CENTER *for* INTEGRATIVE HEALTH

insight to innovation

Convene.
Strategize.
Activate.

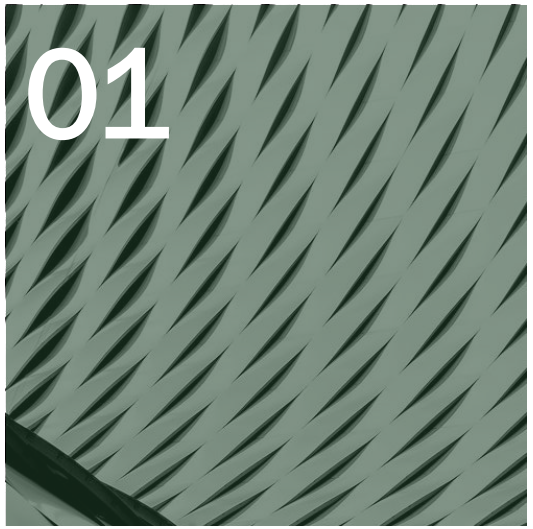
System Change and North Carolina Integration Efforts

COLLABORATING *for* CHANGE

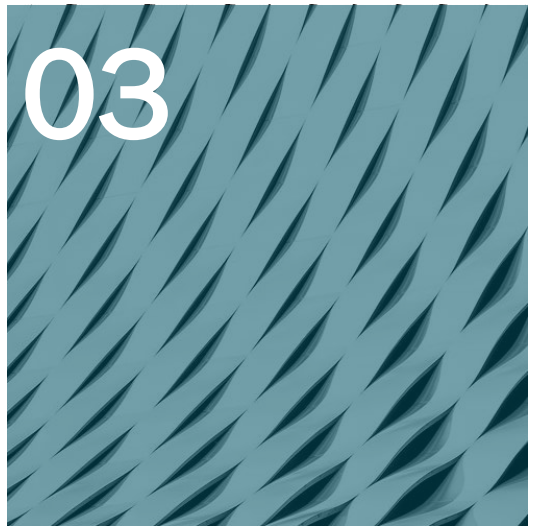
System Change and North Carolina Integration Efforts

David Hughes, PhD
President, HSRI

AGENDA



System Change Must-Haves



Lessons Learned for NC

Importance of Getting this Right

Essentials for NC Integration Efforts

What HSRI does

Behavioral Health

Intellectual and Developmental Disabilities

Aging and Physical Disability

Child, Youth and Family

Housing and Homelessness

Systems Change Essentials

1

Have a system vision

Understand complex systems

Take account of social determinants of health

Embrace meaningful consumer engagement

2

Allow for flexible models

Focus on workforce development

Track implementation

Enhance IT systems

Require data sharing / performance metrics

Importance of Getting This Right

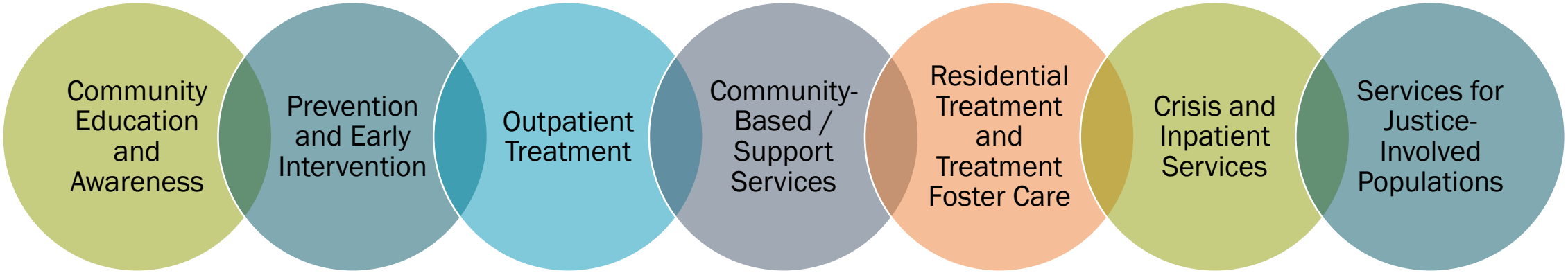
Some Numbers

- Over 70% of all BH is provided in PC settings.
- 30% to 50% of referrals from PC to specialty BH don't make first appointment.
- Only half of all persons with depression seen in PC are diagnosed and treated.
- 67% of all patients with BH disorders do not get treatment.
- 10-year delay between the onset of mental health symptoms and contact with a behavioral health provider

SYSTEM CHANGE MUST-HAVES

Must-Have #1: A System Vision

A good and modern behavioral health system spans numerous program types and agencies to provide the right mix of services at the right time to promote a recovery oriented system.



What do we mean by a "**recovery oriented system**"?

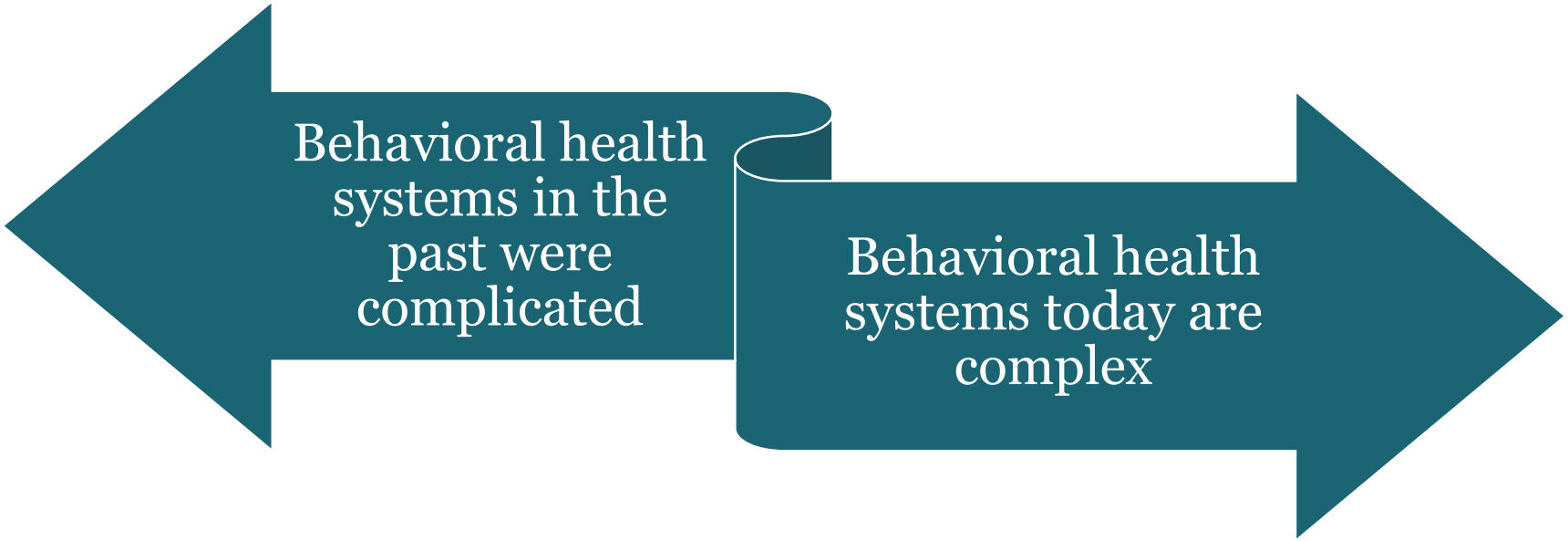
Philosophically . . .

A system that supports recovery defined as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential"

Operationally . . .

A continuum of care: services that are person-centered, that promote dignity, autonomy, and community inclusion

Must-Have #2: An Understanding of Complex Systems



. . . the difference is critical for how system design is conducted.

Complicated vs. Complex

VS.

How does this relate to systems design?

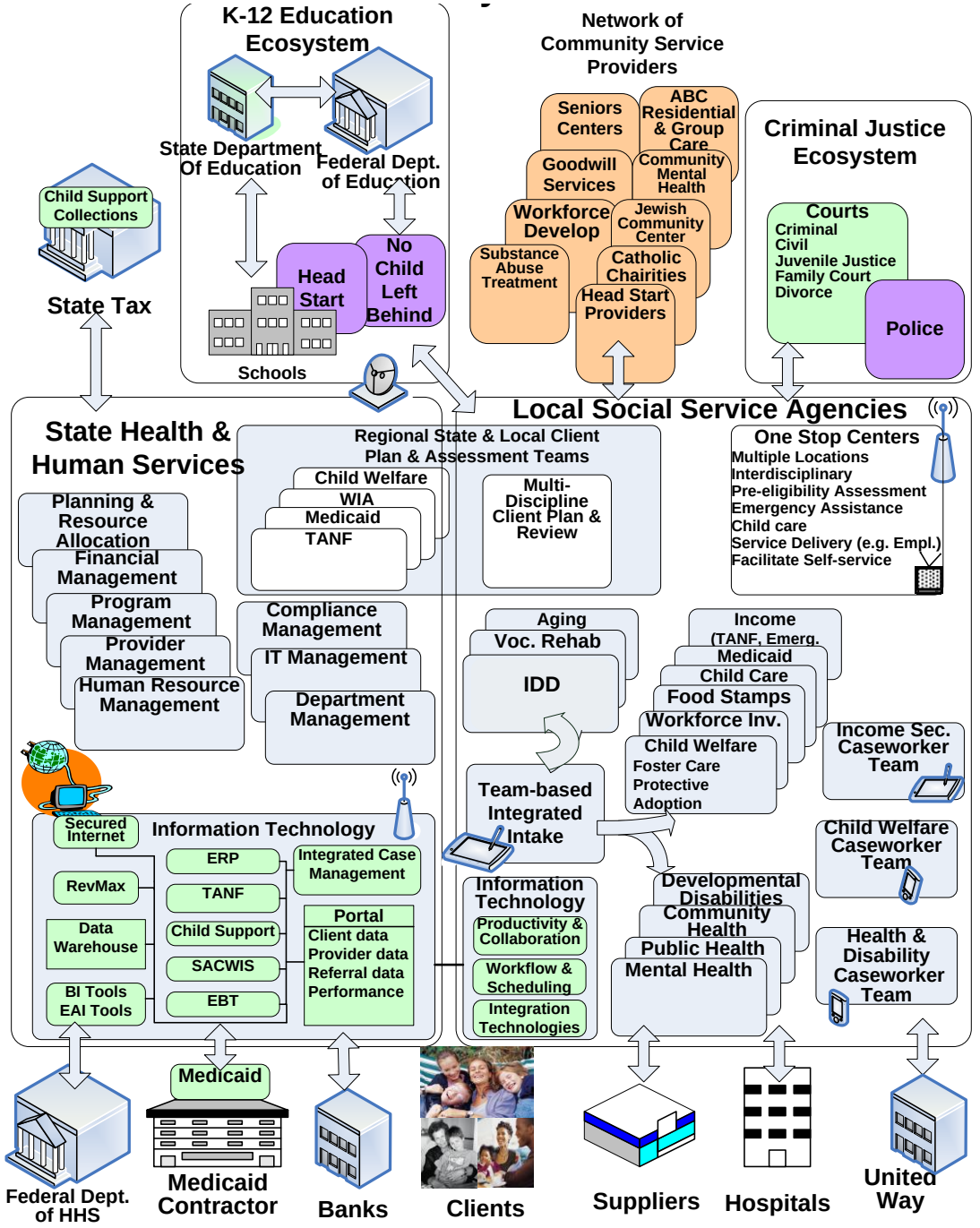
Complicated Systems: Strategies

1) Centralized Control: Top down planning
2) Hierarchical structure: Reorganize
3) Clear boundaries: Inventory the system
4) Direct causality: Flow diagrams
5) Predictable change: Modify functions
6) Similar components/incentives: Appeal to common interests

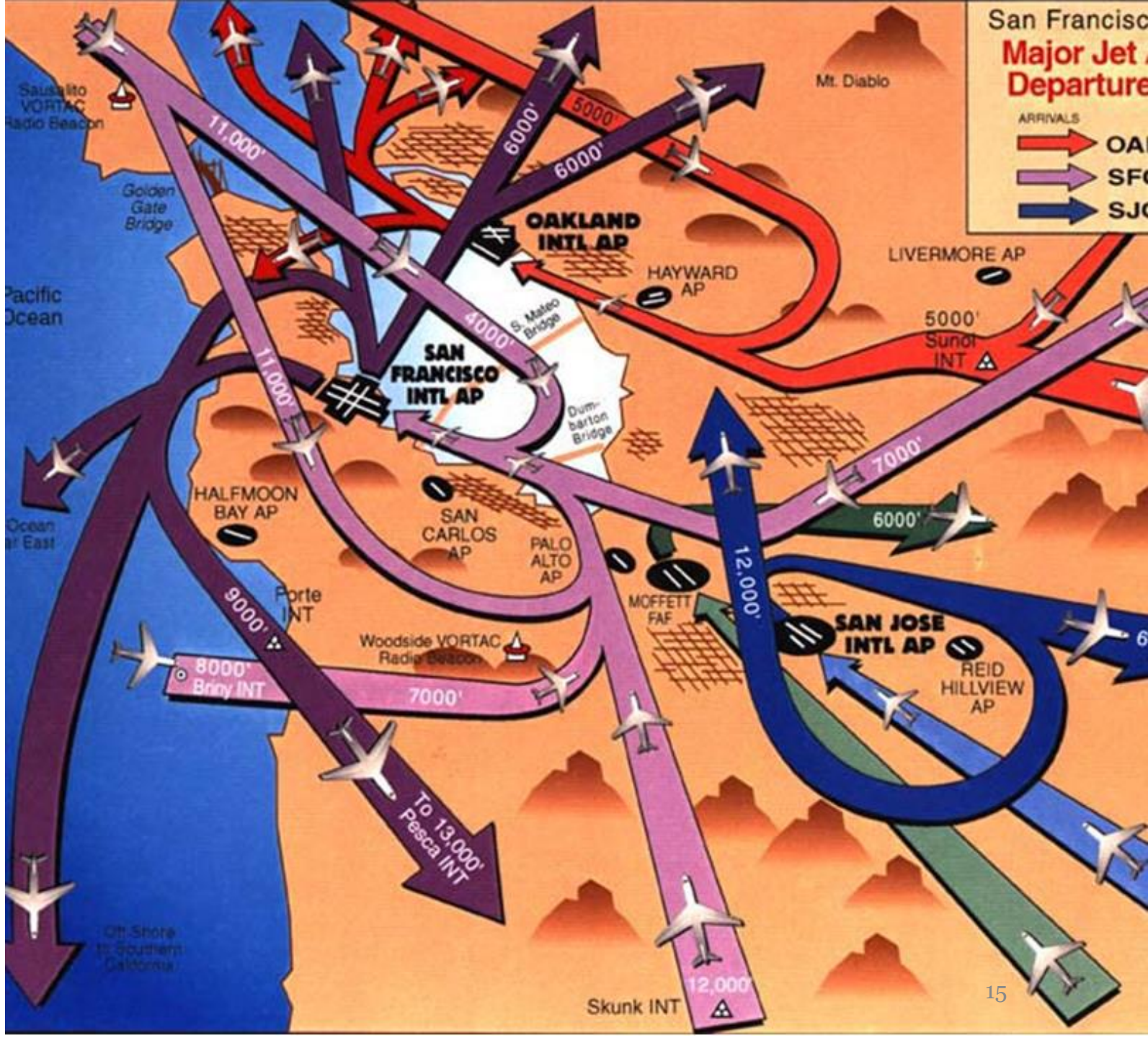
Complex Systems: Strategies

1) Independent agents: Bottom up
2) Loose structure: Linkages/Flexible models
3) Fuzzy boundaries: Define scope/metrics
4) Remote causality: Dynamic Mapping
5) Unpredictable change: Establish communication channels
6) Diverse agents and incentives: Promote consensus and align incentives to meaningful consumer outcomes

Complexity of the Health & Human Services Ecosystem



There are solutions to manage complex systems



Must-Have #3: A Way of Factoring Social Determinants of Health into System Design

"…the social factors and physical conditions of the environment in which people are born, live, learn, play, work, and age."

Office of Disease Control and Prevention. "Healthy People: Determinants of Health."
Available at https://www.healthypeople.gov/2020/about/foundation-health-measures/determinants-of-health

Social Determinants of General Health & Wellbeing

+

Social inclusion, nurturing family, good personal relationships, job and pay equity, bright clean living spaces

—

Poverty, discrimination, social exclusion, poor education, violence, substandard housing

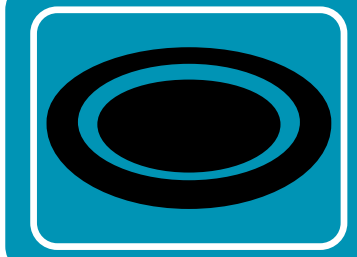
Social Determinants in a Rural State

Transportation

- Rural Americans travel farther to access goods, services, and supports
- 3.7% of rural households use public transportation compared to 17.3% overall

Education

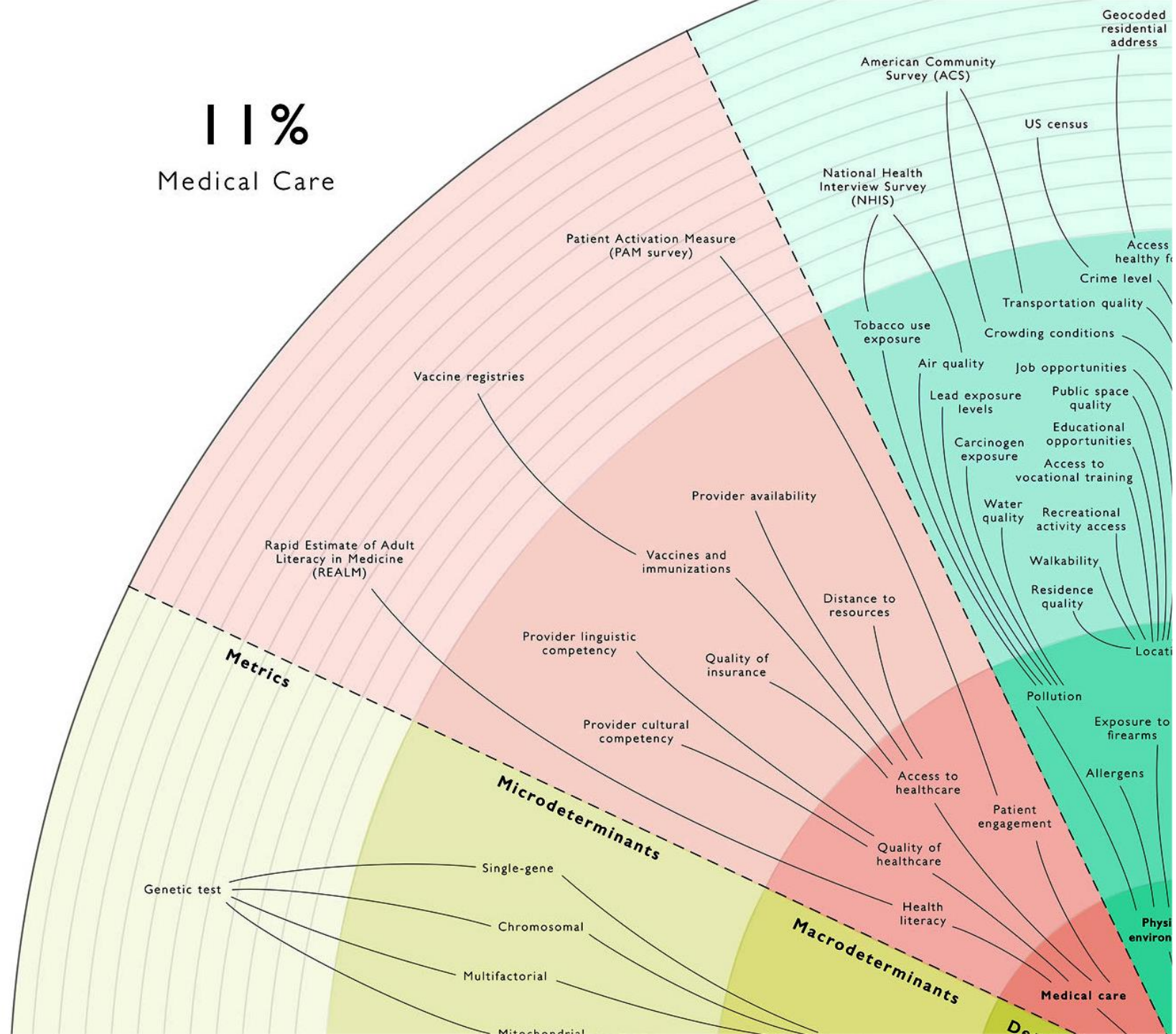
- Higher educational attainment is linked to health, access, and life expectancy
- 16.4% of rural Americans have a bachelor's degree compared with 29.8% overall



Food Insecurity

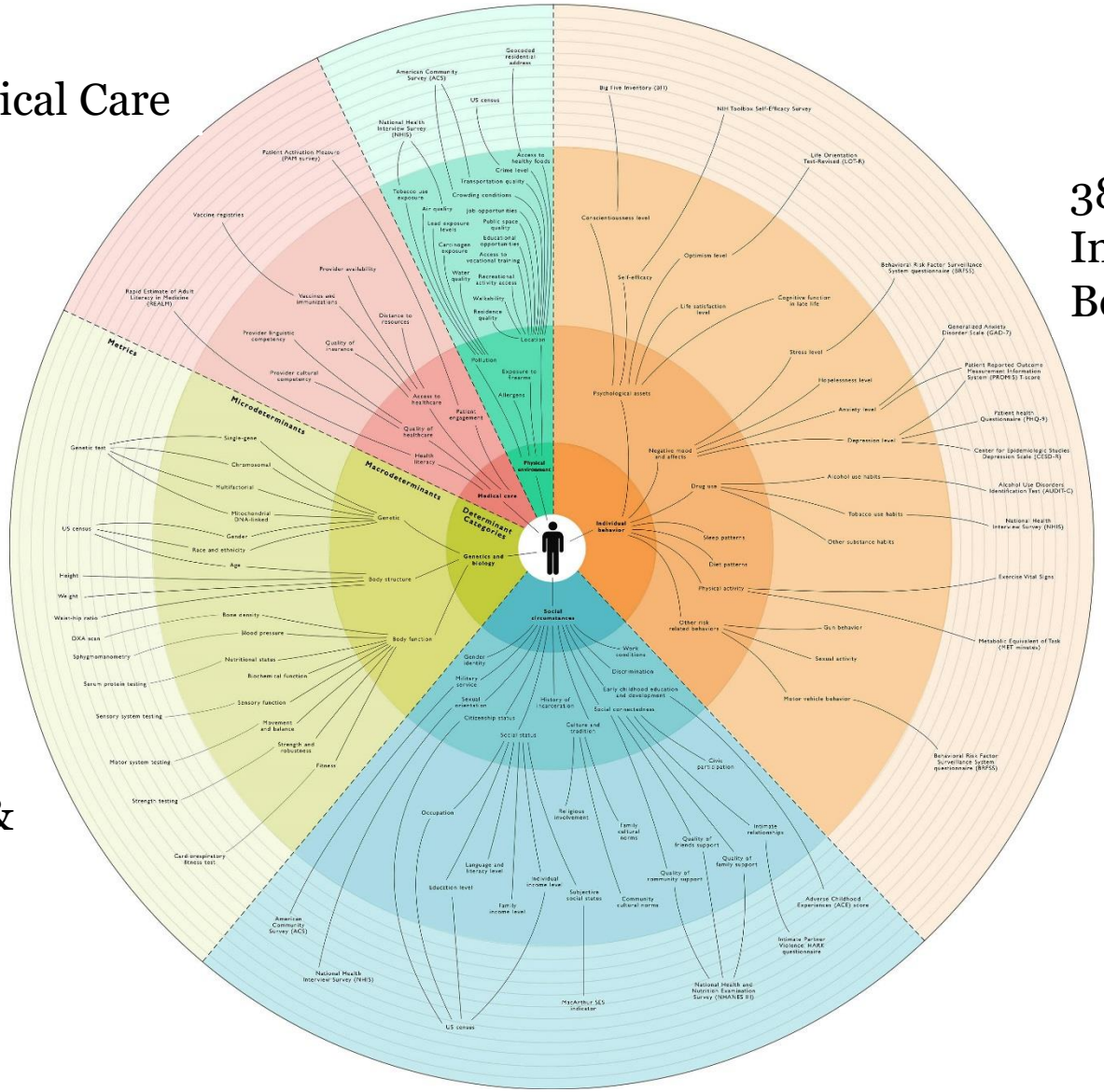
- Rural American households are more likely to experience food insecurity, and households with kids are even more food insecure

Social Determinants of Health: A Quick Reference Guide for State Offices of Rural Health and State and Territorial Health Officials. (2017). Available at http://crh.arizona.edu/publications/guide/1935


11%
Medical Care
Metrics
Microdeterminants
Macrodeterminants
Medical care
Genetic test
Single-gene
Chromosomal
Multifactorial
Vaccine registries
Rapid Estimate of Adult Literacy in Medicine (REALM)
Patient Activation Measure (PAM survey)
Vaccines and immunizations
Provider availability
Distance to resources
Provider linguistic competency
Quality of insurance
Provider cultural competency
Access to healthcare
Quality of healthcare
Health literacy
Patient engagement
National Health Interview Survey (NHIS)
American Community Survey (ACS)
US census
Geocoded residential address
Tobacco use exposure
Air quality
Crowding conditions
Transportation quality
Crime level
Job opportunities
Lead exposure levels
Public space quality
Carcinogen exposure
Educational opportunities
Access to vocational training
Water quality
Recreational activity access
Walkability
Residence quality
Pollution
Exposure to firearms
Allergens

7%
Physical Environment

11%
Medical Care



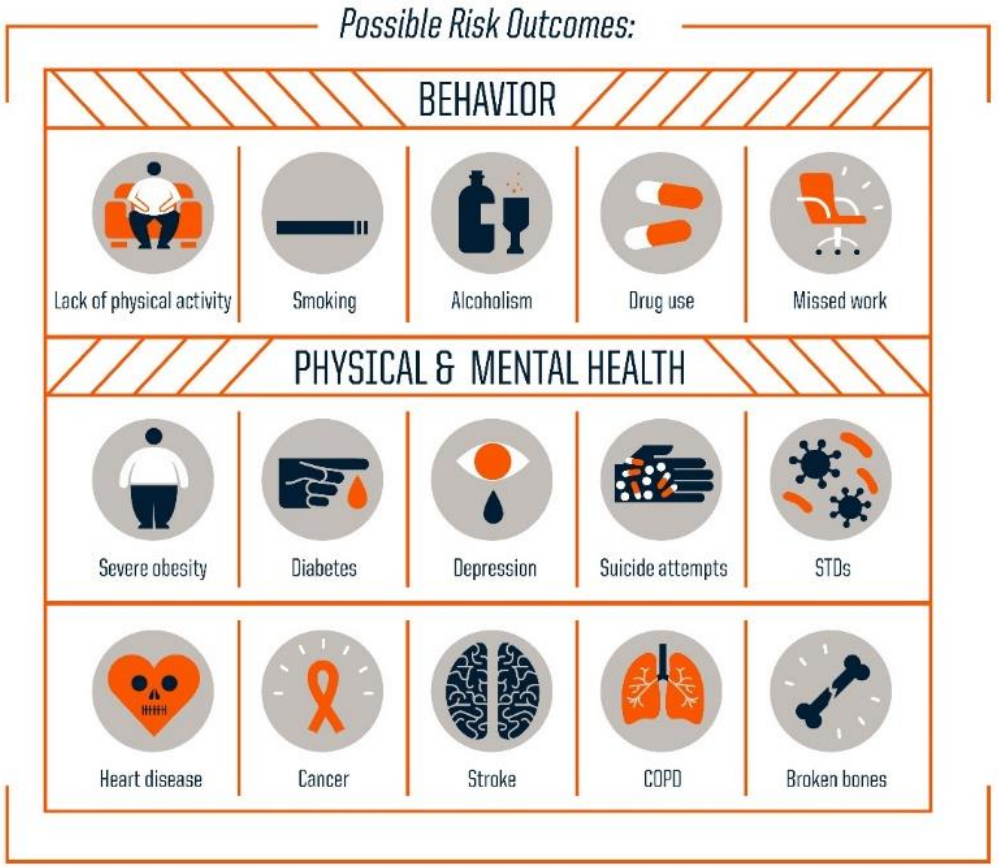
38%
Individual
Behavior

21%
Genetics &
Biology

23%
Social Circumstances

Adverse Childhood Experiences (ACES)

Kids exposed to 4 or more ACEs: **4 to 12 times more likely** to have substance use problems, depression, and suicidal behavior



(Un)employment among people with mental health-related disabilities

65% name employment as a goal,

but only 15% are employed

Barriers to employment:

- lack of appropriate support services
- labor force discrimination
- work disincentives caused by state and federal policies
- ineffective work incentive programs

Job accommodations are effective:

- Longer job tenure
- Less risk of termination

Rental Housing Discrimination:

A study of 1,000 matched pairs of individuals with no disability and individuals with a mental health-related disability

Individuals with a mental health-related issue were significantly. . .

- Less likely to receive a response to their inquiry
- Less likely to be told an advertised unit was available
- Less likely to be invited to contact the housing provider
- Less likely to be invited to see a unit
- More likely to be encouraged to look at a different unit (results in segregation)

Hammel, J., Smith, J., Scovill, S., Campbell, R., & Duan, R. (2017). *Rental Housing Discrimination on the Basis of Mental Disabilities: Results of Pilot Testing.* Available at www.huduser.gov/portal/sites/default/files/pdf/MentalDisabilities-FinalPaper.pdf

Positive Health Determinants as Vaccination and Remedy*

- Trauma-informed and trauma-sensitive approaches
- Culturally appropriate services
- Supports for social inclusion
- Focus on housing and employment
- Understand linkages between social determinants and recovery and wellbeing

Manderscheid, R. 2017. *Positive health determinants as vaccination and remedy*. Available at https://www.behavioral.net/blogs/ron-manderscheid/policy/positive-health-determinants-vaccination-and-remedy

Must-Have #4:
Meaningful Stakeholder Engagement

- "Nothing about us, without us"

  Judi Chamberlin, National Empowerment Center

- "The key to successful integrated care – especially for older adults and people with disabilities – is active, meaningful consumer engagement, since consumers and their caregivers are at the heart of everything we do"

  Dr. Robert J. Master - Former CEO, Commonwealth Care Alliance, Community Catalyst

Meaningful Consumer Engagement:
A Toolkit for Plans, Provider Groups & Communities

- Creating Buy-In and Making Consumer Engagement a Top Priority
- The Ladder Of Engagement
- Consumer Participation Within the Governance Structure
- Consumer Advisory Committees
- Member Meetings
- Recruitment for Consumer Engagement
- Checklist for Diversity, Incentives & Barriers
- Training Consumers for Engagement
- Focus Groups
- Surveys
- Effective Member Newsletters

Community Catalyst
Center for Consumer
Engagement in Health
Innovation
communitycatalyst.org

Ladder of Engagement

Community Catalyst Center for Consumer Engagement in Health Innovation communitycatalyst.org

Factors to Consider to Ensure Greater Diversity

Demographic Factors

- ❑ Age
- ❑ Gender
- ❑ Race, culture, and ethnicity
- ❑ Language spoken
- ❑ Socioeconomic factors
- ❑ Relationship status (including family and other social supports)
- ❑ Education level
- ❑ Living arrangement/type of residence
- ❑ LGBT status

Non-Demographic Factors

- ❑ Medical condition and/or disability type
- ❑ Medicaid rating category
- ❑ Services used
- ❑ Geographic location
- ❑ Primary care site

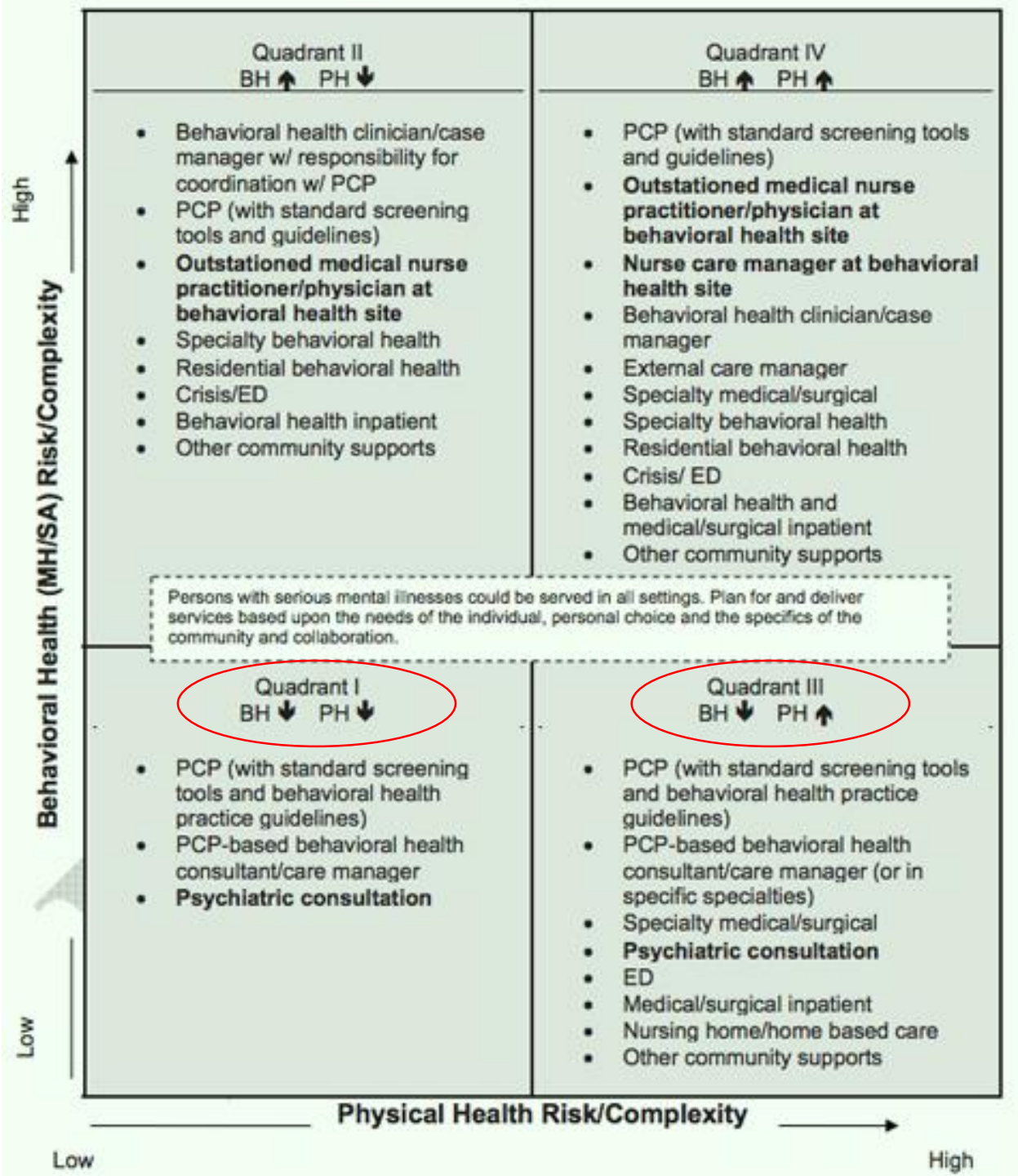
ESSENTIALS FOR NC INTEGRATION EFFORTS

Factor #1: Allow for Flexible Models

- Models By Behavioral Staffing
- Models By Levels and Type Of Collaboration
- Models By Target Population
- Examples
  - Collaborative Care Model
  - Comprehensive Primary Care Model
  - FQHC and CMHC Partnership
  - Many other emerging models

HHS Partners Integrated Care Meeting https://www.youtube.com/playlist?list=PLBXgZMI_zqfTbCNqHiRs7bOkgnmgKkZF0

Four Quadrant Model of Integrated Care



Integration Models

Quadrant	1	2	3	4
	Low Behavioral and Physical Complexity/Risk	**High Behavioral Health, Low Physical Health Complexity/ Risk**	**Low Behavioral, High Physical Health Complexity/Risk**	**High Behavioral, High Physical Health Complexity/Risk**
	Served in primary care with behavioral health staff on site.	Served in a specialty behavioral health system that coordinates with the primary care provider, or in more advanced integrated systems, that provides primary care services within the behavioral health setting.	Served in the primary care/medical specialty system with behavioral staff on site in primary or medical specialty care, coordinating with all medical care providers including disease care managers.	Served in both the specialty behavioral health and primary care/medical specialty systems.

Model Variation

- Model information provide ideas about how the “blocks” that make up an integrated healthcare system might be arranged
- There is as no single definition of the concept of integrated health care
- A 2016 literature review of integrated health care identified more than 70 terms used to describe integration and 175 definitions (Essential Hospitals Institute)
- Given the diversity of organizational, financial and cultural variations within the current health care system, there is no one-size-fits-all model

Recovery, Person-Centered Model (IBHPartners.org)

ILLNESS-CENTERED	PERSON-CENTERED
The diagnosis is the foundation	The relationship is the foundation
Begin with welcoming – outreach and engagement	Begin with illness assessment
Services are based on diagnosis and treatment needed	Services are based on personal suffering and help needed
Services work towards illness reduction goals	Services work toward quality of life goals
Treatment is symptom driven and rehabilitation is disability driven	Treatment and rehabilitation are goal driven
Recovery from the illness sometimes results after the illness and then the disability are taken care of	Personal recovery is central from beginning to end
Track illness progress toward symptom reduction and cure	Track personal progress toward recovery
Use techniques that promote illness control and reduction of risk of damage from the illness	Use techniques that promote personal growth and self responsibility
Services end when the illness is cured	Services end when the person manages their own life and attains meaningful roles
The relationship only exists to treat the illness and must be carefully restricted throughout keeping it professional	The relationship may change and grow throughout and continue even after services end

What barriers interfere with integrating care?

Clinical	Differences in primary care and behavioral health cultures, providers' lack of training, providers' lack of interest and stigma.
Organizational	Difficulties with communication and consultation across physical and behavioral health providers, the physical separation of different provider types, and primary care's orientation to treating acute problems.
Policy	Legal obstacles to sharing information* across provider systems and regulations that limit the services organizations can provide.
Financial	Complex; include issues related to the alignment of incentives in health care funding, as well as the inability to bill for key integrated services.

*www.ibhpartners.org/quality-improvement/introducing-the-behavioral-health-data-sharing-toolkit/

Factor #2: Track Implementation Closely

Factor #2: Track Implementation Closely

Level of Collaboration Dimensions:

- Level of communication between behavioral and primary care services
- Physical proximity of primary care and behavioral services
- Ease and timeliness of accessing services between behavioral and primary care services
- Availability of expertise between behavioral and primary care services
- Amount of cross-training between mental health and primary care services
- Availability of client information/records between services
- Level of care referrals between systems
- Level of understanding of each other's roles and responsibilities between services
- Degree of sharing/blending fiscal responsibilities

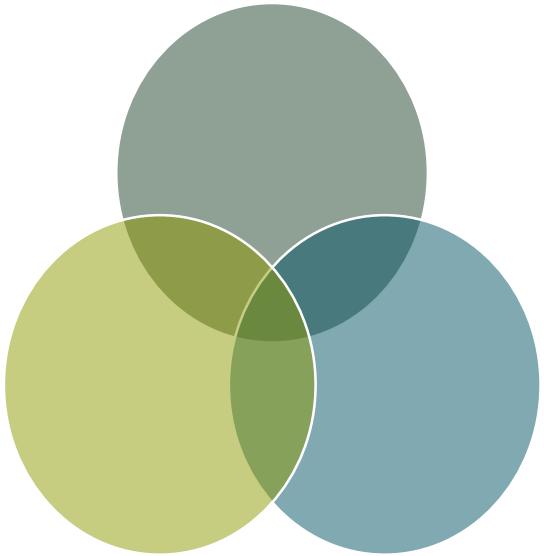
Readiness Self-Evaluation (Dale Jarvis)

Divided into

- Relationship building
- Access and outcomes
- Person-centered care
- Business infrastructure
- Consumer advocacy

Implementation Measurement

Maine Site Self Assessment (SSA) Survey



I. Integrated Services and Patient and Family-Centeredness **(Circle one NUMBER for each characteristic)**

Characteristic	Levels			
1. Level of integration: primary care and mental/behavioral health care	. . . none; consumers go to separate sites for services 1	. . . are coordinated; separate sites and systems, with some communication among different types of providers; active referral linkages exist 2 3 4	. . are co-located; both are available at the same site; separate systems, regular communication among different types of providers; some coordination of appointments and services 5 6 7	. . . are integrated, with one reception area; appointments jointly scheduled; shared site and systems, including electronic health record and shared treatment plans. Warm hand-offs occur regularly; regular team meetings. 8 9 10
2. Screening and assessment for emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse) 2. (ALTERNATE: If you are a behavioral or mental health site, screening and assessment for medical care needs)	. . . are not done (in this site) 1	. . .are occasionally done; screening/assessment protocols are not standardized or are nonexistent 2 3 4	. . .are integrated into care on a pilot basis; assessment results are documented prior to treatment 5 6 7	. . . tools are integrated into practice pathways to routinely assess MH/BH/PC needs of all patients; standardized screening/ assessment protocols are used and documented. 8 9 10
3. Treatment plan(s) for primary care *and* behavioral/mental health care	. . . do not exist 1	. . . exist, but are separate and uncoordinated among providers; occasional sharing of information occurs 2 3 4	. . .Providers have separate plans, but work in consultation; needs for specialty care are served separately 5 6 7	. . . are integrated and accessible to all providers and care managers; patients with high behavioral health needs have specialty services that are coordinated with primary care 8 9 10
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	. . . does not exist in a systematic way 1	. . . depends on each provider's own use of the evidence; some shared evidence-based approaches occur in individual cases 2 3 4	. . .evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence-based treatment depends on preferences of individual providers 5 6 7	. . . follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently 8 9 10

Factor #3 Workforce Development

Workforce development must address the need for cultural and linguistic competence, stigma reduction, and collaborative care skill development across all health care settings.

https://www.ajpmonline.org/issue/S0749-3797(18)X0003-8 Behavioral Health Workforce Special Edition

Workforce Issues

- Inadequate skills for integrated practice
- Reluctance to change practice patterns
- Lack of financial incentives to reinforce the skills required to provide integrated care
- Inadequate data on the number and distribution of healthcare workers in state and local areas
- Scarcity of clinicians in some areas, especially rural areas
- The structure of medical education programs that provide few opportunities for collaborative patient care

https://www.ajpmonline.org/issue/S0749-3797(18)X0003-8

Workforce Strategies

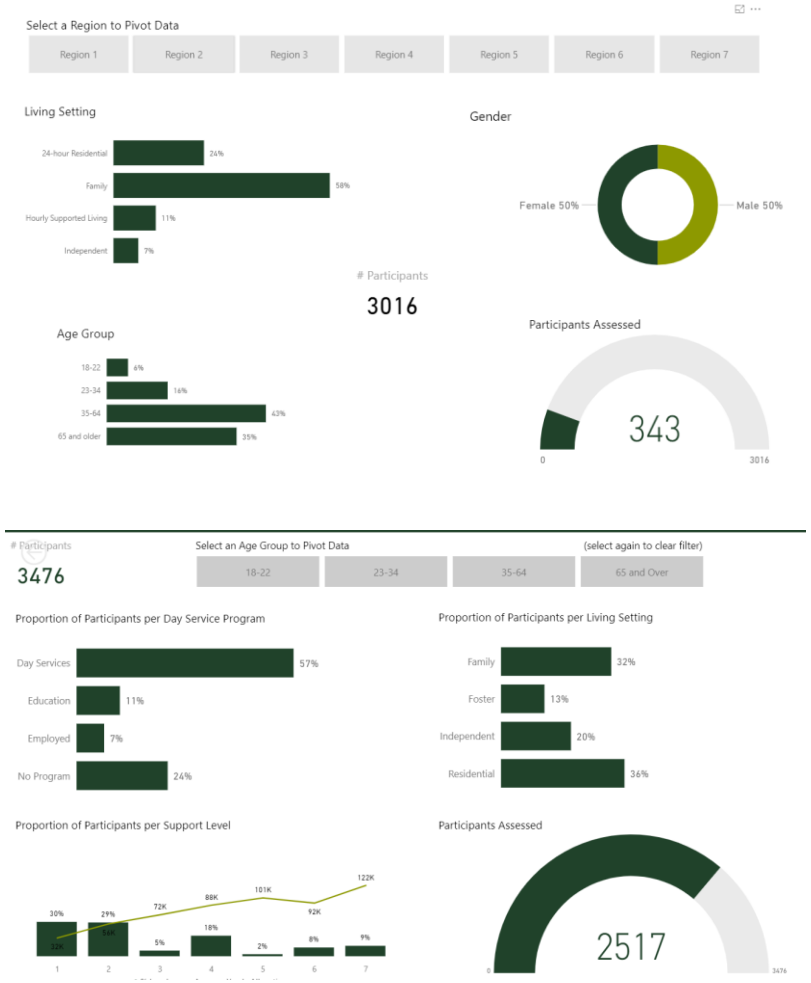
- Needs assessment studies that can identify specialty areas and staff levels that may inhibit the development of truly integrated systems.
- Work with local educational and professional associations to develop a set of core competencies that support practitioners in integrated care systems.
- Encouraging curriculum reform that provides opportunities for healthcare providers to learn and practice skills in collaborative care.

https://www.ajpmonline.org/issue/S0749-3797(18)X0003-8

Workforce Strategies cont’d

- Improve incentives for residency programs in rural and other underserved areas.
- Identify best practice models of Telemedicine and Telepsychiatry in order to extend the reach of scarce provider resources and to mitigate geographic barriers.
- Support the development of training opportunities for peer providers to establish a clear role and competencies for peer services.
- Develop mechanisms to educate clinical providers to appreciate the role of peers within an integrated healthcare system.

Factor #4: Enhance IT Systems



Maximize service planning and bring together strands of services into a single plan for achieving an individual's health and wellness.

Registries help the person-centered healthcare team track individual's self management goals and the impact of the care and supports provided.

IT Innovation: Consumer Facing

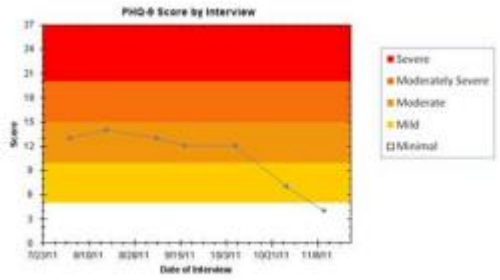
Text messaging, SMS and HIPAA compliant apps, online therapies

Benefits for consumers and providers/practice extenders

IT Innovation: Decision Support

- eConsult
- Psychiatric Project ECHO
- Remote tele-hubs
- Virtual Visits

IT Innovation: Decision Support




INTEGRATED CARE TEAM REPORT

ACTION ITEMS / INITIAL TREATMENT PLAN:

ASSESSMENT SUMMARY SCORES AND TREATMENT HISTORY

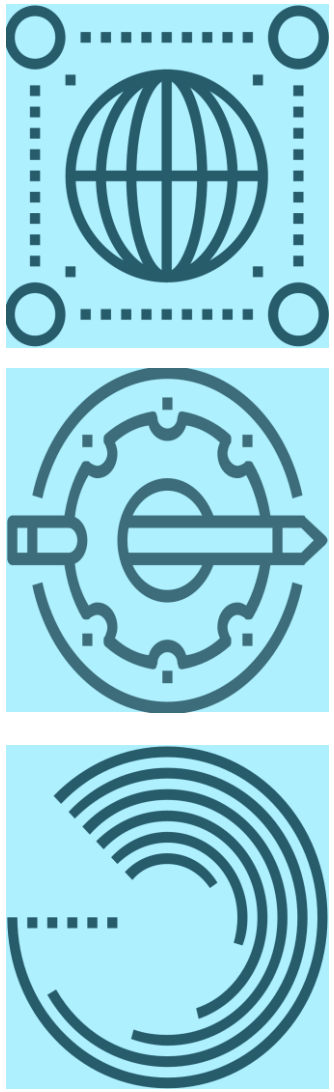
Veteran's Administration:

The *Behavioral Health Laboratory* (BHL) model involves a software-based structured assessment that results in one of three treatment recommendations: watchful waiting, initiation of treatment by the primary care provider or referral to specialty mental health care.

Follow-up support also is provided to the primary care provider.

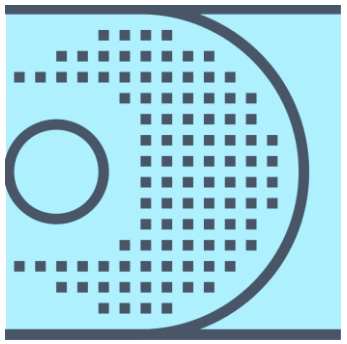
Factor #5: Require Data Monitoring/Contracts

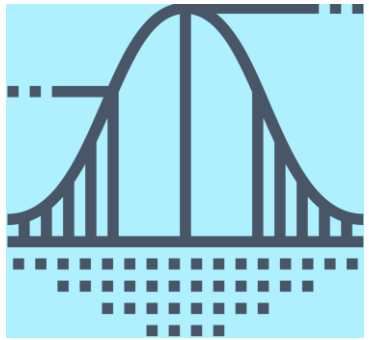
- Routinely collect and use data to inform clinical decision-making and demonstrate improved outcomes.
- Formats that allow for assessment of core functions (e.g., referral tracking, follow-up, care planning, and cross provider or system communication).
- Track whether services are making a difference in the lives of individuals and improving overall population health (i.e., moving from volume-based care to value-based care).



Sample Metrics

- Provider collaboration measures around the referral loop, data sharing and other collaboration measures
- Number receiving employment support services
- Number receiving housing support services
- Number of service users in competitive employment
- Number of service users who attain and maintain stable, integrated housing
- Number receiving housing vouchers





Sample Metrics

- Service user and health and mental health-related functioning
- Substance use disorder treatment, retention and engagement
- Utilization of and fidelity to evidence-based practices
- Rates of screening and other preventive activities
- Number of behavioral health emergency room encounters
- Rates of early intervention for individuals experiencing a first-episode of psychosis

LESSONS LEARNED

Lessons Learned

- Spend time with stakeholders early and often. **Service users** and **advocates** are key to the process
- **Providers** will need a lot of support, and their ongoing feedback will be crucial to success
- **Recovery principles** are just as important for those with mild to moderate behavioral health needs
- Spend a lot of time on the **contracts** and make sure incentives /access to data are in the right direction
- Make sure **performance metrics** are for outcomes most important to service users
- Use **registries** to close the referral loop – screening, diagnosis, referral, first appointment, tx engagement, tx completion., ongoing recovery

Lessons Learned

- Create a robust project implementation team with implementation milestones and responsibilities. Embrace implementation science and project management tools.
- It takes time to set up an infrastructure for program implementation; done appropriately, it will foster provider commitment to the model and motivation to implement.
- Seven C's: Commitment, Culture, Competency, Community, Collaborating, Consulting, Coordinating.

“

Change is disturbing when it is done to us, but exhilarating when it is done by us.”

Rosabeth Moss Kanter, Professor, Harvard Business School

Thank You

Questions Contact:
dhughes@hsri.org

HSRI

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