

Integrated Care



ORANGE COUNTY
HEALTH DEPARTMENT

Continuum of Integration



Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite 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, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
<ul style="list-style-type: none"> » Have separate systems » Communicate about cases only rarely and under compelling circumstances » Communicate, driven by provider need » May never meet in person » Have limited understanding of each other's roles 	<ul style="list-style-type: none"> » Have separate systems » Communicate periodically about shared patients » Communicate, driven by specific patient issues » May meet as part of larger community » Appreciate each other's roles as resources 	<ul style="list-style-type: none"> » Have separate systems » Communicate regularly about shared patients, by phone or e-mail » Collaborate, driven by need for each other's services and more reliable referral » Meet occasionally to discuss cases due to close proximity » Feel part of a larger yet ill-defined team 	<ul style="list-style-type: none"> » Share some systems, like scheduling or medical records » Communicate in person as needed » Collaborate, driven by need for consultation and coordinated plans for difficult patients » Have regular face-to-face interactions about some patients » Have a basic understanding of roles and culture 	<ul style="list-style-type: none"> » Actively seek system solutions together or develop work-a-rounds » Communicate frequently in person » Collaborate, driven by desire to be a member of the care team » Have regular team meetings to discuss overall patient care and specific patient issues » Have an in-depth understanding of roles and culture 	<ul style="list-style-type: none"> » Have resolved most or all system issues, functioning as one integrated system » Communicate consistently at the system, team and individual levels » Collaborate, driven by shared concept of team care » Have formal and informal meetings to support integrated model of care » Have roles and cultures that blur or blend

Key Points



- Includes screening for wide range of behavioral health issues
- Focuses on screening, brief intervention, and targeted referral
- Integrated care is *not* a replacement for specialty mental health/substance abuse services

Considerations



- Assessing readiness
- Choosing a model
- Space & Scheduling
- Financial Considerations
 - Start-up costs
 - Sustainability through billing
- Implementation Team
 - PCP and behavioral health leads

Case: Rural Health Group



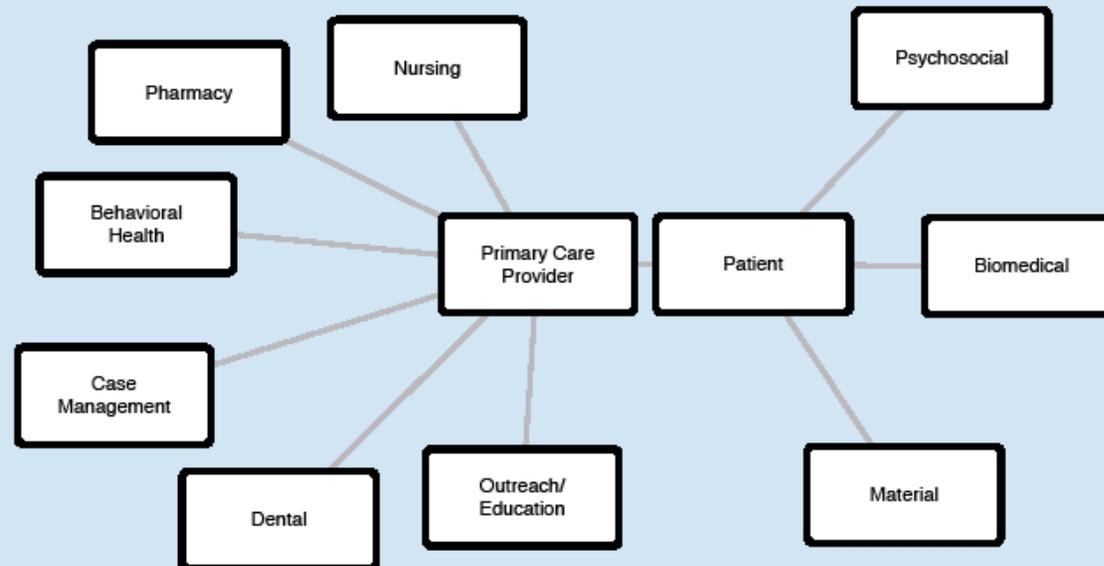
- Federally Qualified Health Center (FQHC)
 - Behaviorist a part of *every* patient's treatment team
- Funding
 - Initial funding for integration from grants and state funds (KBR, Office of Rural Health)
 - Billing by 2nd year, now get reimbursement for 1/3 of behavioral health budget



Case: Rural Health Group



RHG PCMH Model of Integrated Care



Case: Rural Health Group



- Lessons Learned

- Resistance to integrated model and comfort level with another professional in the exam room
- Behavioral health and health management issues
- Challenges of information sharing
- Documentation challenges with EHR
- Support from the top down

“We are a health care facility providing an array of integrated services; we are not a primary care facility that offers separate mental health care.”

Case: Project LAUNCH



5 Prevention & Promotion Domains

- Screenings: Social-Emotional & Maternal Depression
- Integration of behavioral health and support with primary care
- Home visiting
- Early Childhood MH Consultation
- Family Strengthening

Case: Project LAUNCH



- 4 private clinic sites in Alamance County
 - Children 0-8
 - Early childhood mental health teams embedded in pediatric practices
- Funding
 - Pilot project through a federal Substance Abuse and Mental Health Services Administration grant
 - Only North Carolina county, 35 nationally

An Integrated System of Care

**F a m i l y
C e n t e r e d
M e d i c a l
H o m e**



**F C M H
T e a m s**



- Referral Network
- Continuity of Care
- Collaboration



ALAMANCE HOME VISITING

CCNC/Access Care

Children's Developmental Services Agency (CDSA)

Centro La Comunidad

Dept. of Social Services

Exchange Club Family Center

Headstart

Health Department

Institute for Family Centered Services

NC Families United

Partnership for Children

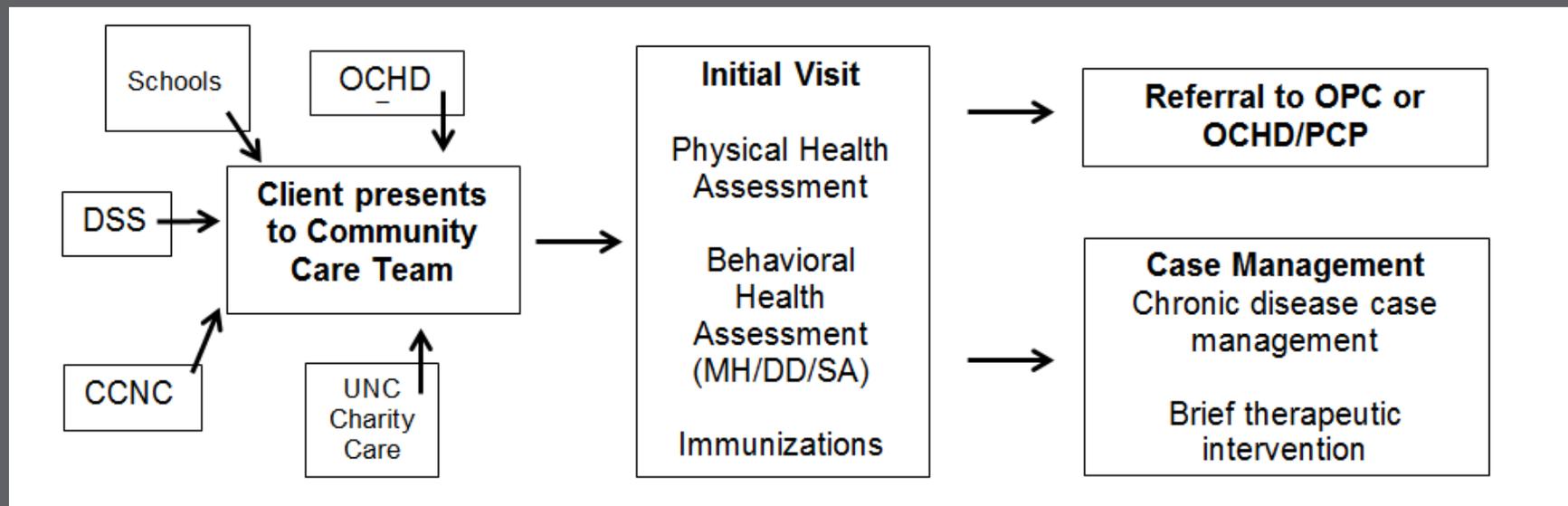
School System (ABSS)
Social Work & Nursing

Medicaid Reform in NC



- Emphasis on Accountable Care Organizations (ACOs)
- Further LME-MCO consolidation (10 → 4)
- Increasing accountability of LME-MCO for medical and dental health of their clients
- Long term expectation of formal cooperation agreements between ACOs and health departments

Office of Rural Health Grant



- Mobile, integrated care team
- Collaboration with Cardinal Innovations-OPC

Next Steps



- Assess readiness and identify action steps
- Develop business plan for integration of behavioral health care into OCHD services
- Advocate for use of standardized screening tools
- Implement communication campaign focused on behavioral health, using strategic framing approach