



# **Behavioral Health Aspects of Integrated Care**

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# International Comparison: 10,000' View

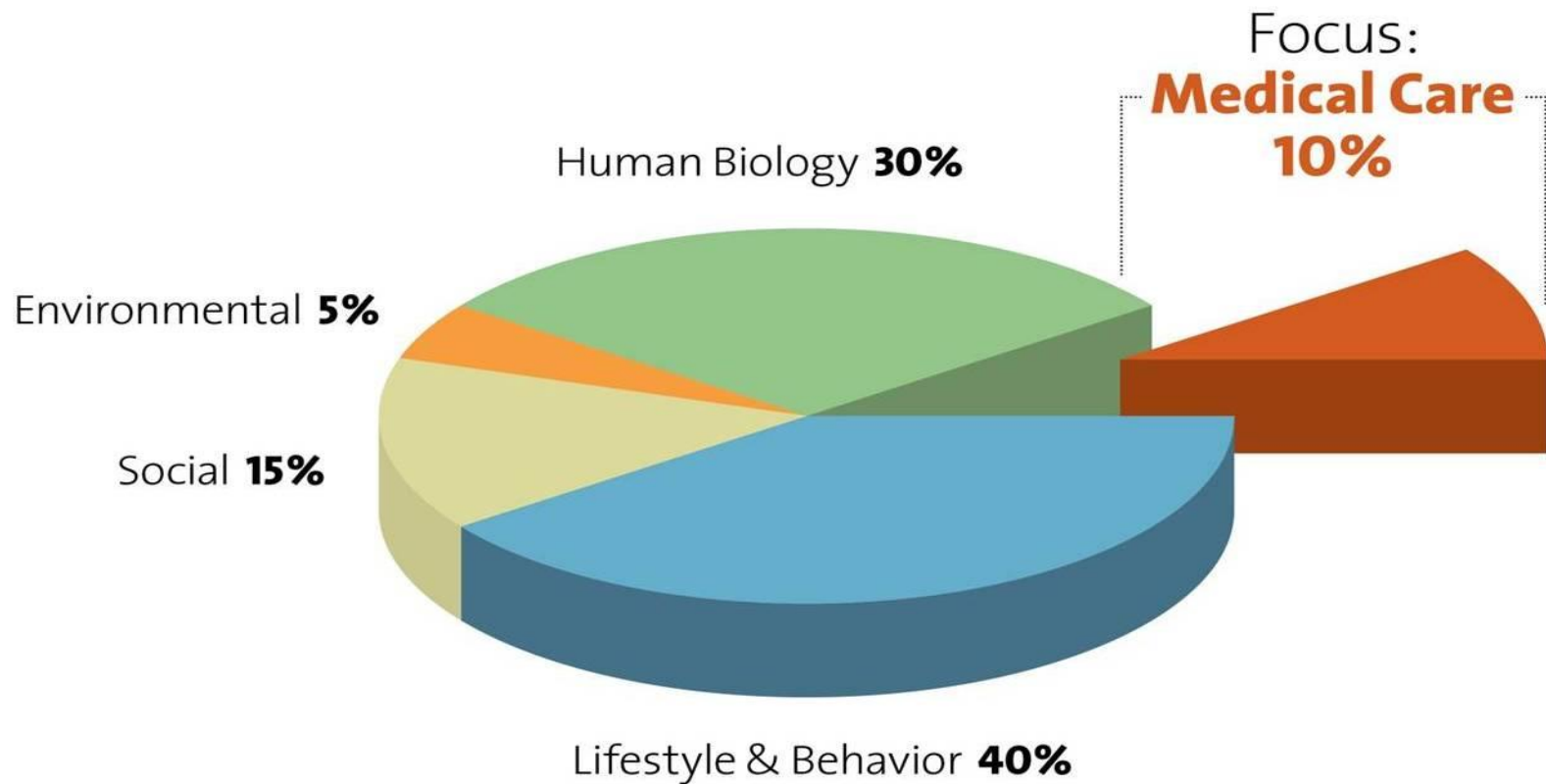
- National health system models (The Healing of America, T.R. Reid)
- US compares poorly with OECD countries (Gapminder.org)
- Impact of income inequality (Spirit Level, Richard Wilkinson)

# Goal: Triple Aim

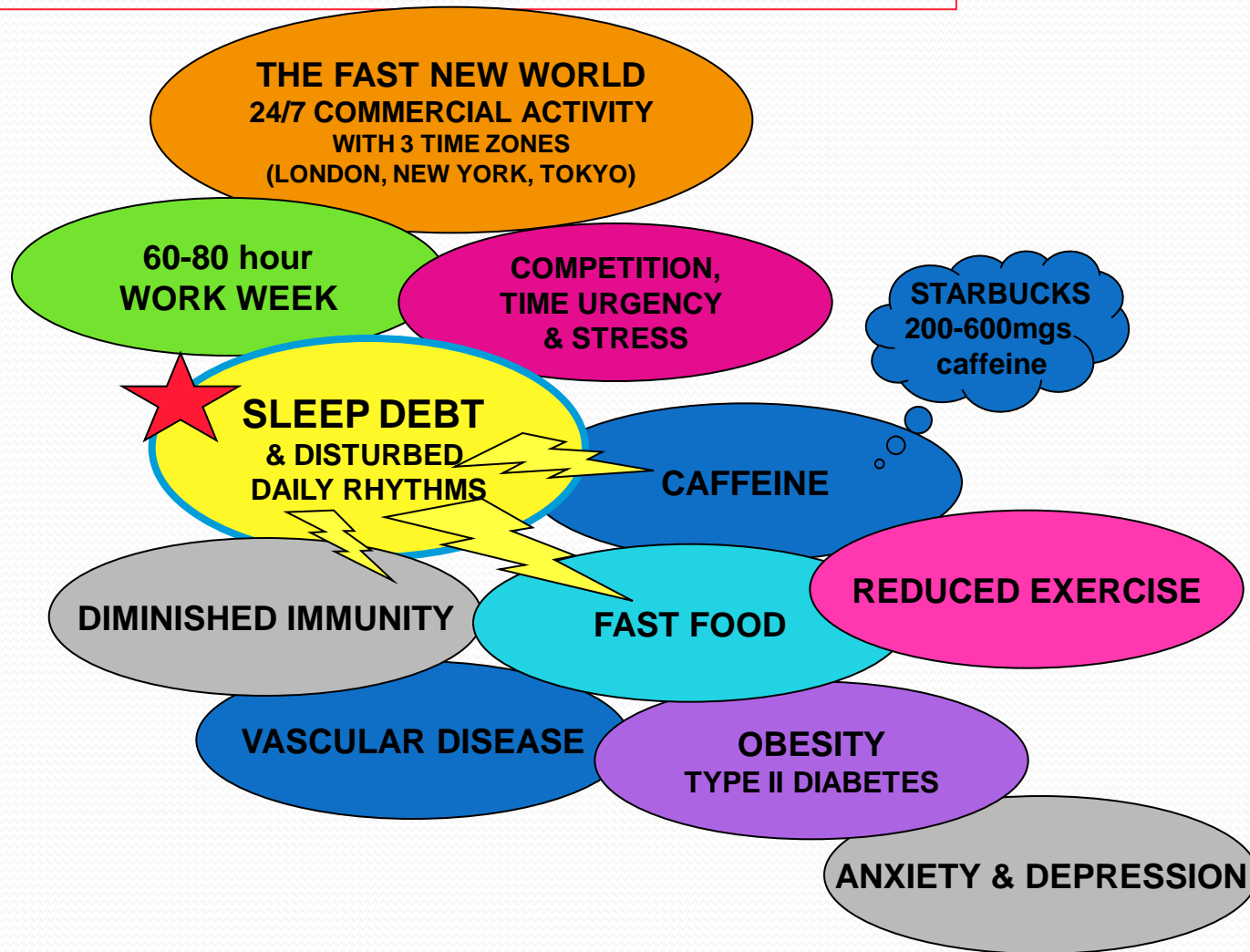
## A New Vision For Health

**1 Better health.**

# Can We Shift Focus To Population Health?



# Time Urgency & a Cascade Of Unintended Health Consequences



Social Organization and Health Pathology in the Fast New World

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**The  
Economist**

DECEMBER 13TH 2003

www.economist.com

Gore anoints Dean

PAGES 12 AND 13

America's Taiwan test

PAGE 12 AND 20

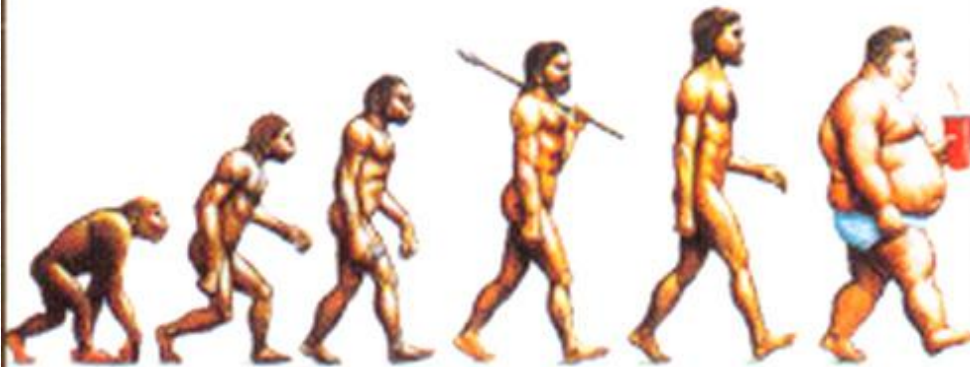
The future of flight

PAGES 19-41

A SURVEY OF FOOD

START PAGE 10

# The shape of things to come



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**America  
is at the leading edge  
of an unusual human experiment**

In 1975 Americans spent approximately 8% of GNP on health care and 15% on food.

Today we spend 15% on health care and 8% on food.

But, in 5-8-12 NYT:  
**“Bans on School Junk Food  
Pay Off in California”**

**The twentieth century may yet be remembered  
as one of monstrous mass feeding.**

**M. F. K. Fisher  
The Art of Eating, 1989.**

# Goal: Triple Aim

## A New Vision For Health

- 1 **Better health.**
- 2 **Better care.**

# Better Care Elusive: Can We Get It Together?





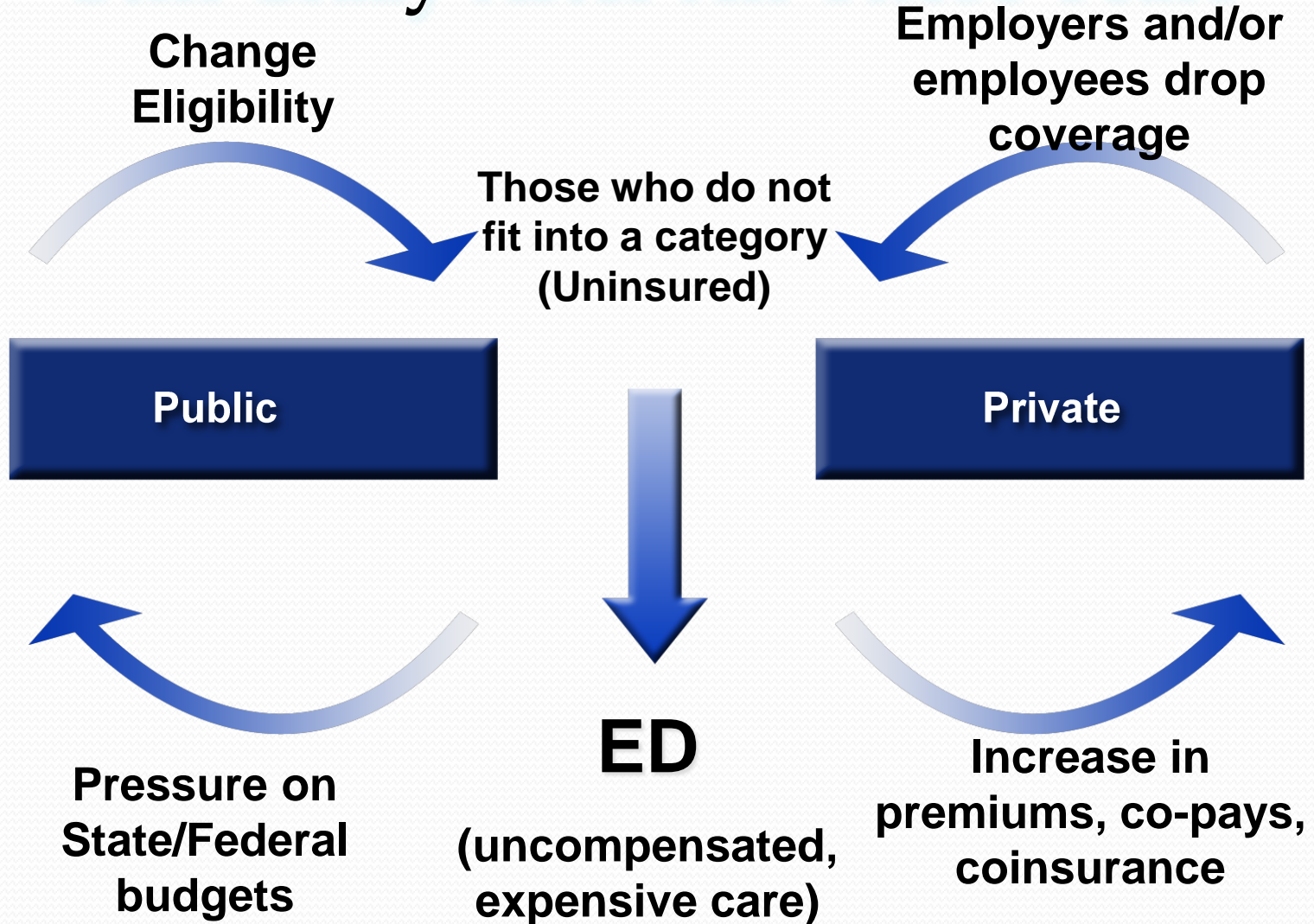
# Goal: Triple Aim

## A New Vision For Health

- 1 **Better health.**
- 2 **Better care.**
- 3 **Lower costs.**

# Costs Shifting:

## Still Crazy After All These Years



# Models for Integration

- **Critical concepts:**
  - Patient-centered Primary Care Home
  - Health Care Team
  - Stepped Care
- **Care Model:** redesign of care system for improved quality (How to organize these functions)
- **Four Quadrant Clinical Integration Model:** population/severity focused tool for identifying locus and intensity of care (Who does what, with whom, and where)

# **Patient-centered Primary Care Home**

- **Access To Care**
- **Accountability**
- **Comprehensive Whole Person Care**
- **Continuity**
- **Coordination And Integration**
- **Person And Family Centered Care**

# Patient-Centered Primary Care Home (PCPCH) Attributes

## **ACCESS TO CARE**

*“Be there when we need you.”*

## **ACCOUNTABILITY**

*“Take responsibility for making sure we receive the best possible health care.”*

## **COMPREHENSIVE WHOLE PERSON CARE**

*“Provide or help us get the health care, information, and services we need.”*

## **CONTINUITY**

*“Be our partner over time in caring for us.”*

## **COORDINATION AND INTEGRATION**

*“Help us navigate the health care system to get the care we need in a safe and timely way.”*

## **PERSON AND FAMILY CENTERED CARE**

*“Recognize that we are the most important part of the care team - and that we are ultimately responsible for our overall health and wellness.”*

# PCPCH Measures

## **Access To Care**

- In-Person Access
- Telephone and Electronic Access
- Administrative Access

## **Accountability**

- Performance Improvement
- Cost and Utilization

## **Comprehensive Whole Person Care**

- Scope of Services

## **Continuity**

- Provider Continuity
- Information Continuity
- Geographic Continuity

## **Coordination And Integration**

- Data Management
- Care Coordination
- Care Planning

## **Person And Family Centered Care**

- Communication
- Education and Self-Management Support
- Experience of Care



### ***Advanced Primary Care Home***

- Mature performance improvement capacity and ability to manage populations of patients
- Accountable for quality, utilization and cost of care
- Meets most Tier 2 and Tier 3 measures and many “additional” measures

### ***Intermediate Primary Care Home***

- Demonstrates performance improvement
- Additional structure and process improvements
- Meets many Tier 2 or Tier 3 measures
- Meets some “additional” measures

### ***Basic Primary Care Home***

- “Foundational” structures and processes in place
- Meets all Tier 1 measures

# Health Care Team

- Doctor-patient relationship replaced with team-patient relationship
- Team members share responsibility for patient care
- Role definition and interoperability



# Stepped Care Principles

- Least disruptive
- Least extensive for positive results
- Least intensive for positive results
- Least expensive for positive results
- Least expensive in terms of staff training required to obtain results

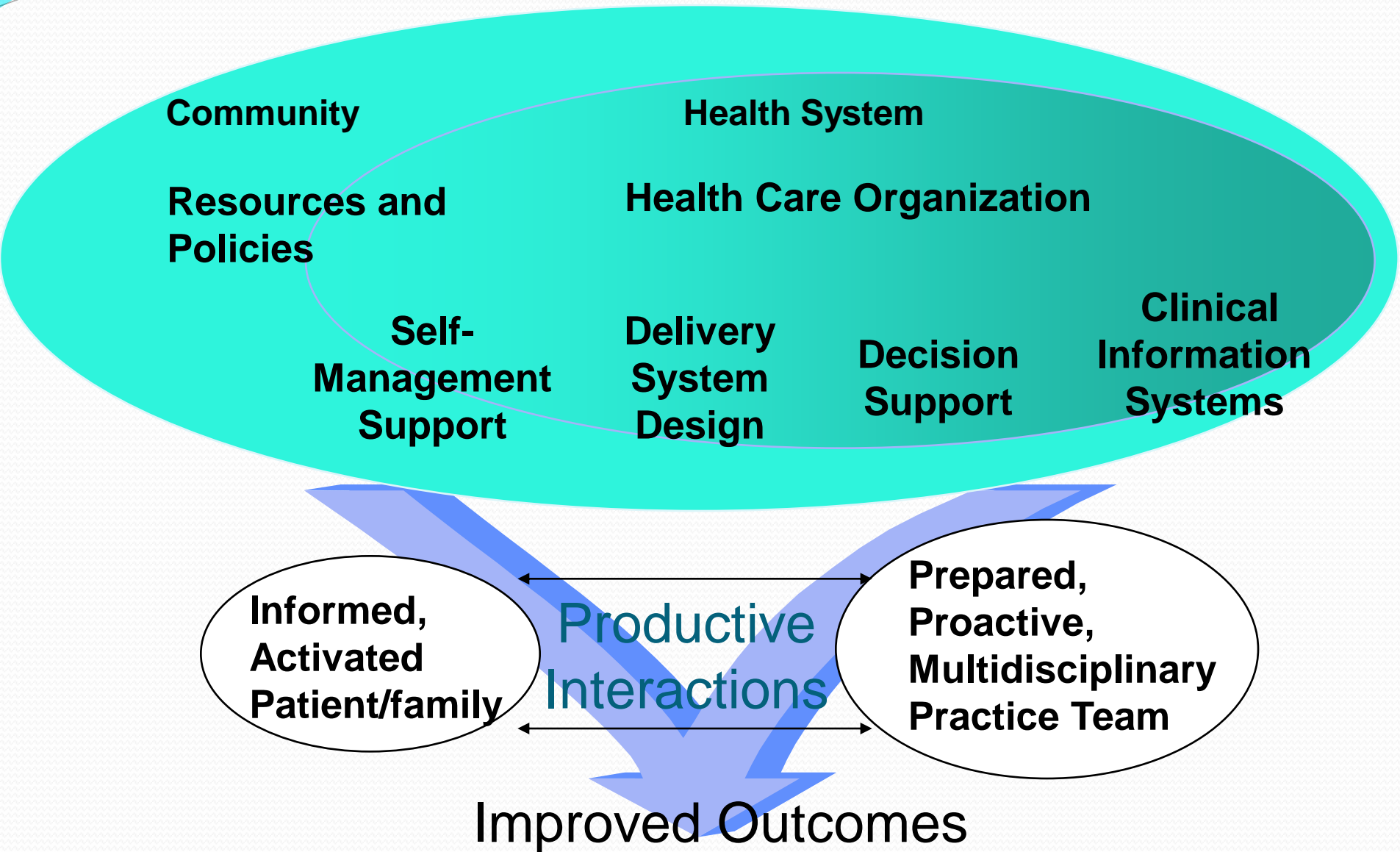
# Stepped Care Levels

1. Basic education: info sharing & referral to self-help resources
2. Clinicians provide psycho-educational & motivational support
3. BH specialists use specific practice algorithms
4. Referral to external specialty or higher level BH providers

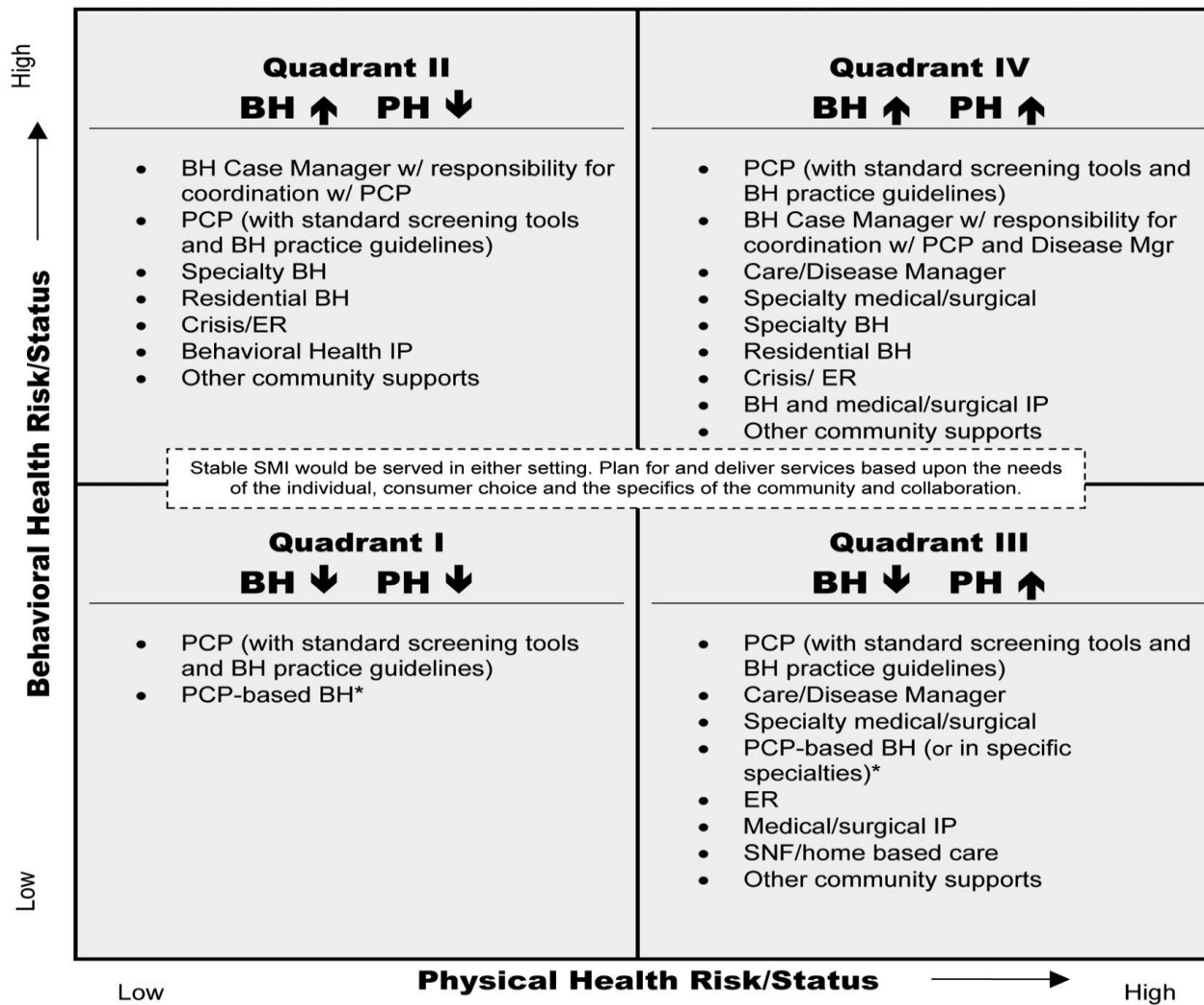
# Care Model

- Good outcomes result of productive interactions btw/ informed, activated pt/family and prepared, proactive practice team
- Model developed by Wagner, et al, at Improving Chronic Illness Care

# Care Model



# The Four Quadrant Clinical Integration Model



\*PCP-based BH provider might work for the PCP organization, a specialty BH provider, or as an individual practitioner, is competent in both MH and SA assessment and treatment

# Implementation Tasks

- Complete environmental scan
- Determine program's capacity and "filters"
- Establish administrative and clinical leadership  
"buy-in"
- Decide whether to rent or own BH staff
- Determine staffing pattern and BH tasks
- Define BH specialist skills

# Clinical Tasks

- Triage
- Comprehensive assessment
- On-site treatment
- Referral
- Consultation
- Care monitoring & condition management
- Treatment/medication optimization
- **The key is balanced management of these tasks!**

# Staffing the Model

- Behavioral health professional (Masters or higher)
- Psychiatric provider (for diagnostic and tx insights, not just for meds)
- Non-BH personnel trained to provide specific support functions



# Utilization of Non-Traditional Health Workers:

## Community Health Workers, Peer Wellness Specialists, Personal Health Navigators

Role	Supplemental Training Elements	CHW	PWS	PH Nav.
1. Outreach and Mobilization	Self-Efficacy	X	X	
	Community Organizing	X		
	Group Facilitation Skills	X	X	
1. Community and Cultural Liaising	Conducting Community Needs Assessments	X		
1. Case Management, Care Coordination and System Navigation	No training elements recommended beyond core that applies to all three worker types			
1. Health Promotion and Coaching	Popular Education Methods (Community Health Workers)	X		
	Cultivating Individual Resilience (Peer Wellness Specialists)		X	
	Recovery Model (Peer Wellness Specialists)		X	
	Healthcare Best Practices (specific to fields of practice)	X (specific to field of practice)	X (specific to field of practice)	X (specific to field of practice)
	Wellness within a specific disease (Personal Health Navigator)			X
	Basic health screenings (e.g. blood pressure measurement)	X (specific to job role)		
	Motivational interviewing	X	X	

# Psychiatric Providers in Integrated Care

- **Integrated care will be an increasingly more prominent component of the care system.**
- **Roles for psychiatric providers in integrated care:**
  - **Complex case assessment**
  - **Limited direct patient care**
  - **Curbside and case-specific consultation with PCPs, BH providers, and care teams**
  - **Guidance re when and how to utilize meds: treatment optimization**
  - **Clinical supervision and training**
  - **Team and systems level administrative, policy, and service coordination functions**
- **Workforce training implications: We must train psychiatrists to be competent, creative, collaborative, and adaptive members of integrated care systems!**

# Motivational Interviewing and Stages of Change

- Applicable to a wide range of chronic illnesses
- Focused on activating patients to develop their own goals
- Tied to recognizing a patient's level of engagement and readiness to acknowledge existence and impact of health care condition, but also to identify other barriers to change.

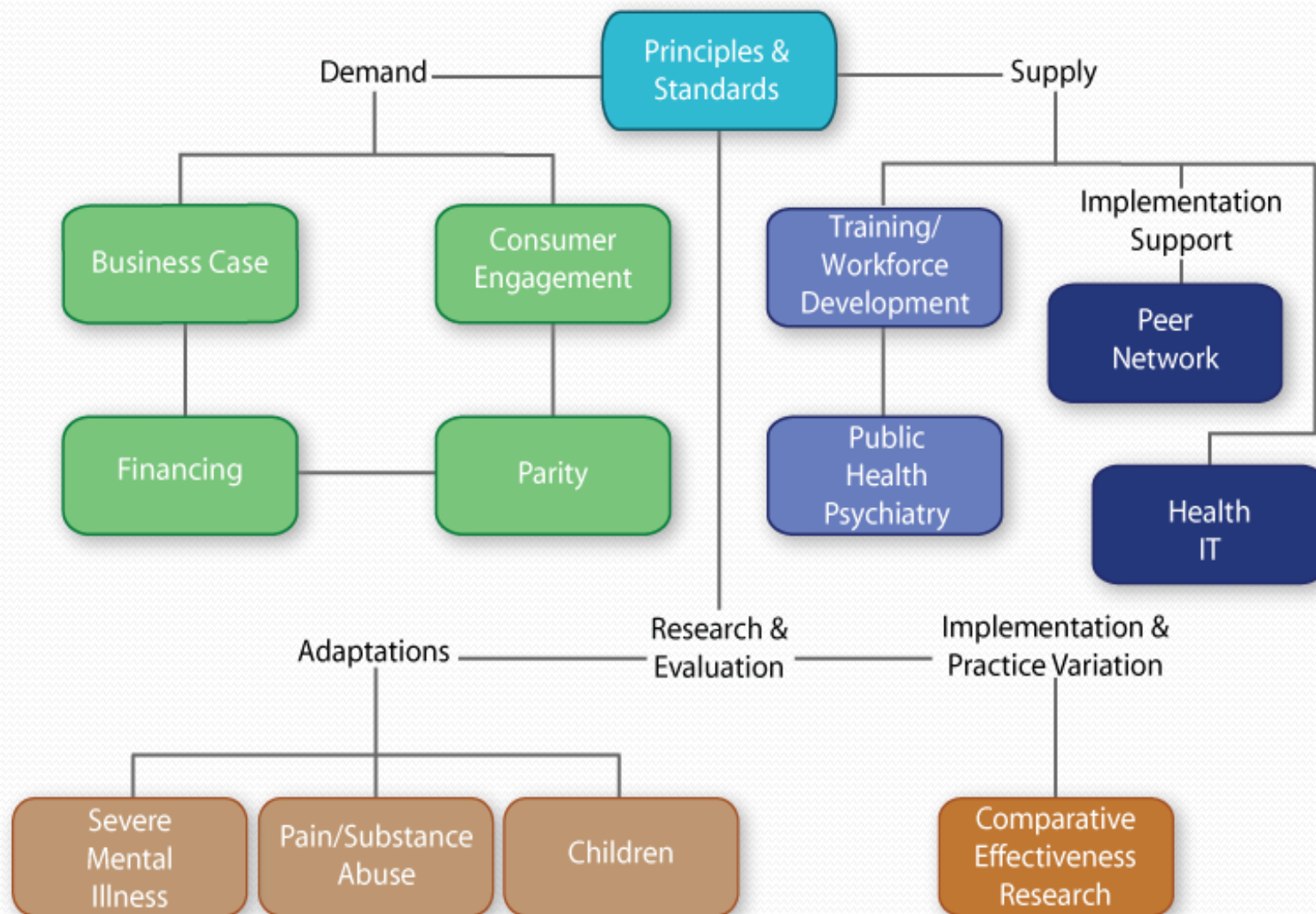
# Impact of Trauma

- Interdependence btw/ accumulated traumatic experiences and manifestations of physical, mental, and substance use symptoms.
- High prevalence of trauma-related experiences in high utilizing (hot-spotter) populations
- High incidence of dismissive stigma → denial of appropriate care
- Need for trauma-informed and trauma-sensitive care throughout the care system

# Treatment Optimization

- Recovery-oriented method that supports judicious use or non-use of psychotropic meds.
- Balanced with other effective, recovery-based services and supports.
- Primary goal is to improve/maximize self-determination, functioning, & quality/meaning of life.
- May include postponing/avoiding use of meds, sensitive & collaborative initiation of meds, timely med tapering/withdrawal, and regular reassessment to guide shared decisions re med adjustments.

# INTEGRATED BEHAVIORAL HEALTH CARE ROADMAP



# **Guiding Principle**

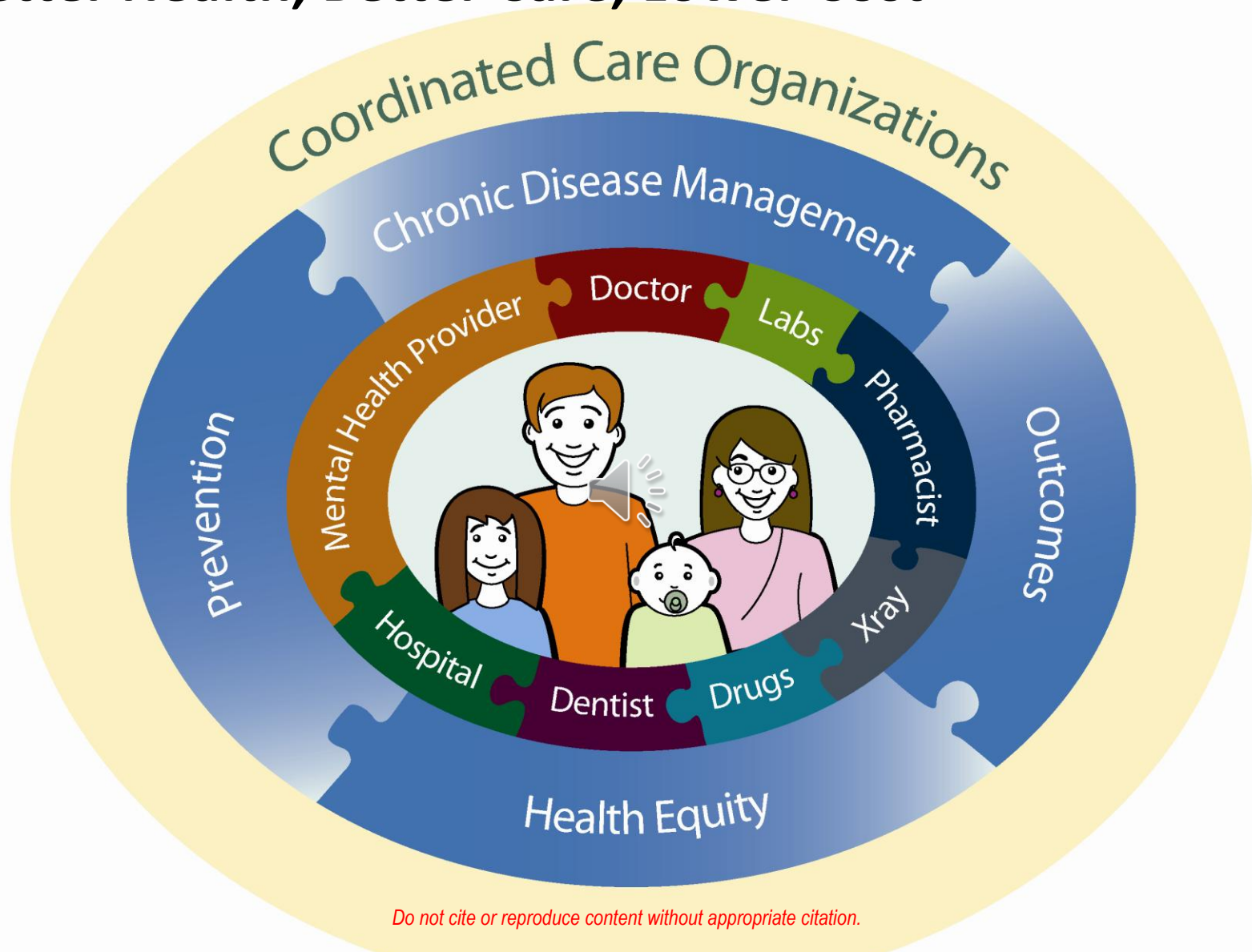
**(stolen from the feminist wo-manifesto)**

The psychiatrist who most needs liberating is the psychiatrist in every primary care provider.

The primary care provider who most needs liberating is the primary care provider in every psychiatrist.



# The Grand Finale: Better Health, Better Care, Lower Cost





# How to Cite this Presentation:

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