Trillium HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

Integrated Care | Tip Sheet

What is Integrated Care?

Fully integrated care is the idea that all of an individual's behavioral health, physical health, and unmet health-related resource needs are managed together by one interprofessional team. For example, a behavioral health provider who has been in contact with a person's primary care physician about their physical health needs can identify how these may affect their behavioral health needs during the person's first visit to the behavioral health provider. At the same time, the person's behavioral health needs are communicated to the primary care provider with consents and information in place to allow for information sharing and a joint care plan to be developed between both clinicians.[1]

Who Benefits from Integrated Care?

Everyone can benefit from integrated care, especially individuals with complex health needs such as mental and behavioral health, substance use disorders, intellectual developmental disabilities, and traumatic brain injuries who can face several other co-occurring problems at once like neurodevelopmental, neurological, and other medical conditions.1,2 When individuals have a unique set of needs, multidisciplinary care teams of professionals from diverse disciplines such as primary care physicians, psychiatrists, psychologists, neurologists, speech pathologists, special nurse educators, care coordinators, social workers, educators, and pharmacists can play an essential role in enhancing effective treatment outcomes.[2]

Models for Integrated Care

While there are several models for integrated care, there are some common frameworks:

Integrated Patient-Centered Care: Evidence-based models such as the Patient-Centered Medical Home Model (PCMH) have been linked to better quality and more cost effective care. When health services are patient centered, culturally appropriate, and team-based, they become more integrated. Care that is coordinated across settings and systems for people with greater health needs can make a difference in health outcomes and chronic health conditions can be more easily managed. The PCMH model has also supported higher patient and provider satisfaction, and increased the use of preventative care for health service users. This not only keeps health conditions from getting worse and more expensive, but also results in less of a population using higher-cost services for a greater cost-savings.[3]

Co-located Care: Care can be co-located with behavioral health providers and medical clinicians who work in different parts of the same practice building. Some of their time can be spent in the same clinic space where the behavioral health provider and medical clinician rotate their visits with the patient in the same treatment area. Co-located care is one way that professionals can work together to achieve shared workflows, culture, and different levels of collaboration to help individuals reach better health outcomes.[4]

Coordinated Care*:* Care Coordination is organized care to facilitate health service delivery.[4] The Community HUB Model connects individuals who are at-risk for negative health outcomes to health and social services. The Community HUB acts as the central enrollment organization and develops pathways to services for individuals by connecting them to care coordination agencies. Based on a person's needs, these agencies also connect individuals to other needed services such as hospitals, community-based organizations, social services, and health departments. A major benefit to these types of programs is that they avoid duplicating the same services and help different organizations work together for consumers.[5] This takes collaboration among organizations and especially departments within the same organization. When information is shared in agreement and each system works together toward the same goals, integration occurs. Finally, programs like the Community HUB Model where health data can be de-identified and aggregated to track the use of services by a target population can facilitate and improve quality measures. Having the ability to monitor and track service quality and utilization can also contribute to the development of financial models by payers such as Value-Based Purchasing.[5]

Assessing Readiness for Integrated Care

Integration occurs over time, is a process that takes an entire organization, and involves multiple components working together at the same time. While some of integration is linear, it can also be bi-directional with different processes occurring at once. Because integration is not time-limited, there are always new challenges, populations, quality improvement opportunities, and partnerships to develop.[6] The Substance Abuse and Mental Health Services Administration (SAMHSA) Health Resources & Services Administration Center for Integrated Health Solutions Organizational Assessment Toolkit for Primary and Behavioral Health Care Integration recommends four self-assessment tools for organizations to measure their readiness for integrated care: The Partnership Checklist, The Executive Walkthrough, the Administrative Readiness Tool (ART) for Primary Health Behavioral Health Integration, and the COMPASS-Primary Health and Behavioral Health.™ These tools can answer questions such as:

- How do I select a partner for integration?
- Is the organization welcoming to consumers and does it provide them with access?
- Do administrative processes support the foundation for integration such as health information technology, billing and coding, overall cost, policies and procedures, and human resources?

- Is integration language used and are processes such as Person-Centered Planning, documentation, medication management, and professional competencies and training incorporated into clinical services?
- Does the organization have quality improvement processes that can respond to rapid change and is there an action plan to support implementation and improvement?

As North Carolina shifts from a fee-for service environment towards integrated care under Tailored Plans, both the state and healthcare organizations will be in different stages of readiness. Through the Tailored Care Management model, providers and Tailored Plans will need to work closely together in new and innovative ways and collaborate across care team members, disciplines, and settings.[7] This means finding the best next steps that organizations and networks can take to join processes and create new workflows to move toward change, advance quality, and drive health outcomes. Together, we must celebrate these small steps and remember that the goal is progress, not perfection.

Resources

1. Montefiore Health System, New York Community Trust, and National Council for Mental Wellbeing: Advancing Integration of General Health in Behavioral Health Settings
2. National Institute of Health: StatPearls [Internet] Intellectual Disability
3. Centers for Disease Control: Patient Centered Medical Home Model
4. Agency for Healthcare Research and Quality: Lexicon for Behavioral Health and Primary Care Integration
5. Rural Health Information Hub: Community HUB Model
6. Substance Abuse and Mental Health Services Administration Center for Integrated Health Solutions: Organizational Assessment Toolkit for Primary and Behavioral Health Care Integration
7. Tailored Care Management for Providers