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Integrated Policy Health Care & Practice

Social Workers on the Front Line of the Opioid Epidemic
Learning Collaborative

Spring 2020 Webinar Series

Today's Presenter

Jeff Capobianco, PhD, LLP
Integrated Health Senior Consultant,
National Council for Mental Wellbeing

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Learning Objectives:

- Describe seminal policy and research that has led to a focus on integration in the US health care system
- Describe evidence-based approaches to integrated health care delivery
- Identify the role of social workers have in policy development, services planning and the delivery of integrated health care services

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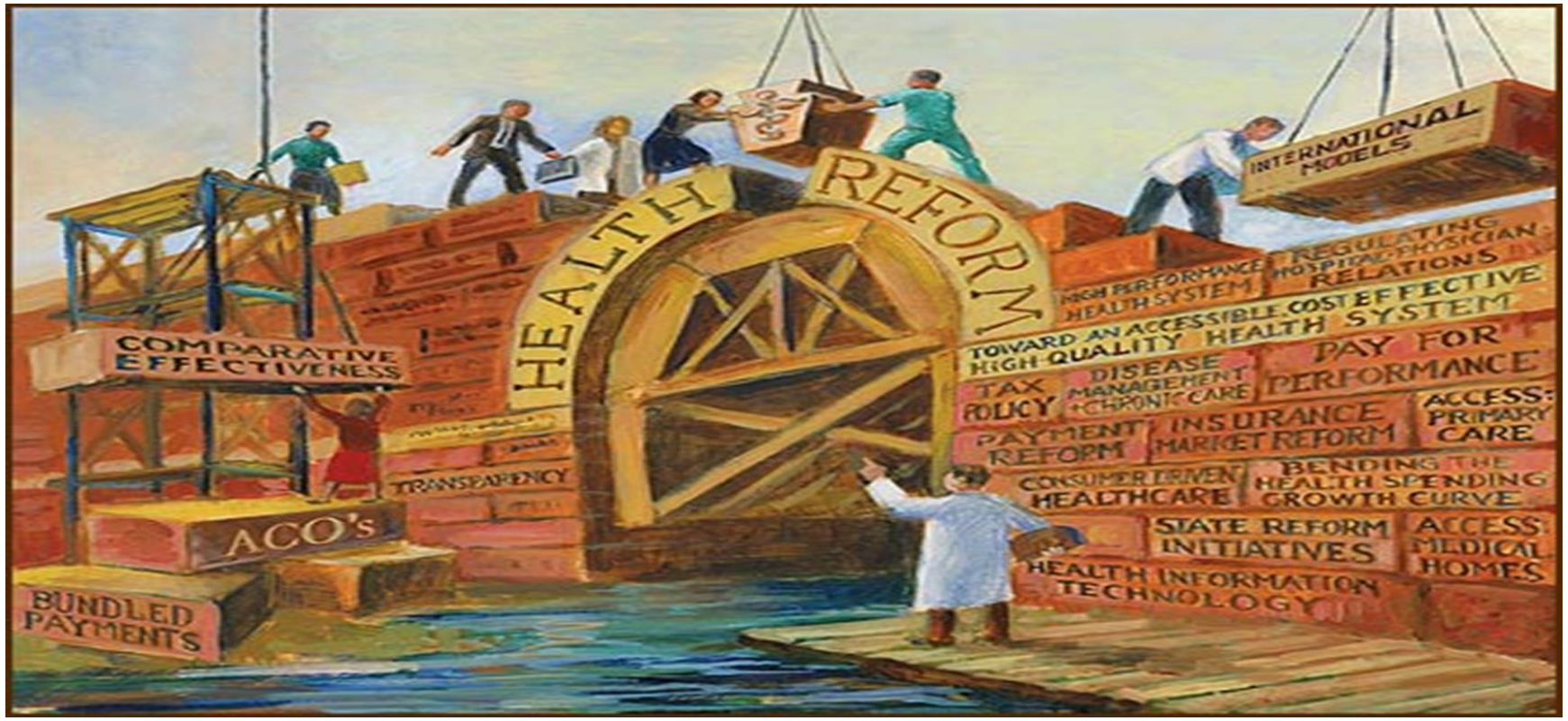
So Many Terms…So Much Still Happening!



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Discussion Question!

What is integrated health?

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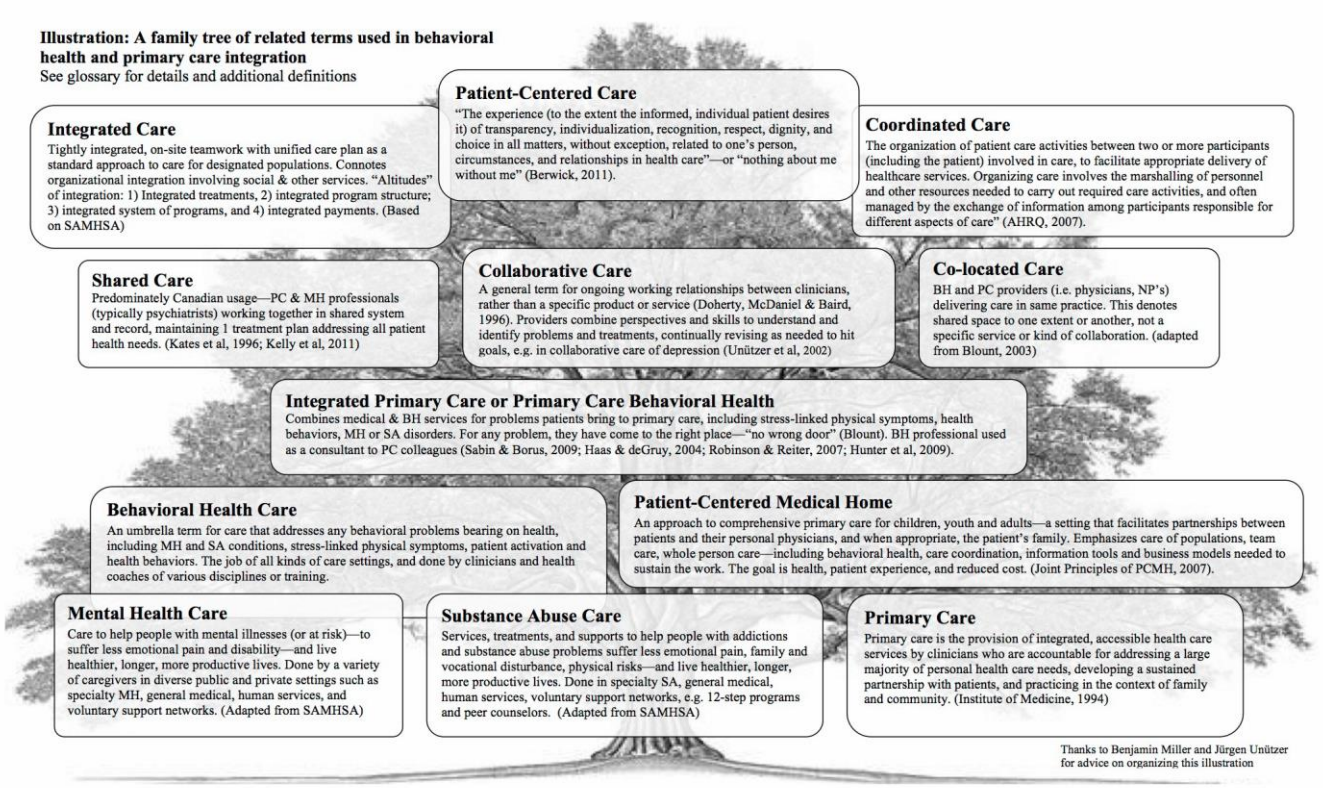
Integration Terms

Some Integrated Health Term Sources:

- **Research Literature-** ”Collaborative Care”
- **Federal & State Policy-** “Health Home”
- **Accrediting Bodies-** “Patient Centered Medical Home”
- **Provider Agencies-** “Pt. Centered Healthcare Home”

Defining Integrated Health…



From: Peek CJ and the National Integration Academy Council. Lexicon for Behavioral Health and Primary Care Integration: AHRQ Publication No.13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality. 2013. Available at http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf

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Defining Integrated Health

"A practice team of primary care and behavioral health clinicians working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization."

Peek CJ The National Integration Academy Council. Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus [AHRQ Publication No. 13-IP001-EF] Rockville, MD: Agency for Healthcare Research and Quality; 2013. Available at http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf.

What Policy & Research is Driving the Movement to Integrate?

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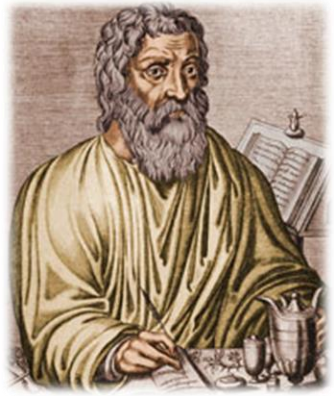
Integration: A New Initiative?

“The Body must be treated as a whole and not just a series of parts.”

--Hippocrates 300 BC



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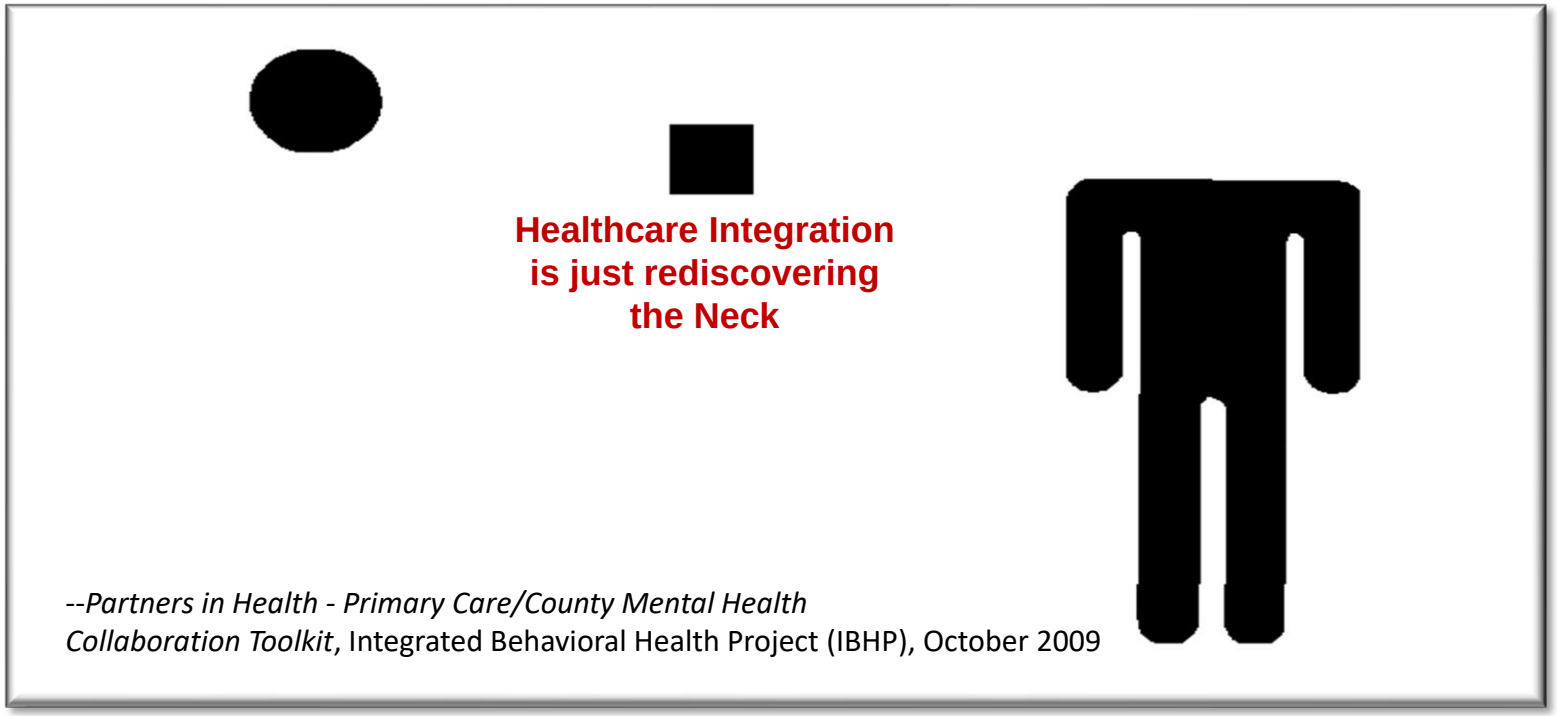
Integrated Care
Reconnection of the Head and the Body

Behavioral Health

Physical Health



--*Partners in Health - Primary Care/County Mental Health Collaboration Toolkit*, Integrated Behavioral Health Project (IBHP), October 2009

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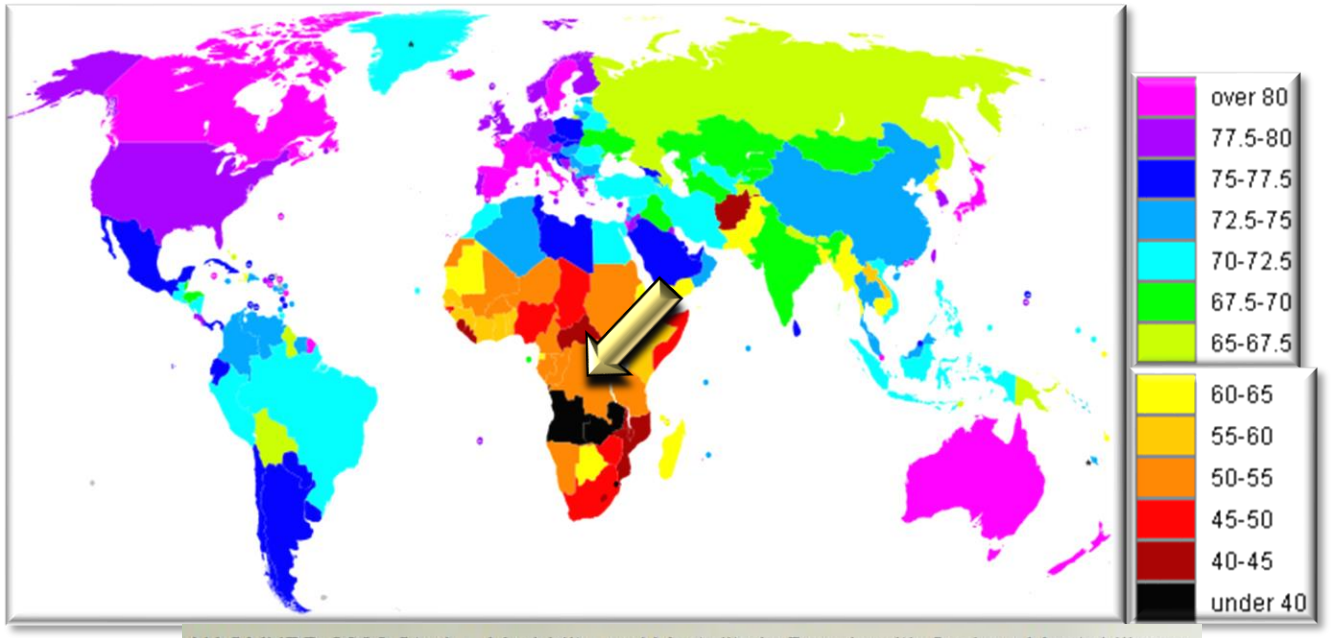
Medical Issues in BH Settings

- 2/3 of premature deaths are due to preventable/treatable medical conditions such as cardiovascular, pulmonary, and infectious diseases.

Alexander, L. (2010). Bidirectional Integrated Care 101:What you need to know. Retrieved from https://www.integration.samhsa.gov/about-us/Understanding_Primary_and_Behavioral_Healthcare_Integration_2010-09-15_FINAL.pdf

The 53 year lifespan for people *with* Serious Mental Illness is comparable with Sub-Saharan Africa



NASMHPD 2006 Study: *Morbidity and Mortality in People with Serious Mental Illness*

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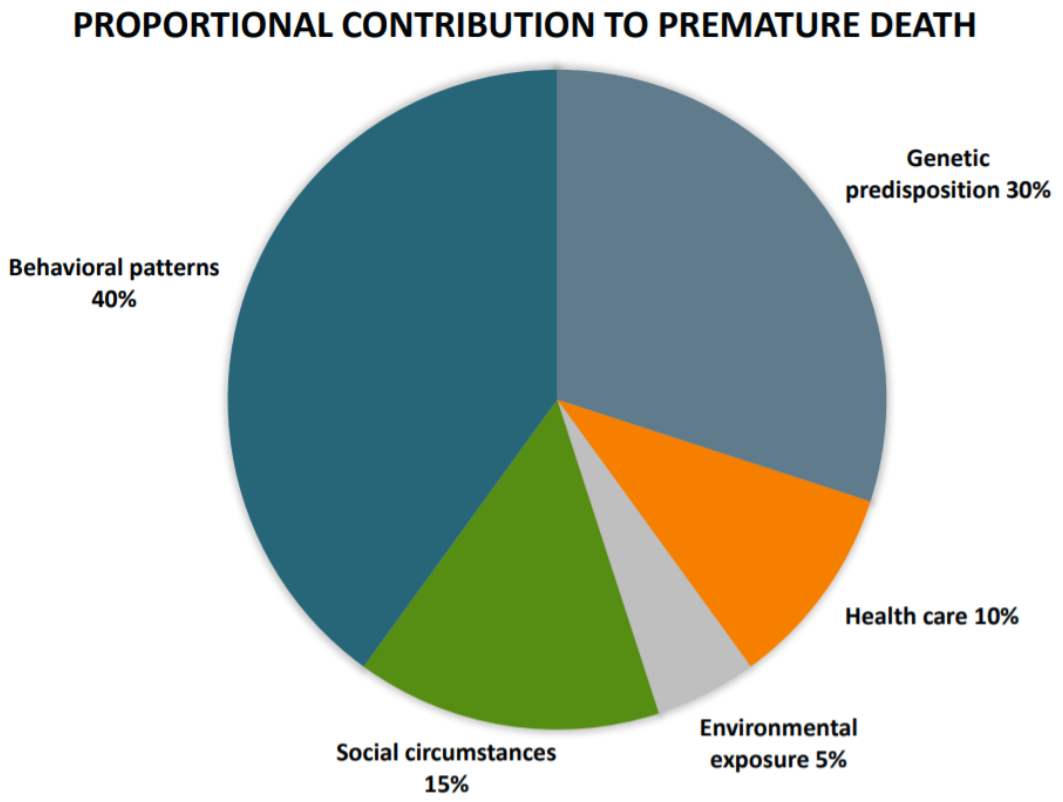
Health Behaviors and Premature Death



McGinnis et al. The case for more active policy attention to health promotion. *Health Affairs*. 2002;21(2):78-93.

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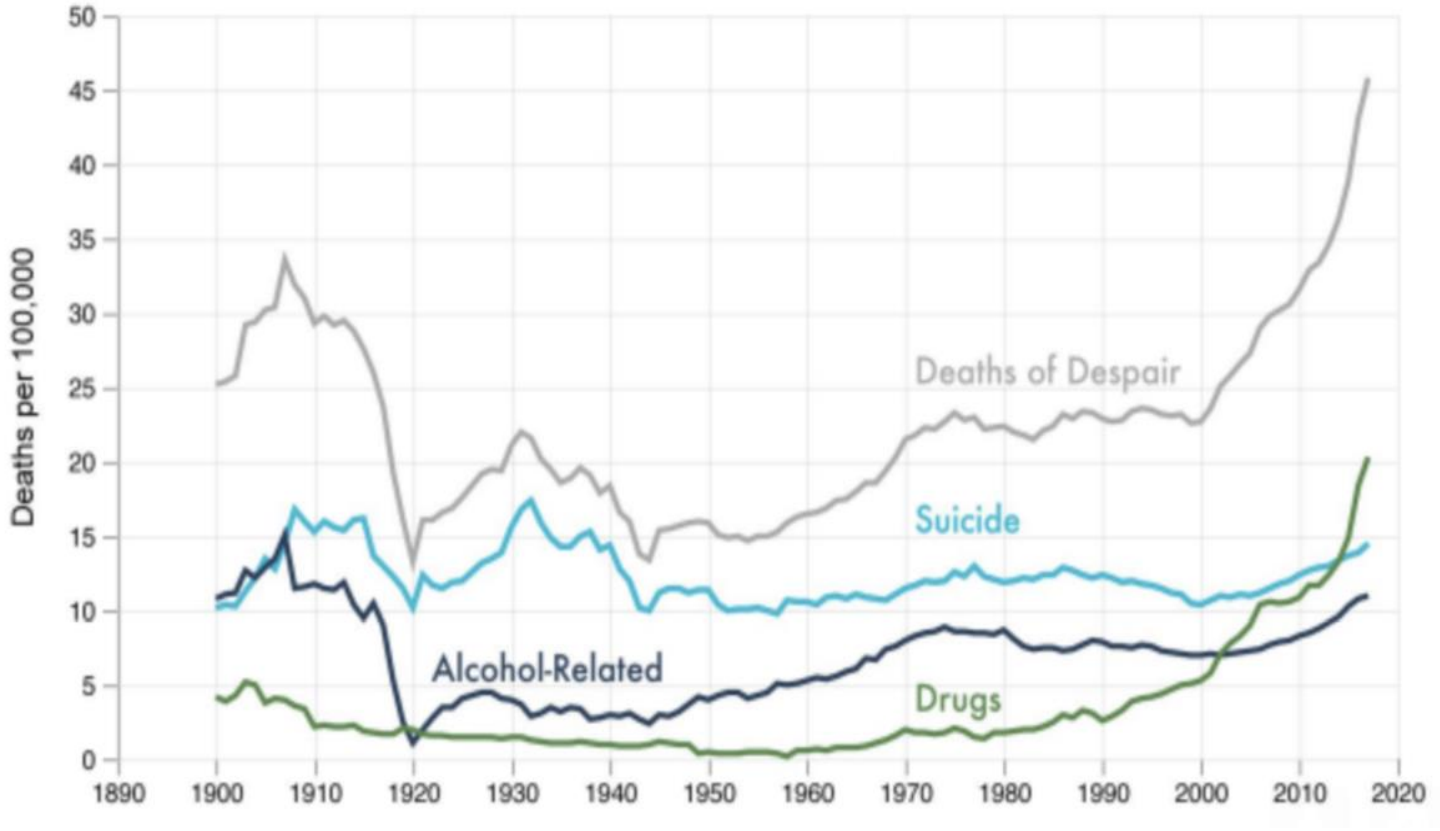
Deaths of Despair



Source: "Long-Term Trends in Deaths of Despair," Joint Economic Committee, Sept. 5, 2019

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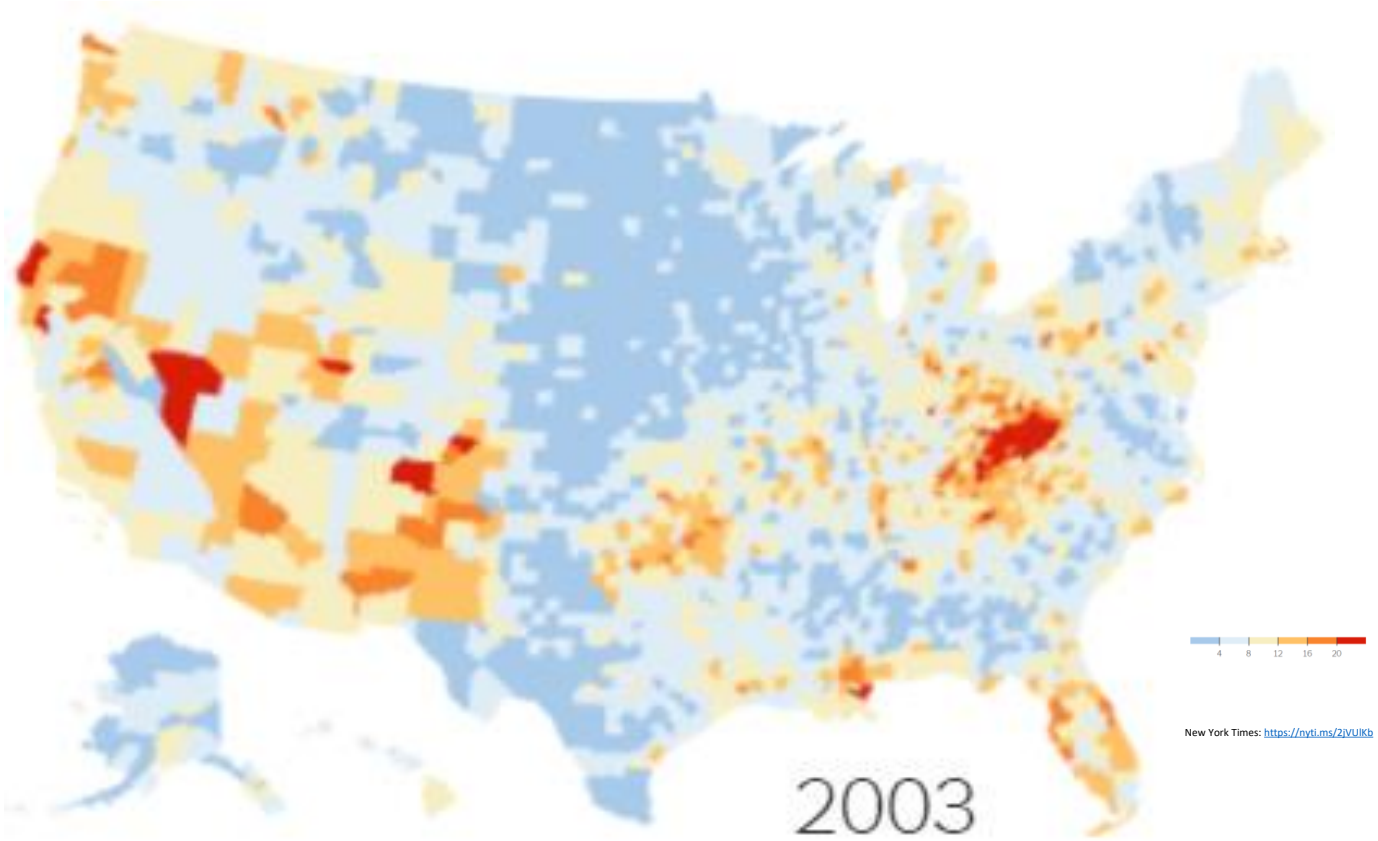
Overdose Deaths per 100,000



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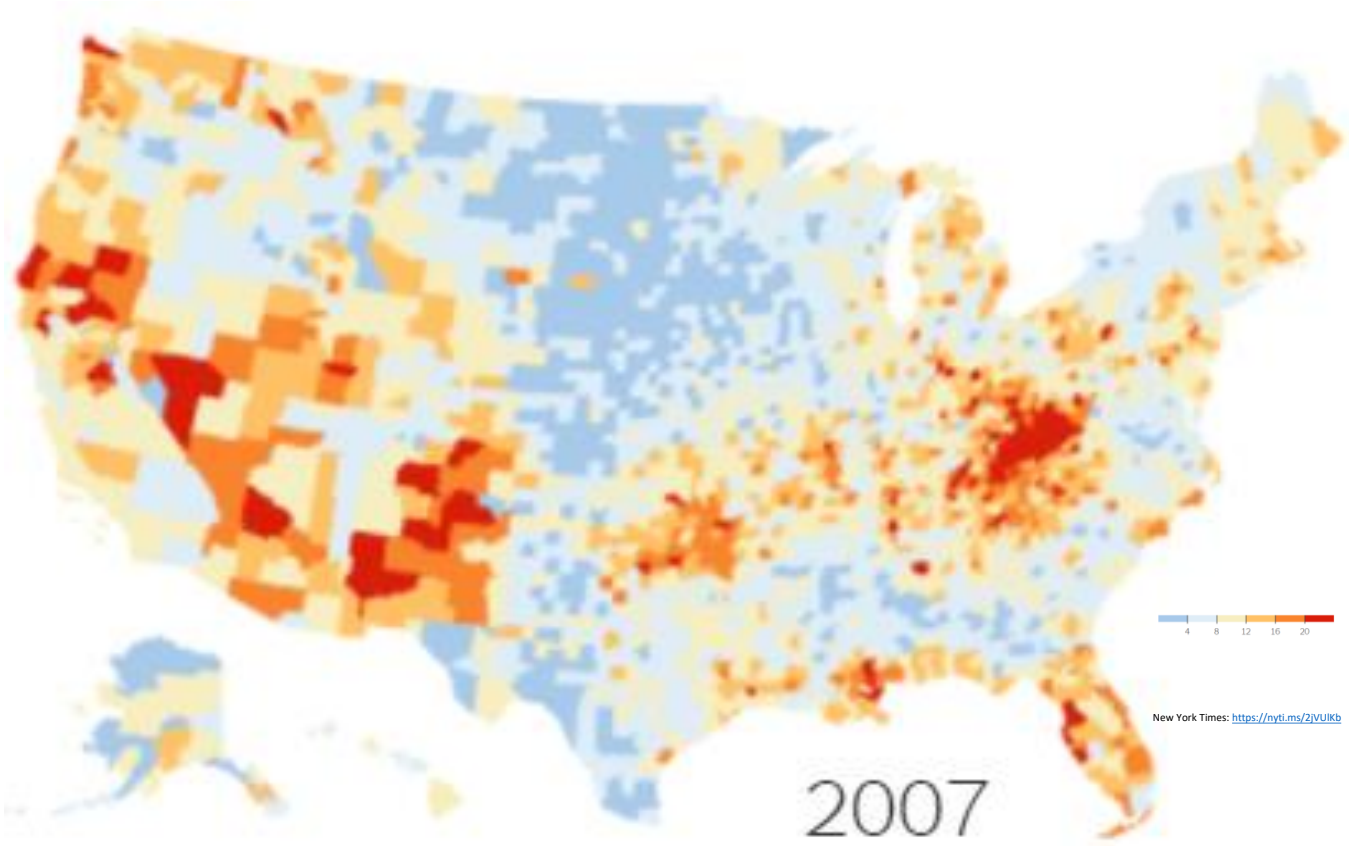
Overdose Deaths per 100,000



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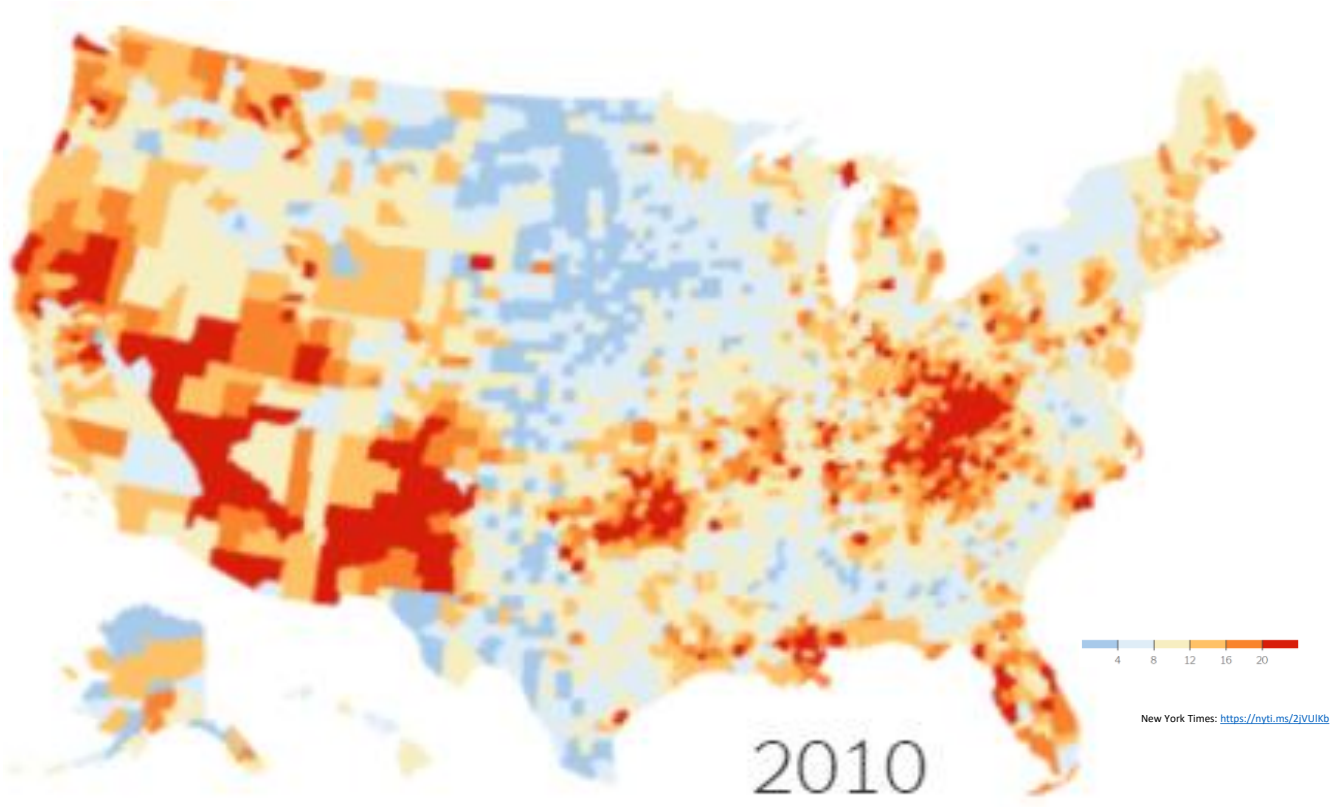
Overdose Deaths per 100,000



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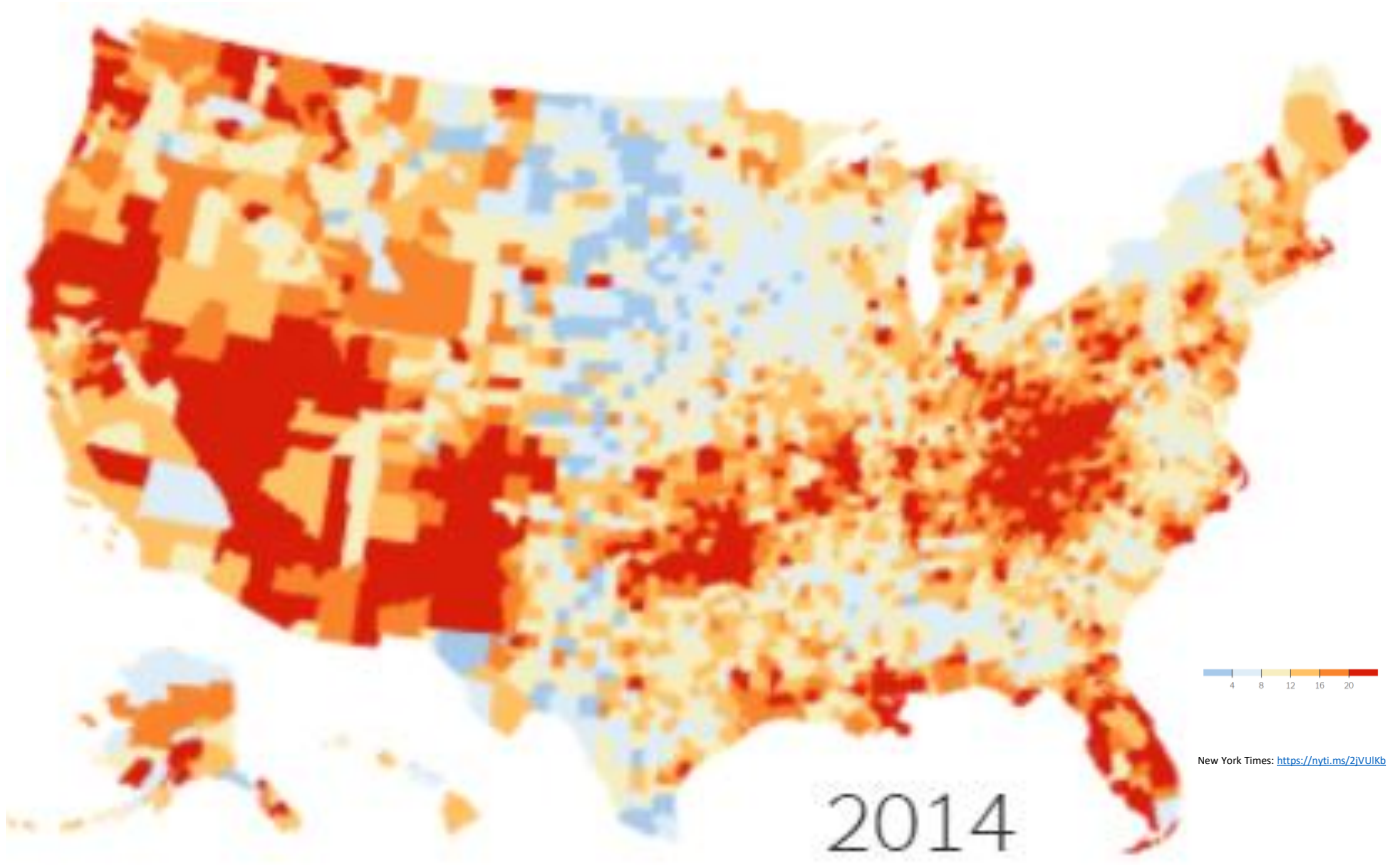
Overdose Deaths per 100,000



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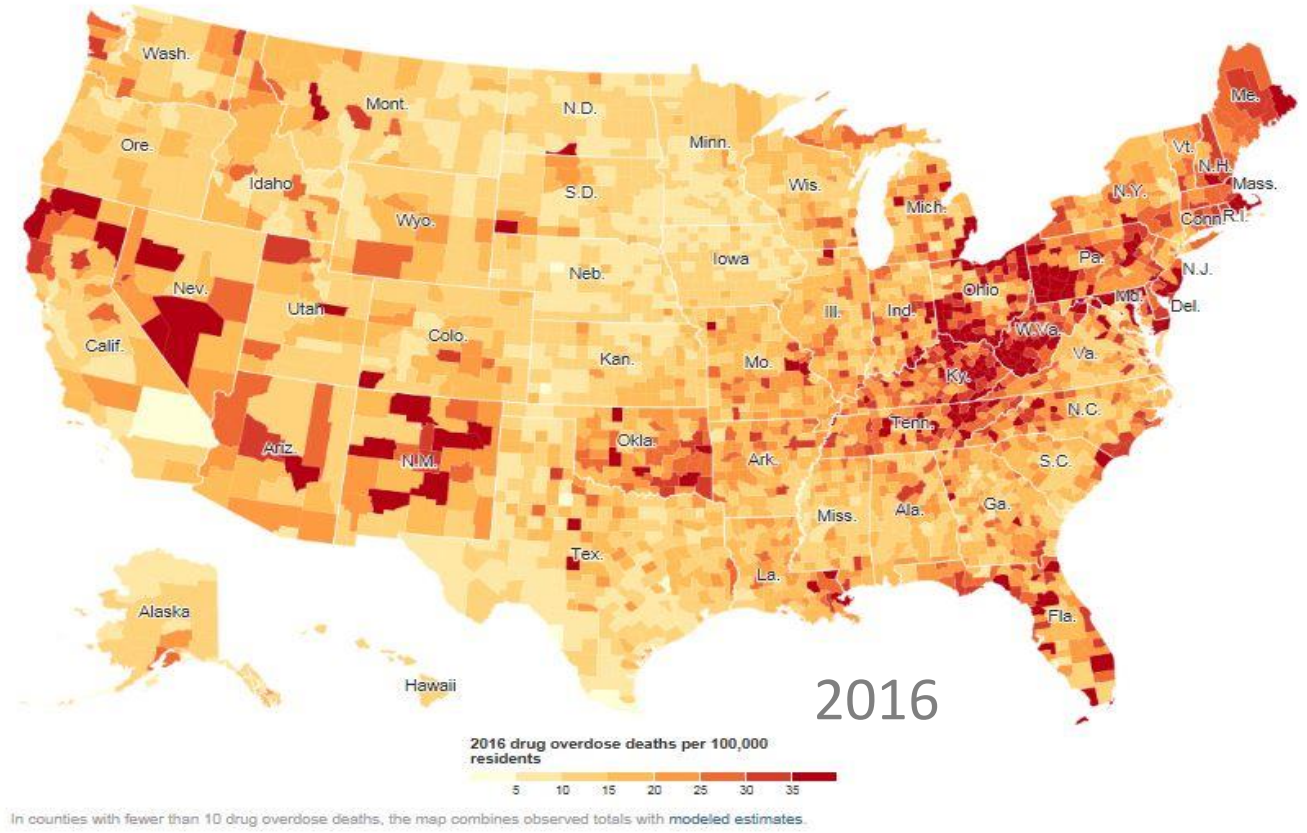
Overdose Deaths per 100,000



Source: National Center for Health Statistics, Centers for Disease Control and Prevention

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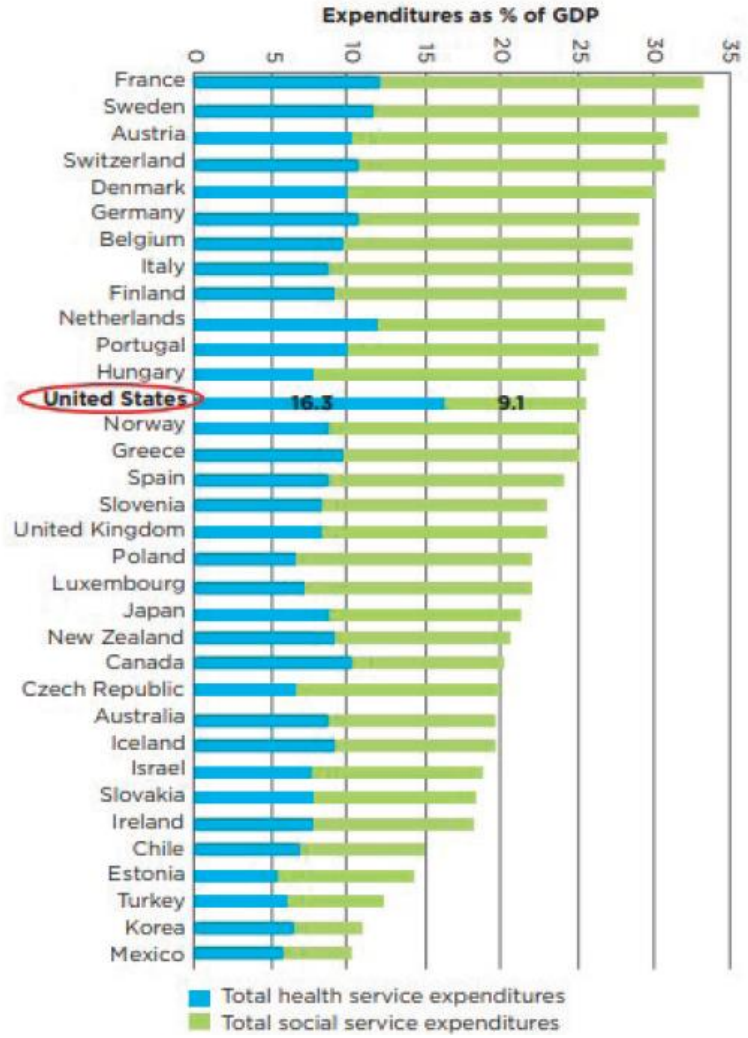
Need to Integrate Social Determinant Factors into Health Care System Delivery



Wellness Graphic: SAMHSA, Adapted from Swarbrick, M. (2006). A Wellness Approach. Psychiatric Rehabilitation Journal, 29(4), 311–314.
Expenditure Graphic: National Academies of Sciences, Engineering, and Medicine 2019. Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health. Washington, DC: The National Academies Press. https://doi.org/10.17226/25467.

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The Triple Aim is…in Essence a Call for Care Integration

- Targets identified by Don Berwick (former director of the Center for Medicaid/care Services & Institute for Healthcare Improvement) that new approaches to healthcare services provision should aim to achieve:

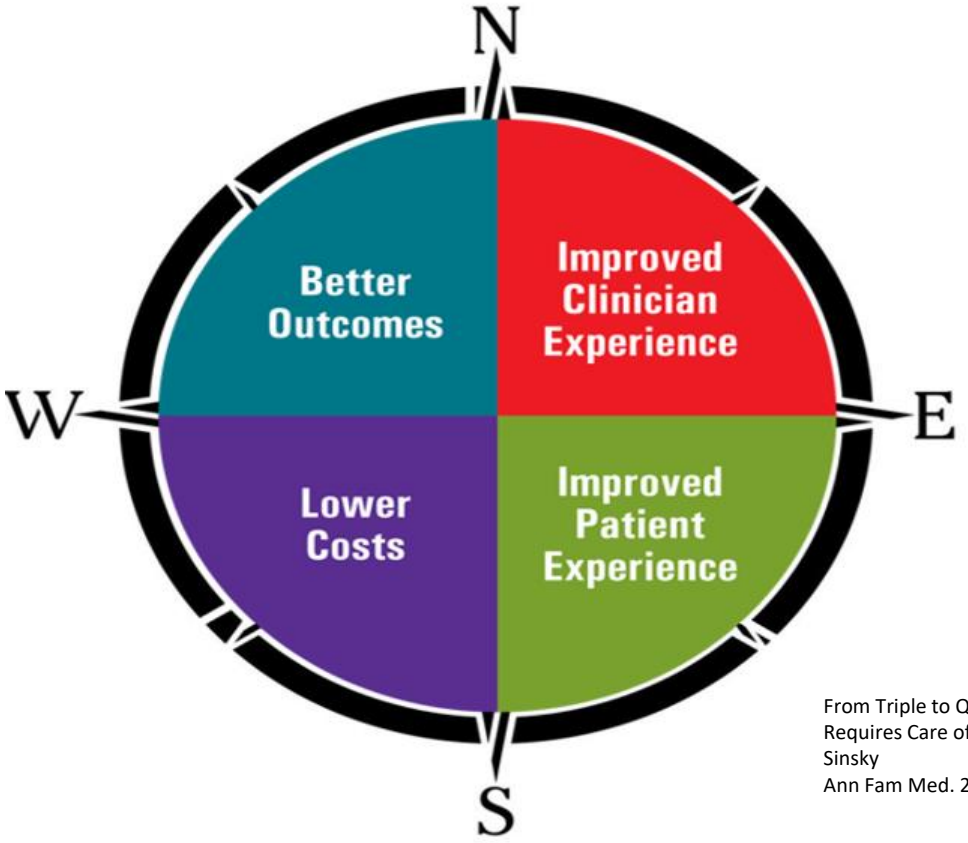
1. Improving the Health of Populations of People

2. Bending the Cost Curve

3. Improving the Patient's Experience/Quality of Care

- Source: Berwick, Nolan, & Whittington (2008).
  - The Triple Aim: Care, Health, And Cost.
    - *Health Affairs*. vol. 27 no.3, 759-769.

The Quadruple Aim…



From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. Bodenheimer & Sinsky
Ann Fam Med. 2014 Nov; 12(6): 573–576.

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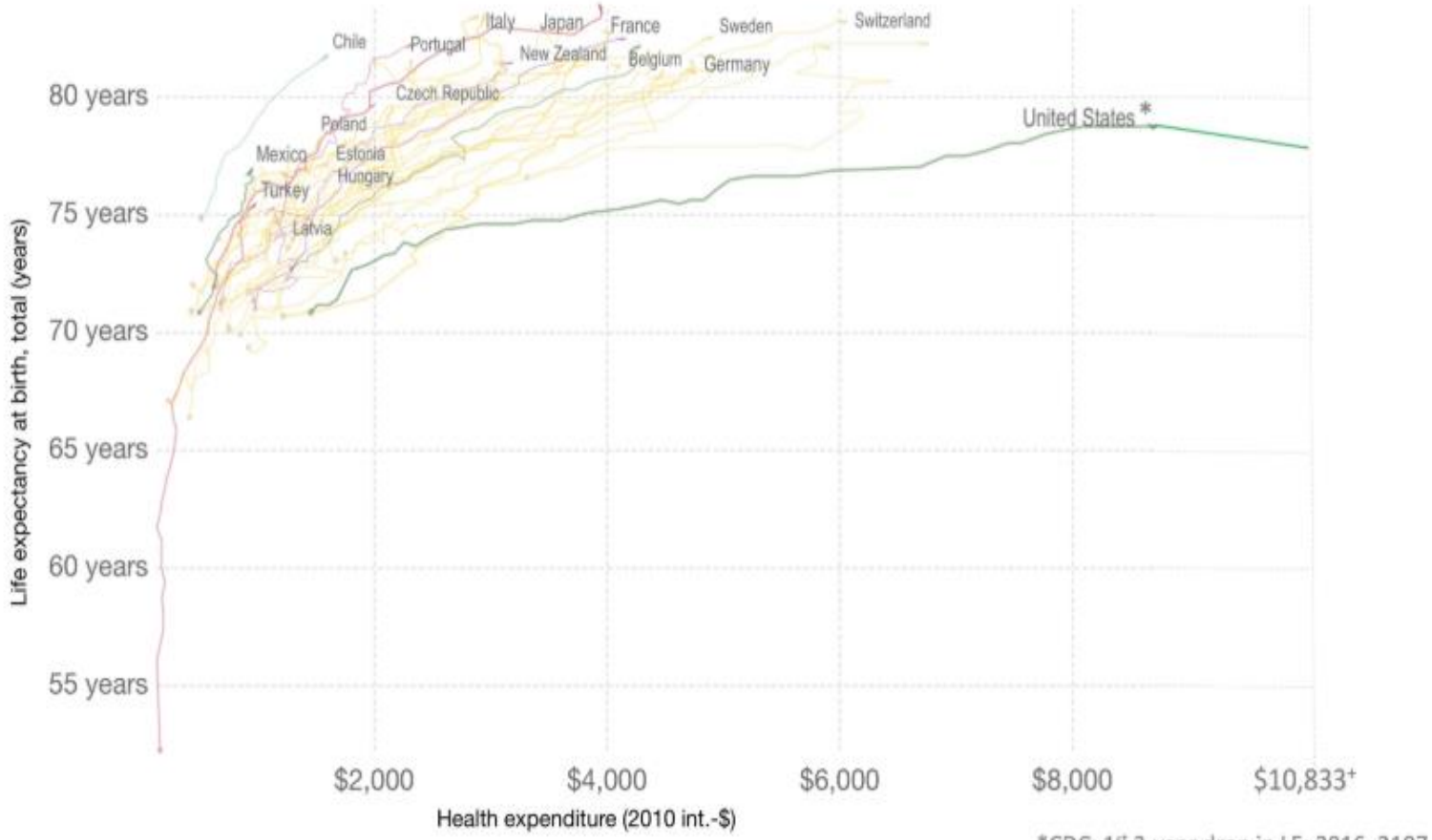
Our World in Data

Life expectancy vs. health expenditure, 1970 to 2017

Health financing is reported as the annual per capita health expenditure and is adjusted for inflation and price level differences between countries (measured in 2010 international dollars).



Source: World Bank – WDI, Health Expenditure and Financing - OECDstat (2017)
OurWorldInData.org/the-link-between-life-expectancy-and-health-spending-us-focus • CC BY-SA

*CDC: 1st 2-year drop in LE: 2016, 2107 since 1962 †From Statista

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Cost Calculation

Total Cost for Service Delivery

- Direct Service Staff Salary
- Direct Service Staff Fringe Benefits
- Non-Direct Costs (All other costs)

Total Revenue for Service Delivery

- Net Reimbursement actually Attained/ Deposited. *(This takes into account Denial Rate, Self Pay, Sliding Fee Scale, etc.)*

- Divided By -

Total Billable Direct Service Hours Delivered **

- All Direct Service Hours Delivered by Direct Service Staff that are eligible to be billed via a CPT Code or against a Grant.

** Utilizing the common denominator of total Billable Direct Service Hours instead of total hours worked per year assures an apples to apples comparison of an organization's true cost versus revenue per direct service hour.

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The Value Equation
Integrates Quality Data with Dollars

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Value-based Healthcare

Effective Healthcare:

- Producing quality outcomes, health literacy & customer satisfaction

Efficient Healthcare:

- Clinical & administrative processes that operate within optimal time & cost specifications

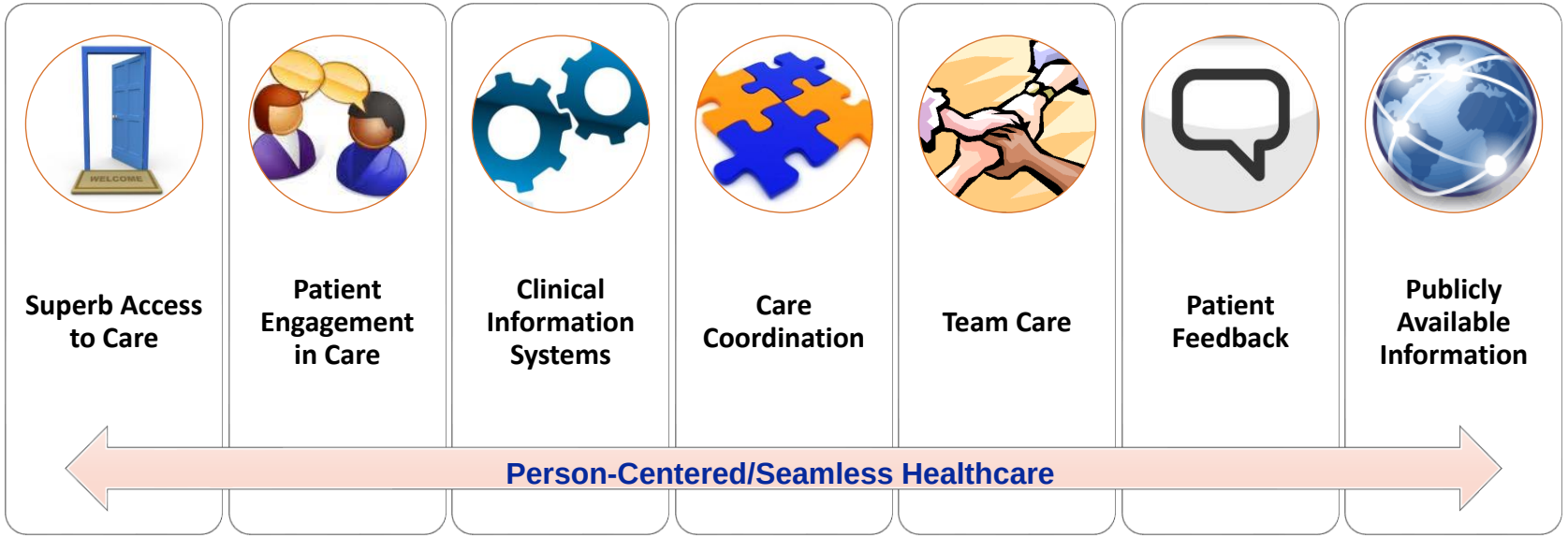
Fee-for-Service/Volume Based Care =>

Focus is on Efficiency

Value Based Purchasing =>

Focuses on Both Efficiency & Effectiveness

Consumer's View of Integration



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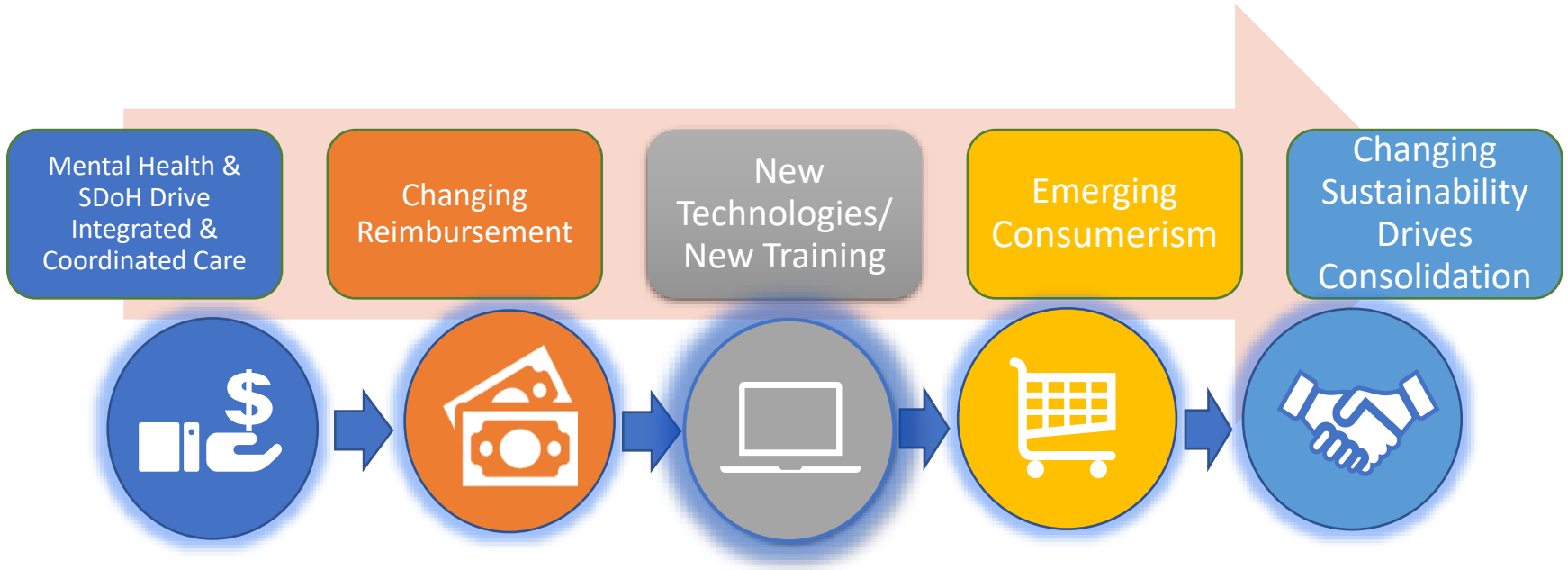
Policy, Funder & Provider's View of Integration



Source: Ken Carr, Senior Associate, OPEN MINDS

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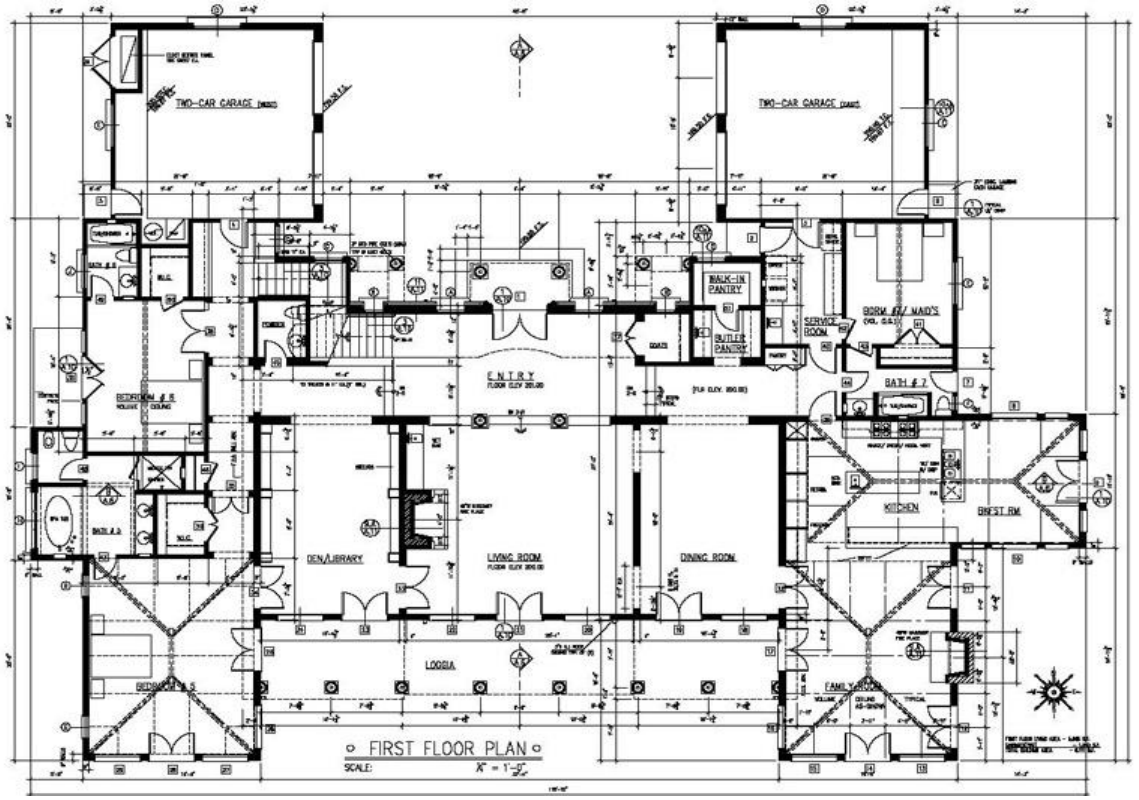
Evidence-based IH Designs



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Wagner's Chronic Care Model

Source: Victoria Barr, Sylvia Robinson, Brenda Martin-Link, Lisa Underhill, Anita Drotts & Darlene Ravensdale (2002). Adapted from Glasgow, R., Orleans, C., Wagner, E., Curry S., Solberg, L. (2001). *Does the chronic care model also serve* as a *template for improving prevention? The Milbank Quarterly*, 79(4), 579—612, and The World Health Organization, Health and Welfare Canada and Canadian Public Health Association (1986). Ottawa Charter of Health Promotion.

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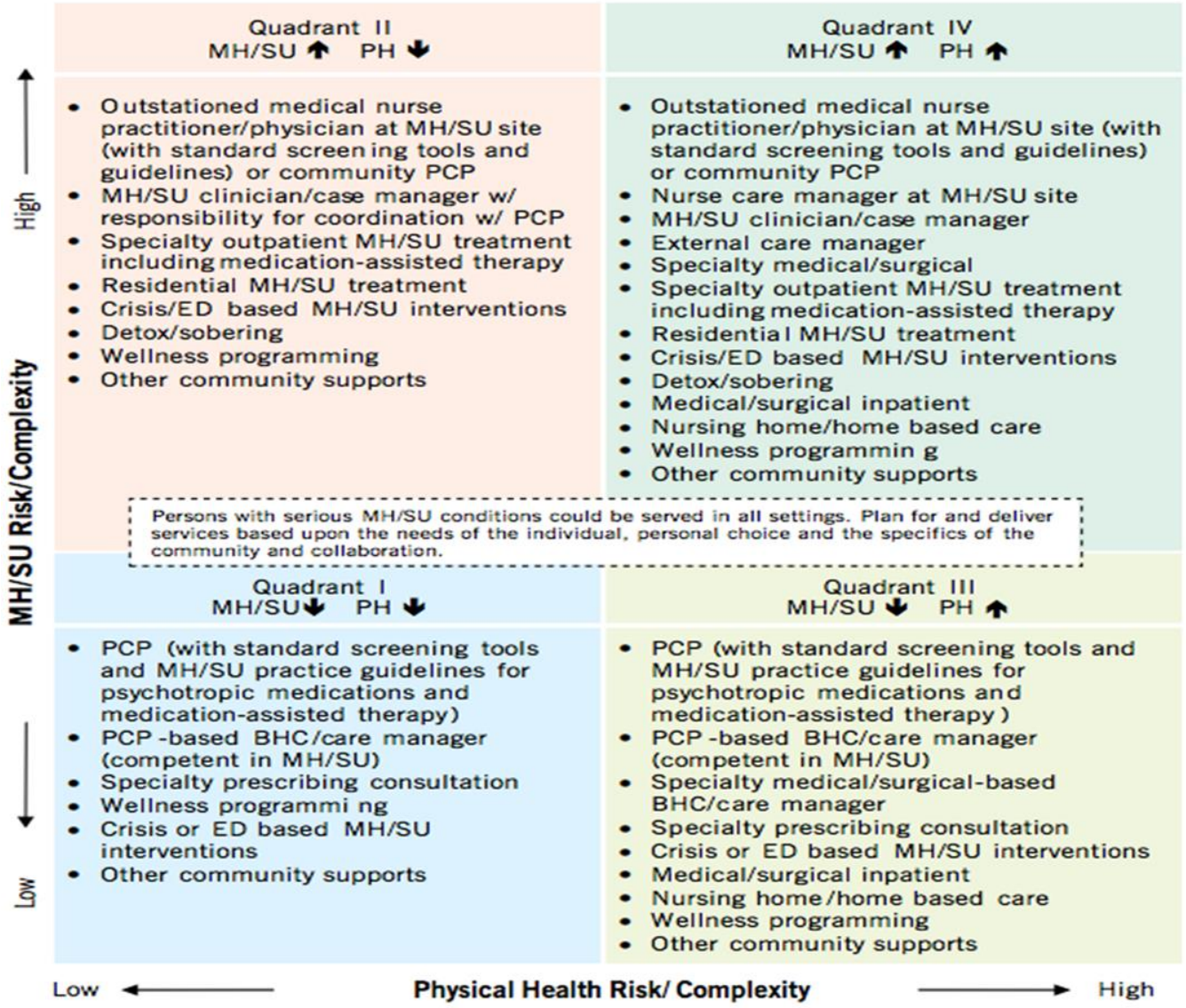
The Four Quadrant Model

- Conceptual framework for designing integrated programs.
- Offers guidance to determine which setting can provide the most appropriate care
- Defines what care people need and where care is best delivered based on the severity of the person's behavioral health and physical health needs.
- Describes the need for a bi-directional approach, addressing the need for primary care services in behavioral health and visa versa.



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Function	Minimal Collaboration	Basic Collaboration from a Distance	Basic Collaboration On-Site	Close Collaboration/ Partly Integrated	Fully Integrated/Merged
THE CONSUMER and STAFF PERSPECTIVE/EXPERIENCE					
Access	Two front doors; consumers go to separate sites and organizations for services	Two front doors; cross system conversations on individual cases with signed releases of information	Separate reception, but accessible at same site; easier collaboration at time of service	Same reception: some joint service provided with two providers with some overlap	One reception area where appointments are scheduled; usually one health record, one visit to address all needs; integrated provider model
Services	Separate and distinct services and treatment plans; two physicians prescribing	Separate and distinct services with occasional sharing of treatment plans for Q4 consumers	Two prescribers (BH/PC) consultation as needed; two treatment plans but routine sharing on individual plans, probably in all quadrants;	Q1 and Q3 one prescriber, with consultation; Q2 & 4 two prescribers some treatment plan integration, but not consistently with all consumers	One treatment plan with all consumers, one site for all services; ongoing consultation and involvement in services; one prescriber for Q1, 2, 3, and some 4; two prescribers for some Q4: one set of lab work
Funding	Separate systems and funding sources, no sharing of resources	Separate funding systems: both may contribute to one project	Separate funding, but sharing of some on-site expenses	Separate funding with shared on-site expenses, shared staffing costs and infrastructure	Integrated funding, with resources shared across needs; maximization of billing and support staff;
Governance	Separate systems with little of no collaboration; consumer is left to navigate the chasm	Two governing Boards; line staff work together on individual cases	Two governing Boards with Executive Director collaboration on services for groups of consumers, typically Q4	Two governing Boards that meet periodically to discuss mutual issues; Orgs may share board member(s)	One Board with equal representation from each partner
Evidence-Based Practice	Individual EBP's implemented in each system	Two providers, some sharing of information but responsibility for care cited in one clinic or the other	Some sharing of EBP's around high Q4; some sharing of knowledge across disciplines	Sharing of EBP's across systems; joint monitoring of health conditions for more quadrants	Team Based Care with EBP's cross staffed (e.g., IDDT, diabetes management; cardiac care) across populations in all quadrants
EMR, Data Collection, & Use	Separate systems, often paper based, little if any sharing of data	Separate data sets, some discussion with each other of what data shares	Separate data sets; some data sharing on individual cases	Separate data sets, some data sharing on individual cases; maybe some aggregate data sharing on population groups	Fully integrated, EMR with information available to all practitioners on need to know basis

SAMSHA Standard Framework for Integration

Referral		Co-Located		Integrated	
Key Element: Communication		**Key Element: Physical Proximity**		**Key Element: Practice Change**	
Level 1 *Minimal Collaboration*	**Level 2** *Basic Collaboration at a Distance*	**Level 3** *Basic Collaboration On-Site*	**Level 4** *Close Collaboration On-Site with Some System Integration*	**Level 5** *Close Collaboration Approaching an Integrated Practice*	**Level 6** *Full Collaboration in a Transformed/ Merged Integrated Practice*
Behavioral health, primary care and other healthcare providers work:					
In separate facilities.	**In separate facilities.**	**In same facility not same offices/clinic (e.g., separate waiting areas).**	**In same space within the same facility but separate workflows/ teams.**	**In same space within the same facility regular teaming & cross staffing.**	**In same space within the same facility, sharing all practice space (one clinic/one team).**

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As we discussed there are many ways to define integrated health and to model

- Collaborative Care
- Patient Centered Medical Home (PCMH)
- Health Home
- Reverse Integration
- Mental Health/Substance Use Treatment Integration
- Integration of Social Determinants of Health into Health Care Delivery

2012 Review Study of 57 experimental trials across 78 articles found 6 components consistent with the Collaborative Care Model:

1. Pt self-management support
2. Delivery system redesign
3. Use of clinical information systems
4. Provider decision support (guidelines)
5. Health care organization support
6. Linkage to community resources

Source: Woltmann E, Grogan-Kaylor A, Perron B, Georges H, Kilbourne AM, Bauer MS (2012). Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, specialty, and behavioral health care settings: systematic review and meta-analysis. *Am J Psychiatry. 2012 Aug; 169(8):790-804*

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Key components of the Collaborative Care Model

Patient-Centered Team Care

Primary care and behavioral health providers collaborate effectively using shared care plans that incorporate patient goals. The ability to get both physical and mental health care at a familiar location is comfortable to patients and reduces duplicate assessments. Increased patient engagement oftentimes results in a better health care experience and improved patient outcomes.

Population-Based Care

Care team shares a defined group of patients tracked in a registry to ensure no one falls through the cracks. Practices track and reach out to patients who are not improving and mental health specialists provide caseload-focused consultation, not just ad-hoc advice. Read how to identify a population-based tracking systemin our Implementation Guide.

Measurement-Based Treatment to Target

Each patient's treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured by evidence-based tools like the PHQ-9 depression scale. Treatments are actively changed if patients are not improving as expected until the clinical goals are achieved. Sometimes called Stepped Care. Read more about Treatment to Target.

Evidence-Based Care

Patients are offered treatments with credible research evidence to support their efficacy in treating the target condition. These include a variety of evidence-based pyschotherapies proven to work in primary care, such as PST, BA and CBT, and medications. Collaborative Care itself has a substantial evidence base for its effectiveness, one of the few integrated care models that does.

Accountable Care

Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided. Read more about accountability in our Financing section.

Source: Uni of Washington AIMS Center Website

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Core Elements for Integrated Health Model Implementation: Where are you?

Core Element	Details	Application/Evidence
Intentional choice of level of integration	See A standard Framework for Levels of Integrated Healthcare and Update Throughout the Document	• The program has made intentional choice to coordinate, co-locate or integrate based on the available resources in the community and at whatever level it has practices in place to decrease patient burden, support active outreach, engagement and follow-up.
Team based care	There is clear identification of team members (virtual or on site)	• Practices in place to support team communication, coordination and functioning, team roles, and interdisciplinary planning.

Core Elements for Integrated Health Model Implementation: Where are you?

Core Element	Details	Application/Evidence
Evidence based clinical models	Must fit the need of a practice setting	• The practice chooses an approach that fits their setting (i.e. collaborative care, behavioral health consultant model) and educates staff in brief, evidence-based interventions like motivational interviewing, problem solving therapy, behavioral activation. etc.
Data driven systems	Practices in place that focus on population health and measurement-based care	• Established workflows for patient identification through screening and clinical pathways are in place to guide intervention and planning. • Outcomes and quality measures are defined, tracked, reported and used to modify care. The question is, are people getting better, is addressed through data and the practice focuses on treat to target. • Registries on patients are maintained and teams are accountable for their work and patient improvement.

Core Elements for Integrated Health Model Implementation: Where are you?

Core Element	Details	Application/Evidence
Clear leadership	Clear leadership toward a transformed delivery system that sees behavioral health not as an add on but as a key element of health care.	• Articulates a clear vision with demonstrable targets from the top down and the bottom up on how to improve patient care, develops policy and procedures supporting IH • Tackle barriers with creativity that leads adaptation of practices to support integrated care.
Stepped care	Stepped care is a system of delivering and monitoring treatments so that the most effective, yet least resource intensive, treatment is delivered to patients first; only 'stepping up' to intensive/specialist services as clinically required.	• Primary care is the clinical home, everyone in the practice is trained to manage health as a combination of physical and behavioral health, all staff "work at the top of their license", and care is provided in primary care unless referral out to specialty care is required. • Providing same day access is part of the continuum of care. • Referrals out to specialty behavioral health are made when the needs are complex and beyond the scope of integrated primary care. During specialty care the care is coordinated with primary care.

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Core Elements for Integrated Health Model Implementation: Where are you?

Core Element	Details	Application/evidence
Defined continuum of care	Each practice and provider knows when to treat, when to consult, and when to refer.	• Clear parameters are established for these consultation and referral. • Agreements are in place with external partners for specialty care referrals and communication.
Psychiatric & Primary Care Consultation	Each practice has a plan for psychiatric or primary care consultation	• Consultation may be face to face, through telehealth or through embedded prescribers. • Practices work on developing the consultative role that includes regular collaborative contacts and data/information sharing.

The Role of the Social Worker in Policy Development, Services Design & Delivery

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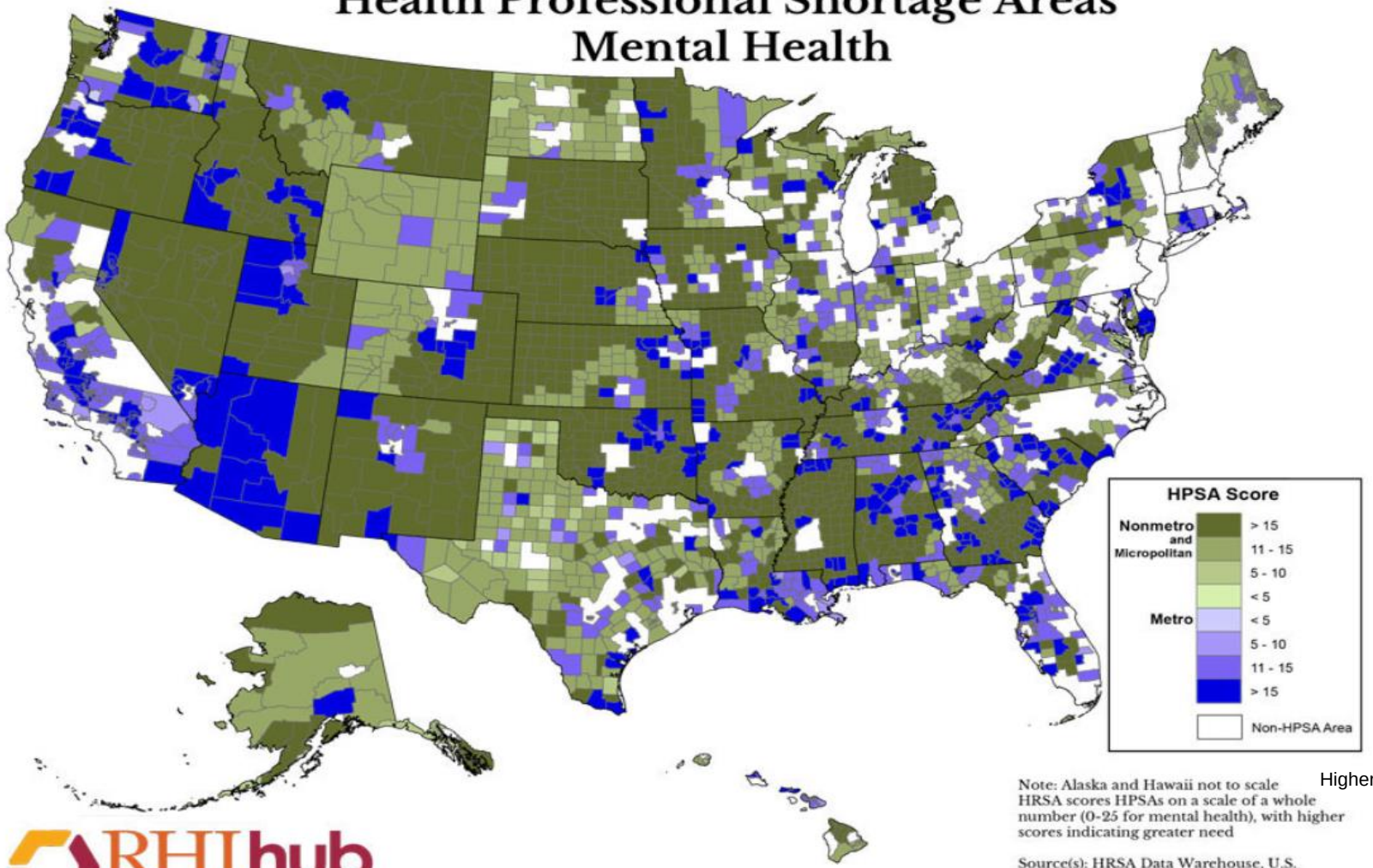
Who is the IH Workforce?

- Social Workers
- Psychologists/Counselors
- Primary Care Providers/Prescribers
- Psychiatric Providers/Prescribers
- Nurses
- Addiction Treatment Specialists
- Peer Workforce: Peer Support Staff, Recovery Specialists/Coaches, Community Health Workers
- Medical Assistants, Ancillary and Administrative Staff
- Increasingly other domains of health (e.g., special care for diabetes, dialysis, endocrinology, etc.)

Health Resources Services Administration (HRSA) professional shortages

- By 2025…
- If levels of demand increase, shortages projected among 9 key provider types
  - Including shortages of **more than 10,000 FTEs** among psychiatrists, psychologists, social workers, SUD counselors, mental health counselors, & school counselors

Health Professional Shortage Areas
Mental Health



Note: Alaska and Hawaii not to scale
HRSA scores HPSAs on a scale of a whole number (0-25 for mental health), with higher scores indicating greater need

Source(s): HRSA Data Warehouse, U.S. Department of Health and Human Services, November 2016

Higher score = Greater need

RHIhub
Rural Health Information Hub

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Discussion Question!

What specifically do Social Workers do in an Integrated Health setting?

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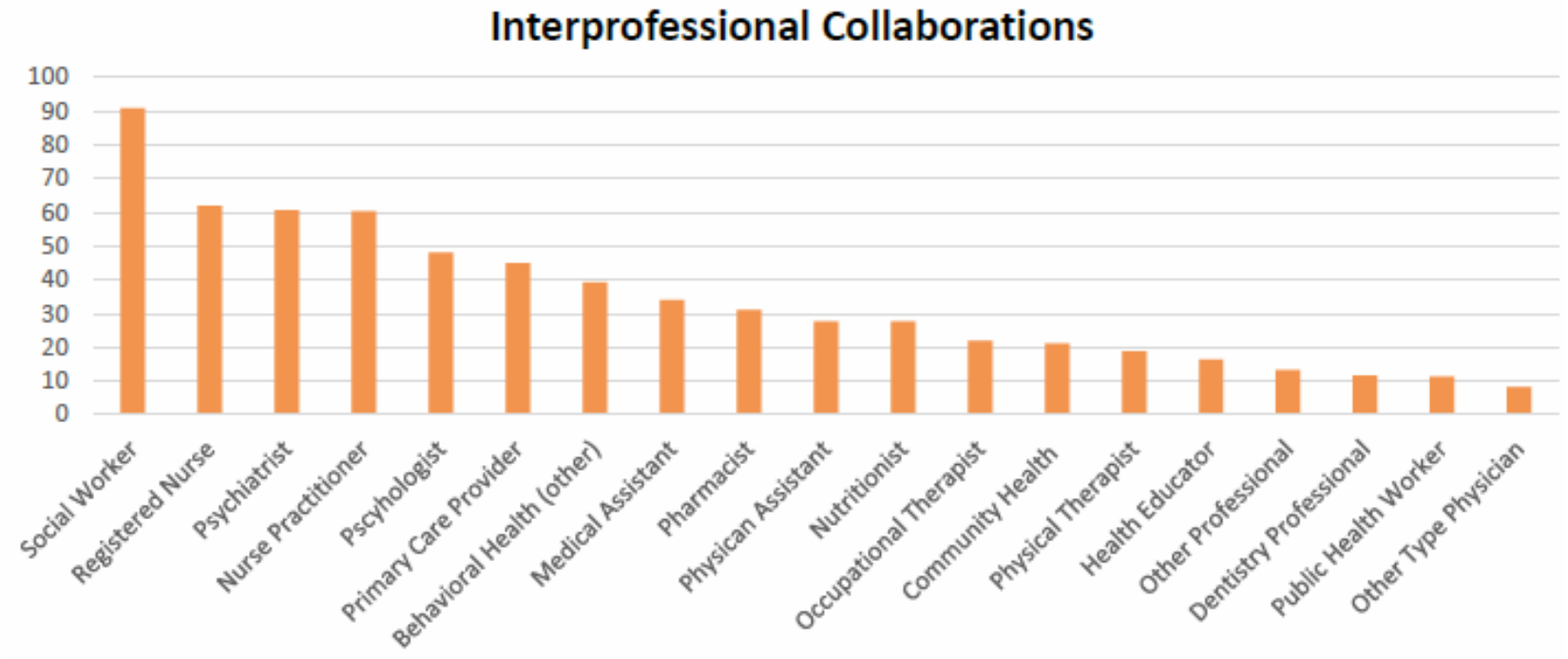
Who are Social Workers Most Likely to Work with in an IH setting?



L. de Saxe Zerden; B.M. Lombardi; E. Richman (2018). Barriers and Facilitators to Social Worker Practice in Integrated Care Settings, Poster Society for SW Research

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The Social Worker's Experience in the IH Setting

- On average social work respondents indicated working with about 7 (SD=3.8; Range: 1-18) different disciplines on teams, most commonly, RN (62%), Psychiatrist (60%), NP (59%)
- Overall, respondents identified feeling organization supported on the integrated care team (Mean=3.6) and felt valued on the team (Mean=3.7)
- Barriers around language/terminology on teams remains, as well hierarchal differences by professions
- No differences in reported barriers and facilitators between MSW students and field instructors
- Social workers reported lack of role clarity on the team (Mean=2.5)
- Respondents reported varied components of integration-key elements like co-location, shared electronic records, and communication were not consistently present in the practices

Conclusions & Implications

- Social work respondents, both students and field instructors, indicated working extensively on interprofessional teams in a variety of interdisciplinary settings, highlighting the significant heterogeneity of practice settings that social work amongst
- Continued work and training is needed to define and conceptualize social work role function and clarity
- Interprofessional efforts at the practice and training level are necessary to re-tool current workforce

L. de Saxe Zerden; B.M. Lombardi; E. Richman (2018). Barriers and Facilitators to Social Worker Practice in Integrated Care Settings, Poster Society for SW Research

What Competencies will be needed?

1. Interpersonal Communication
2. Collaboration & Teamwork
3. Screening & Assessment
4. Care Planning & Care Coordination
5. Intervention
6. Cultural Competence & Adaptation
7. Systems Oriented Practice
8. Practice Based Learning & Quality Improvement
9. Informatics
10. Telehealth*

Source: Annapolis Coalition on Behavioral Health Workforce White Paper, "Core Competencies for Integrated Behavioral Health and Primary Care"

*https://www.integration.samhsa.gov/operations-administration/practice-guidelines-for-video-based-online-mental-health-services_ATA_5_29_13.pdf

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Integrated Health Conditions

- Diabetes
- Cardiovascular Disease (CVD)
- Obesity
- Metabolic Syndrome (diabetes/CVD/obesity)
- Chronic Respiratory Illness (asthma, emphysema, etc.)
- Depression (Pt. Health Questionnaire 9=PHQ9)
- Suicide (Columbia Suicide Severity Rating Scale=CSSRS)
- Anxiety (General Anxiety Disorder 7=GAD7)
- Substance Use Disorders (Alcohol Use Disorders Identification Test = AUDIT C +2)

Social Work Policy Practitioners Competencies

Political Competencies	Analytic Competencies
Empowering others	Using social science research
Advocating for the needs of a client	Analyzing the source & context of policies
Understanding your personal position	Designing policy assessments & briefs
Interactional Competencies	**Value-clarifying Competency**
Coalition building	Engaging in ethical reasoning
Managing conflict	Helping others with ethical reasoning
Presenting & writing	Identify areas of ethical conflict

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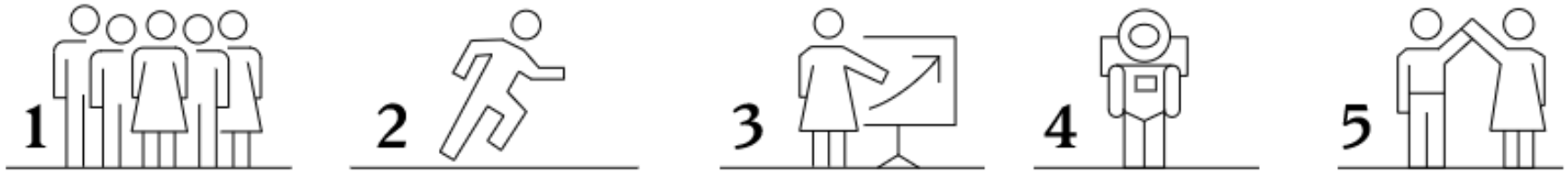
Social Worker Workforce Expertise

- Experts in Policy Development and Evaluation
- Experts in screening/assessment/diagnosis and brief interventions
- Experts in engagement and health literacy through motivational approaches to health behavior change for all health conditions
- Training and comfort working in diverse treatment settings with diverse populations
- Leadership in team settings
- Ability to build the service around the person (i.e., their skills/strengths and determinant needs), not around the interests of the discipline or what one thinks "the patient ought to do…"

Looking back & forward!

Companies need to think and act across five horizons.

The five horizons



Resolve

Address the immediate challenges that COVID-19 represents to institution's workforce, customers, technology, and business partners

Resilience

Address near-term cash-management challenges and broader resiliency issues during virus-related shutdowns and economic knock-on effects

Return

Create detailed plan to return business to scale quickly as COVID-19 situation evolves and knock-on effects become clearer

Reimagination

Reimagine the next normal: what a discontinuous shift looks like and implications for how institutions should reinvent

Reform

Be clear about how regulatory and competitive environments in industry may shift

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Questions & Comments
Thank you!

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