Early Lessons from Advancing Care Together

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Background

- Evidence strongly supports integration of primary care and behavioral health services
  - Improves process of care, clinical outcomes
  - Various strategies effective (e.g., co-location, shared medical records, proactive referrals)
- Widespread adoption has not occurred
- Few studies describe the factors influencing implementation

Background

- Regional and national policy changes are enabling practices to tackle integration
  - Patient Centered Medical Homes (PCMH)
  - Accountable Care Organizations (ACOs)

- Joint Principles: Integrating Behavioral Health Care Into The Patient-centered Medical Home
  - Research to better define the optimal provision of whole person health services in the PCMH, with attention to patient, practice, training, and financing issues
  - Recognition of local adaptations of integrated, whole-person care so as to include all persons and to take advantage of the differing requirements and resources of different communities across the entire country

- Early findings from Advancing Care Together (ACT) begin to address this gap

Shared Definitions

- **Behavioral health care**: A broad term used to encompass care for patients around mental health and substance use conditions, health behavior change, life stressors and crises, as well as stress-related physical symptoms.
- **Integrated care:** Care rendered by a practice team of primary care and behavioral health providers, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care.
- This care may address diverse behavioral health needs. Models of integrated care may vary on numerous levels, including but not limited to characteristics of the care team, spatial arrangements, type of collaboration, and protocols for patient detection, treatment, and follow-up.

What is ACT?

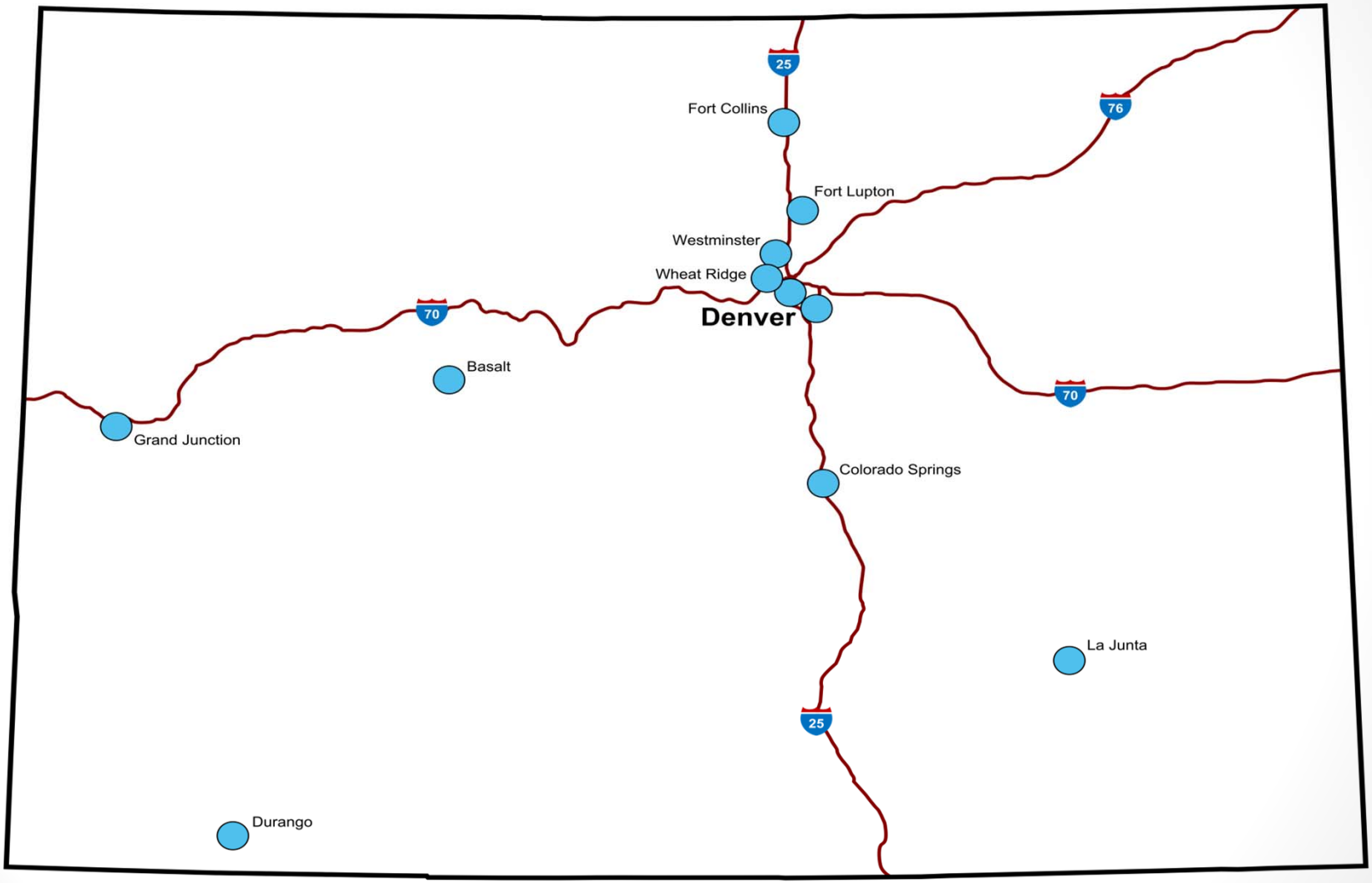
Advancing Care Together (ACT)

- Four-year practice redesign program to test various strategies to integrate BH, PC, and SU services
- Timeline: September 2011 – September 2014
- Participants: Primary care practices and community mental health centers
- Scope: Colorado
- Sponsor: The Colorado Health Foundation
- Headquarters: Department of Family Medicine at the University of Colorado

Program Goals

- Identify and test promising demonstrations to provide integrated care for patients and clients in primary care and community mental health settings.
- Evaluate processes and outcomes of demonstrations to determine what strategies work and don't work and what it takes to provide integrated care in real life settings.
- Disseminate best practices and real-time lessons to other CO practices and other interested stakeholders.

ACT Portfolio: 11 Innovation Sites



Innovation Site Characteristics

ID	Type (Primary Care unless specified)	Ownership	Geography	Annual patient visits
1	Single specialty	FQHC, Private	Rural	31,200
2	Multispecialty	FQHC, Hospital	Urban	8,372
3	Multispecialty	Clinician	Urban	31,720
4	Mental health	CMHC, Non-Profit	Rural	7,904
5	Multispecialty	Clinician	Urban	47,476
6	Single specialty	FQHC, Hospital	Urban	17,680
7	Single specialty	Clinician	Urban	15,600
8	Mental health	CMHC, Non-Profit	Urban	4,732
9	Multispecialty	HMO, Hospital	Urban	298,168
10	Single specialty	Clinician	Rural	4,680
11	Multispecialty	FQHC, Private	Urban	14,924

Examples of ACT Innovations

- ID 1: A CMHC in a rural community is opening a primary care clinic within its center by adding a full-time primary care provider (PA). The PA will provide full-range of integrated primary care services.

- ID 5: A private behavioral health practice is expanding services into a private family medicine clinic using a collaborative care schedule. Training on integrated care will be provided.

- ID 7: This private primary care practice is partnering with a CMHC to hire, train, and supervise a co-located behavioral health provider.

ACT Evaluation

- Mixed-methods evaluation to observe the implementation of integrated care among ACT innovators and compare reach and effectiveness
- Learning from the first 15 months addressed the following evaluation questions:
- How did the ACT practices make the changes required to integrate care for patients?
- What factors enable and impede efforts to integrate care for patients, with particular attention to teamwork, information exchange, and shared decision making

Early Lessons

- What did we learn during the first 15 months of ACT?
  - Organizational and Interpersonal Relationships Matter
  - Innovators faced early challenges in three areas:
    - Workflow and access to care
    - Leadership and culture change
    - Tracking patients and using data

Davis MM, Balasubramanian BA, Waller E, Miller BF, Green LA, Cohen DJ. Integrating Behavioral and Physical Health Care in the Real World: Early Lessons from Advancing Care Together. *Journal of the American Board of Family Medicine.* Sept - Oct 2013; 26:588-602. doi:10.3122/jabfm.2013.05.130028
http://www.jabfm.org/content/26/5/588.abstract.html

Organizational Relationships

Isolation / Mutual Awareness	Cooperation	Collaboration	Partnership	Merger / Single Organization
• Isolation: Entities working completely separately • Mutual Awareness: Agencies are informed about each other and each others' activities	• Denotes some sharing of resources, such as space, data, or personnel	• Involves joint planning and execution, with both entities working together to coordinate at multiple points to carry out a combined effort	• Implies programmatic integration, with two entities working so closely that there is no separation from the end user's perspective. Effect is nearly seamless	• Merger: One combined entity replacing the formerly separate entities • Single Organization: One organization to start

Interpersonal Relationships

Referral-triggered periodic exchange	Regular communication / coordination	Full collaboration / integration
• Information exchanged periodically with minimally shared care plans or workflows	• Regular communication and coordination, usually via separate systems and workflows, but with care plans coordination to a significant extent	• Fully shared treatment plans and documentation, regular communication facilitated by a care coordinator and/or clinical workflows that ensure effective communication and coordination of care

Keys to Success

- Buy-in from top and bottom is essential
- Trust grows over time - - transparency is crucial
- Develop shared vision
- Clearly articulate each partners' needs, assets and limitations
- Establish clear expectations
- Written agreements are necessary

The Compact

- A starter tool to ‘spell out’ how integrated care partners will collaborate to:
  - provide optimal health care for all patients with physical or mental illness across all life stages.
  - create team care by providing a framework for better communication and safe transition of care between primary care and behavioral health care providers.
  - provide a definition for integrated behavioral health care and the relational elements with primary care.
  - encourage the proper selection of a model of integrated care according to the practice capabilities and increase awareness to operational barriers and challenges.

Workflow and Access to Care

- Innovators developing workflows to ensure consistent access
- Factors contribute to limited availability
  - Part-time schedules; vacations or illness
  - Patient care renders professionals inaccessible
- Strategies and solutions
  - Expanding hours and refining flexible schedules
  - Creating rules for interruption
  - Developing ideal and contingency workflows

Understanding Team Tasks

- Screening
  - screen reviewed
- Clinician Counseling
- Traditional Referral
- Referral with Outreach
- Warm Handoff Referral
- Intensive Counseling - Psychiatry
- Intensive Counseling - health coaching
- Intensive Counseling - Behavioral Health Professional
- Follow-up - No Shows
- Follow-up-Psychiatry
- Follow-up HC or BHC
- Billing for Visits
- Tasks that occur outside practice

Leadership and Culture Change

- New collaborations can be difficult to foster among professional equals
- Struggles emerge around key patient care activities
- Staff turnover common
- Leadership, and emerging boundary spanning positions, critical to navigating change

Learning Community

- Build capacity to communicate and collaborate across differences
  - Shared language
  - Communicating your vision
  - Sharing power
  - Understanding professional identities
  - Conflict management
  - Crucial conversations
- Five practices of exemplary leadership (Jim Kouzes and Barry Posner)
  - Model the way
  - Inspire a shared vision
  - Challenge the process
  - Enable others to act
  - Encourage the heart

Tracking Patients & Using Data

- Prior to ACT, limited systematic screening for behavioral health
- Screening protocols developed, however
  - Few electronic health records (EHRs) well designed to capture or share information
  - Referral and outcome data not routinely collected
  - Limited staffing infrastructure to track/review data
- Work-arounds and learning to use data

Early Lessons Learned

- ACT suggests that implementing integrated care requires
  - More than adding new professionals or refining screening protocols
  - Flexibility and the ability to respond to non-linear changes
  - Building organization and interpersonal relationships (or ending them)
  - Fostering leadership throughout an organization
  - Tailoring strategies to fit the resources available in the local setting

Early Lessons Learned

- Real-time data collection (and review) is critical
  - Provides insight into what works and what does not
  - Facilitates conversations on how innovations might change
  - Allows overlay of qualitative data onto quantitative changes

Summary

- Innovators are “starting where they are”
  - Progress in organizational and interpersonal relationships in just 15 months
  - Address diverse patient and practice needs

- All faced early challenges in three areas:
  - Workflow and access to care
  - Leadership and culture change
  - Tracking patients and using data
    - Targets for technical assistance, learning and development

Stories from patients and providers

http://www.advancingcaretogether.org/acts-story.php

For More Information

www.advancingcaretogether.org

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