impact Clinical Staff

**Where:** Emory IDP, AID Atlanta, AID Gwinnett, Grady IDP, GA Crisis & Access Line (GCAL)

**Screenings**

**Who:** HIV Test Counselor

**Where:** Positive Impact HIV Testing

*N = 545*

**Mental Health Services**

**Substance Abuse/HIV Prevention**

**Substance Abuse Treatment**

**HIV Primary Care**

**Hepatitis Testing**

*N = 3,831*

**Who:** Peer Counselor/Treatment Navigator

**Where:** Hope House, Making A Way, Atlanta & Fulton County Jails

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**HOW? CO-LOCATING CARE**

- Positive Impact provides all behavioral health (MH/SA, prevention and wrap-around services).

- Positive Impact utilized project funds to pay for infrastructure improvements needed to facilitate primary care: medical equipment, exam rooms, EMR.

- AID Gwinnett provides funds/staff for provision of primary care: medical supplies, labs, specialty care referrals, patient advocacy.

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**GOAL 1: CO-LOCATING HIV PRIMARY CARE AND BEHAVIORAL HEALTH**

1.1: Two exam rooms will be operational.

1.2: A minimum of one day a week of primary care will be provided.

1.3: 100% of FUSE HIV-positive consumers will be eligible to access on-site primary care services.

1.4: Between 50 and 75 consumers annually will receive primary care services at the Positive Impact offices.

1.5: Behavioral health consumers enrolled in primary care will receive medical case management.
GOAL 2: HIV/HEPATITIS TESTING, HEPATITIS VACCINATION.

2.1: HIV testing (CDC-funded) will be provided for 120-160 individuals annually, 100% of whom will be screened for behavioral health (MH and SA issues).

2.2: FUSE consumers testing positive for HIV will be linked to medical care and receive follow-up by the Nurse Case Manager.

2.3: 175 consumers per year will be provided with SAMHSA-funded tests for Hepatitis B and C.

2.4: Consumers testing positive for Hepatitis A, B or C will be linked to medical care and receive follow-up by the Nurse Case Manager.

2.5: 50 consumers per year will receive the SAMHSA-funded vaccination series.

PROGRESS TOWARD CO-LOCATING SERVICES

- Exam rooms are built and medical equipment and supplies are in place.
- A single point of contact and process was created to schedule patients.
- HIV specialty care began in January 2015 one day per week.
- A nurse case manager has been hired.
- Demonstrations and needs assessment for behavioral health services are beginning with Cerner, the new EMR currently utilized by AID Gwinnett.

CHALLENGES IN BEGINNING CO-LOCATED CARE

- Inadequate staffing for the midtown clinic. More medical and patient advocacy staff are needed on site.
- Need to have ability to connect patients to medication through ADAP.
- Need to have front-desk access to Cerner, the EMR.
- Need specialty medical referral sites.
- Need dedicated electrical line for vaccine refrigerator.
- Need to streamline case management process.
### COLLABORATION: CONNECTION BETWEEN PROFESSIONALS

- Medical clinic implementation meetings held bi-weekly with behavioral health and prevention departments represented.
- The nurse case manager works directly with medical and behavioral health staff.
- More formal referral processes will be created as the clinic grows.

### INTEGRATION: SERVICE DELIVERY

- Clients are able to enter primary care services through behavioral health.
- Clients are able to enter behavioral health through primary care.
- Referrals are made to primary care through a single point of contact.
- Referrals to behavioral health can be made by medical personnel or by the case manager.
- The nurse case manager keeps track of client appointments and works with clients on adherence.

### KEY CHALLENGES

- Lack of a finalized data collection instrument and determining how to enroll clients in the project.
- Lack of a unified EMR with primary care. Addressed by close coordination with AID Gwinnett staff and agency's new EMR.
- Agency merger with AID Gwinnett to become Positive Impact Health Centers. This provides additional capacity and streamlined coordination but has also required time from the project to address merger issues.
The co-location of primary care services was met with an overwhelming positive response.

Clients receiving a confirmatory HIV positive diagnosis were, immediately linked with the agency's new primary care services via the nurse case manager.

ORGANIZATIONAL MEETINGS
- Organizational meetings to develop referral processes to all FUSE programs including flow charts and training of primary staff.
- Client focus group held to identify potential challenges in enrolling individuals HIV negative into the substance abuse treatment program that is historically specifically for individuals that are HIV positive.

EXAM ROOMS
- Exam rooms have been outfitted and staff from AID Gwinnett has been operating the clinic one day a week since January 2015.
- Nurse case manager was recently hired and is being trained.
- Meeting have been held with new EMR to determine behavioral health documentation needs.
QUESTIONS AND ANSWERS

Additional Resources


Presenter Contact Information

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Additional Questions?
Contact the SAMHSA-HRSA Center for Integrated Health Solutions
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Visit www.integration.samhsa.gov or e-mail integration@thenationalcouncil.org

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