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:
  o From the perspective of expert panelists
  o From the perspective of workshop participants
Introductions
Regional Mental Health Center, Inc.

Merrillville, Indiana

PBHCI/FQS 1&2 (TJC-BH)
PBHCI/FQ 1 (TJC-BH)
PBHCI w/PCPs (w/intensive CC)
FQHC w/embedded BH (TJC and HRSA)
Integrated Med Svc & CM

John Kern, M.D.
Chief Medical Officer
Southeast Inc.
Columbus, New Philadelphia, and St. Clairsville, Ohio

Sandy Stephenson, MSW
Director of Integrated Healthcare Services

PBHCI Solo Model (TJC-BHH)  Sustained, post –grant

FQHC w/Embedded BH (TJC-BH/Ambtry/PCMH/HRSA)

New Rural PBHCI

New IHC


• Solo Model – BH/PC equal partners
• Solo model for Acute Care and Follow up in Homeless Shelter
• CMHC – Hospital System Mobile Outreach Partnership
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 assess\(^3\)
- Lack of research indicating which standards are most closely related to improved performance, patient outcomes, and cost\(^4\)
- Organization of recognition tools vary so comparison process takes time and effort\(^1,3\)

\(^1\) Burton, Devers, Berenson (2010).
\(^2\) Stange, Nutting, Miller et al. (2010).
\(^3\) Stange, Miller, Nutting (2010),
\(^4\) Alexander & Druss (2012)
Initial Working Set of Core Elements of BHH

• Considered three frameworks\(^1\):
  o CMS Health Home Service Requirements
  o Chronic Care Model (CCM), essential elements for high-quality chronic disease care
  o Four Principles of Effective Care (AIMS Center, University of Washington, 2011)

• Used an inductive process \(^2\)

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\(^1\)Alexander & Druss (May, 2012); \(^2\)Crane & Panzano, 2014
Initial Set Elaborated with Program Standards

Documents reviewed

- 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

<table>
<thead>
<tr>
<th>CARF IBHPC</th>
<th>CARF HH</th>
<th>OHH</th>
<th>TJC HH Cert</th>
<th>TJC PCMH</th>
<th>PBHCl Program</th>
<th>FQHC - HRSA</th>
<th>NCQA</th>
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## 30,000 Foot View

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<thead>
<tr>
<th>Core Elements</th>
<th>CARF IBHPC</th>
<th>CARF HH</th>
<th>OHH</th>
<th>TJC HH Cert</th>
<th>TJCP CMH</th>
<th>PBHCI Pgm</th>
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<tr>
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<td>Culturally Appropriate Care</td>
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<td>Comprehensive Care Plan</td>
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<tr>
<td>Continuing Care Strategies (Care Mgmt., Coordination, Transitional Care)</td>
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<tr>
<td>Self-Management Support</td>
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<td>Team-based Care</td>
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<tr>
<td>Full Array of Services (e.g., PH, MH, Health Promotion, LTC)</td>
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<td>Quality Improvement Processes</td>
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<td>Evidence Based Practice</td>
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<tr>
<td>Outcomes measurement</td>
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<tr>
<td>Health Info Technology/ Meaningful Use</td>
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<tr>
<td>Enhanced Access to care</td>
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</tbody>
</table>
Initial Observations

- $A \neq \checkmark$
  - 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)

- The documents reviewed include implied expectations that might get overlooked
  - It’s important to make implied expectations explicit
  - PBHCl and the Chronic Care Model (e.g., PACIC domains)

- All core elements have workforce implications

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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

• 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.\textsuperscript{6}

Self Management Support

• What others do to assist individuals with chronic illness develop and strengthen their self-management skills.\textsuperscript{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

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

* 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

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

* 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; dieticians; 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

Adapted from ACA definitions of team in Sections 2703 and 3502
## Team-based Care: Structure

<table>
<thead>
<tr>
<th>Sub-Feature</th>
<th>CARF HH</th>
<th>CARF IBHPC</th>
<th>OH H</th>
<th>TJC HH</th>
<th>TJC PCMH</th>
<th>PBHCI</th>
<th>FQHC 1 App</th>
<th>NCQA</th>
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</thead>
<tbody>
<tr>
<td>The team has a designated caseload</td>
<td></td>
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<td>✓</td>
<td>✓</td>
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<tr>
<td>Members from complementary disciplines</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Required disciplines or positions are specified (e.g., nurse care manager, embedded PCP, care coordinator)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>A leader for the team is designated</td>
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<td>✓</td>
<td>✓</td>
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<td>✓</td>
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<tr>
<td>Job descriptions are developed for all clinical and non-clinical team members</td>
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<td></td>
<td></td>
<td>✓</td>
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<tr>
<td>Team members are cross-trained</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
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<tr>
<td>The team psychiatrist or psychologist is available during all hours of operation</td>
<td>✓¹</td>
<td>✓¹</td>
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<tr>
<td>Required services</td>
<td>See Full Array of Services</td>
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¹ Term “team” does not appear in FQHC regulations;
² Can be provided via consultation
# Team-based Care: Process

<table>
<thead>
<tr>
<th>Sub-Feature</th>
<th>CARF HH</th>
<th>CARF IBHPC</th>
<th>OHH</th>
<th>TJC HH Cert</th>
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<th>PBHCI Pgm</th>
<th>FQHC</th>
<th>NCQA</th>
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<tbody>
<tr>
<td>Service delivered in integrated way</td>
<td>✓</td>
<td>✓</td>
<td>✓¹</td>
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<tr>
<td>Patient-centered approaches used</td>
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<td>See Person-Centered Care</td>
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<tr>
<td>Warm handoffs are provided to clients</td>
<td>✓</td>
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<tr>
<td>All team members review care plans</td>
<td>✓</td>
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<td>✓</td>
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<tr>
<td>Coverage plans for absent disciplines or team members are specified</td>
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<tr>
<td>Team members follow written procedures for collaborating with</td>
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<td>✓</td>
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<td>external providers</td>
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<tr>
<td>A structured approach is used to foster communication among</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
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<tr>
<td>team members (e.g. written procedures, team meetings, HIT)</td>
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<tr>
<td>Care Management., Care Coordination, Transitional Care</td>
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<td>See Continuing Care Strategies</td>
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¹ Integrated delivery may involve different approaches (face to face, video conferencing, telephone)
## Six Levels of Collaboration

<table>
<thead>
<tr>
<th>COORDINATED</th>
<th>CO-LOCATED</th>
<th>INTEGRATED</th>
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<tbody>
<tr>
<td><strong>Level 1:</strong> Minimal Collaboration</td>
<td><strong>Level 2:</strong> Basic Collaboration (at distance)</td>
<td><strong>Level 5:</strong> Close Collaboration (approaching integrated practice)</td>
</tr>
<tr>
<td><strong>Level 3:</strong> Basic Collaboration (on-site)</td>
<td><strong>Level 4:</strong> Close Collaboration (on-site; some system integration)</td>
<td><strong>Level 6:</strong> Full Collaboration (transformed/merged/IHC practice)</td>
</tr>
</tbody>
</table>

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 Continuum\(^9\)

**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

\(^9\)Adapted from Boon et al, 2004.
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

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