

# Trillium Integration Incubator Project



TIIP

Healthcare Workforce Meeting  
September 2, 2015



# Introductions

*Lynnea Lindsey-Pengelly, PhD, MSCP*

- Primary Care Psychologist
- Medical Services Director –
- Trillium Behavioral Health @ Trillium  
Community Health Plan – Lane County's  
CCO



# “The **TIPP**ing Point”:

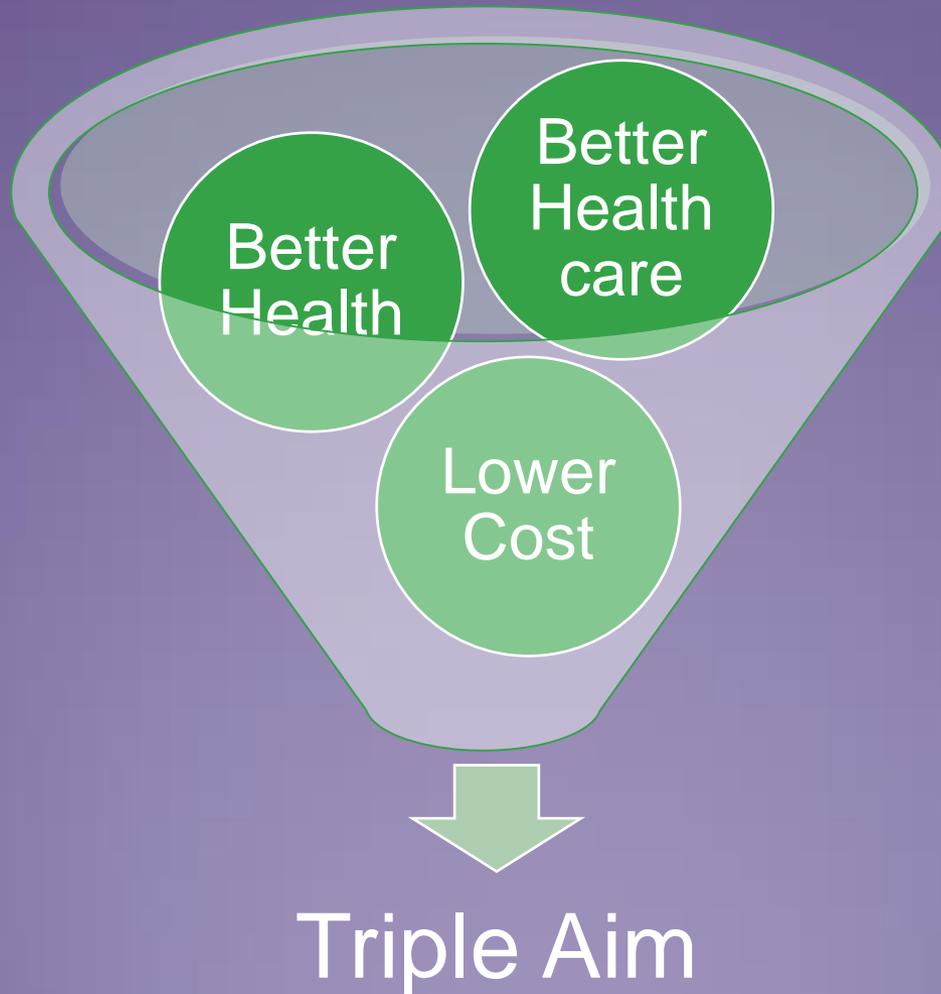
*How Little Things Can Make a Big Difference*

“The tipping point is that magic moment when an idea, trend, or social behavior crosses a threshold, tips, and spreads like wildfire.”

- Malcolm Gladwell



# Essential Elements of Integration



# Trillium Integration Incubator Project

- ▶ RFP
- ▶ All 8 sites chosen:
  - 4 Primary Care Medical Homes
  - 4 Behavioral Health Medical Homes
- ▶ Launch – July 1, 2014

*Covers up to 17,000 of the 94,000 Trillium Members*



# TIIP: Further Definition of the Models of Integration

- ▶ The patient-centered medical home model has been promoted as a potential way to improve health care.



# The interface of physical and behavioral health delivery is gaining importance in the medical home

## Coordinated

Behavioral and physical health clinicians practice separately within their respective systems. Information regarding mutual patients may be exchanged as needed, and collaboration is limited outside of the initial referral.

## Co-located

Behavioral and physical health clinicians deliver care in the same practice. Co-location is more of a description of where services are provided rather than a specific service. Patient care is often still siloed to each clinician's area of expertise.

## Integrated

Behavioral and physical health clinicians work together to design and implement a patient care plan. Tightly integrated, on-site teamwork with a unified care plan. Often connotes close organizational integration as well, perhaps involving social and other services.



# 2015 Patient Centered Primary Care Home (PCPCH) Standards Advisory Committee - OHA



**PATIENT CENTERED**  
**PRIMARY CARE HOME PROGRAM**

The Patient-Centered Primary Care Home Program is part of Oregon's efforts to fulfill a vision for better health, better care and lower costs for all Oregonians.



# 2015 Patient Centered Primary Care Home (PCPCH) Standards Advisory Committee - OHA

- ▶ Committee was convened at the end of June and will continue through November 2015
- ▶ “An emphasis for the 2015 Committee will be the integration of behavioral health services and primary care.”



# 2015 Patient Centered Primary Care Home (PCPCH) Standards Advisory Committee - OHA

- ▶ “While looking across the PCPCH Standards, the Committee will dedicate time to ensure that the current PCPCH model has appropriate standards related to the integration of behavioral health services in physical health-focused primary care settings.”

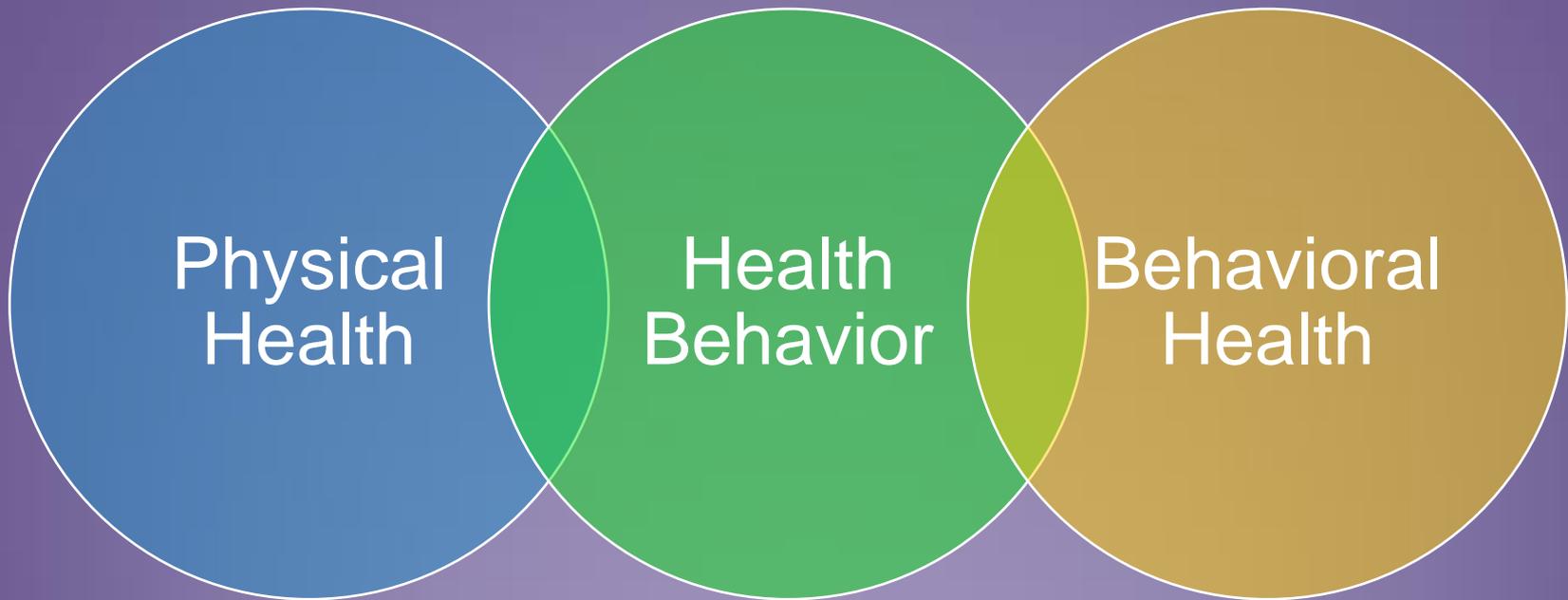


# 2015 Patient Centered Primary Care Home (PCPCH) Standards Advisory Committee - OHA

- ▶ “The Committee will also develop recommendations on standards for integration of primary physical health care in sites where the main focus is delivery of behavioral health care services.”



# Integrated Medical Home



# SB 832 Definitions

- ▶ **“Integrated health care” means care provided to individuals and their families in a patient centered primary care home or behavioral health home by licensed primary care clinicians, behavioral health clinicians and other care team members, working together to address one or more of the following:**



# SB 832 Definitions

- ▶ **“Integrated health care” (continued)**
- ▶ **(A) Mental illness.**
- ▶ **(B) Substance use disorders.**
- ▶ **(C) Health behaviors that contribute to chronic illness.**
- ▶ **(D) Life stressors and crises.**
- ▶ **(E) Developmental risks and conditions.**
- ▶ **(F) Stress-related physical symptoms.**
- ▶ **(G) Preventive care.**
- ▶ **(H) Ineffective patterns of health care utilization.**

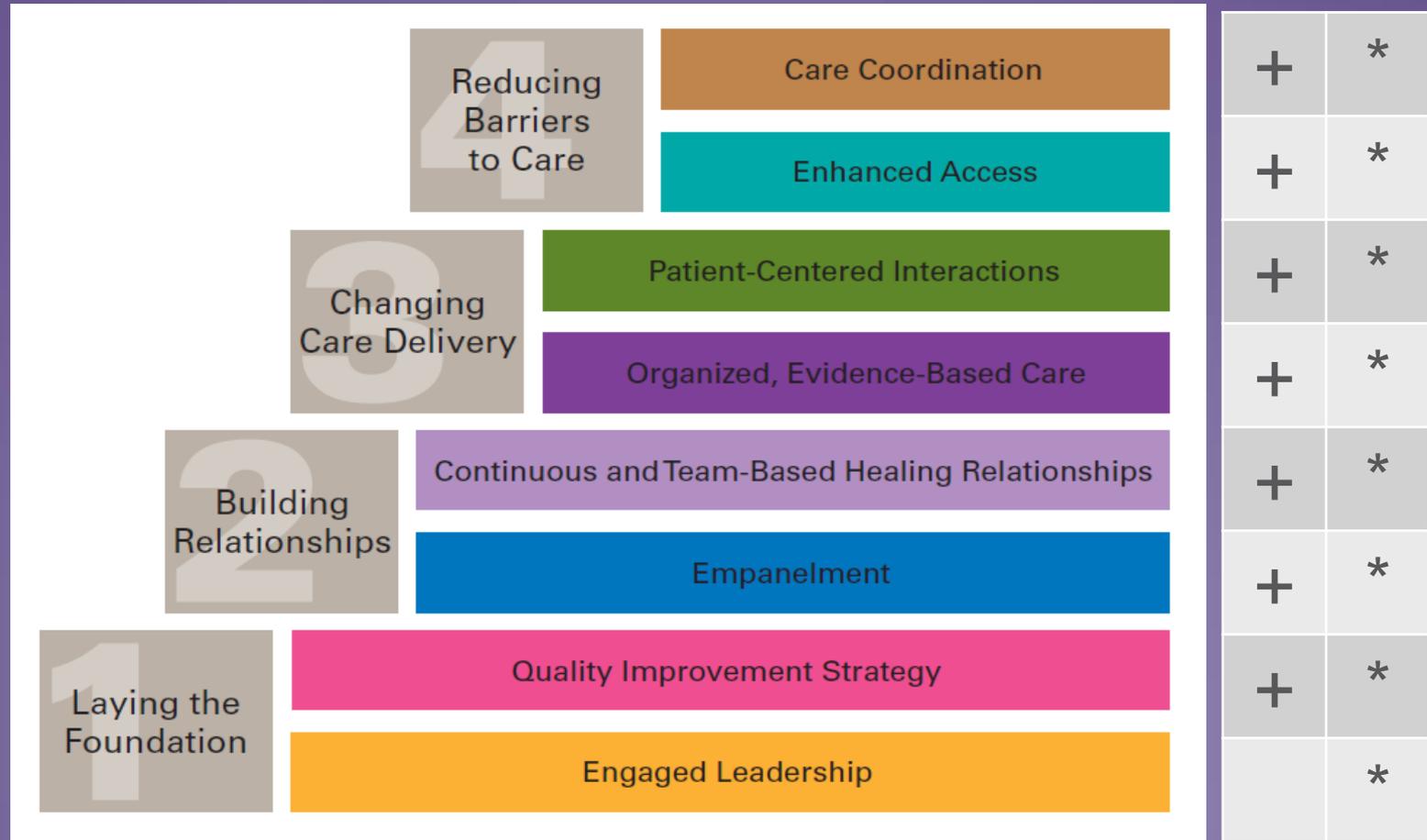


# SB 832 Definitions

- ▶ **(b) As used in this subsection, “other care team members” includes but is not limited to:**
  - **(A) Qualified mental health professionals or qualified mental health associates meeting requirements adopted by the Oregon Health Authority by rule;**
  - **(B) Peer wellness specialists;**
  - **(C) Peer support specialists;**
  - **(D) Community health workers who have completed a state-certified training program;**
  - **(E) Personal health navigators; or**
  - **(F) Other qualified individuals approved by the Oregon Health Authority.**



# Wagner: High Performing PCMH Elements



Safety Net Medical Home Initiative – [www.safetynetmedicalhome.org](http://www.safetynetmedicalhome.org)

+NCQA Patient-Centered Medical Home 2014 Standards

\**The 10 Building Blocks of High -Performing Primary Care.* Tom Bodenheimer, et al. Annals of Family Medicine. March/April 2014.



# Why integrated team-based care?

- ▶ Improved clinical outcomes
- ▶ Better access to care in an era of expanded coverage
- ▶ Reduced staff and clinician burnout
- ▶ Able to meet PCMH standards/expectations



# Wagner: Teams expand access

<i>Type of care</i>	<i>Percent of physician's time in traditional practice</i>	<i>Estimated percent of physician's work that can be reallocated to non physicians</i>	<i>Estimated percent of physician's time saved</i>
Preventative	17%	60%	10%
Chronic	37%	25%	9%
Acute	46%	10%	5%
<b>TOTAL</b>	<b>100%</b>	<b>-</b>	<b>24%</b>

Thomas S. Bodenheimer and Mark D. Smith: Primary Care: Proposed Solutions To The Physician Shortage Without Training More Physicians, *Health Affairs*, 32, no.11 (2013):1881-1886



# Wagner: Teams improve patient AND provider experience

- ▶ “Multiple elements related to team function were positively correlated [with clinical] quality, patient satisfaction, and clinician satisfaction.”
- ▶ Day et al. Ann Fam Med 2013; 11,Supp1: 550-9.



# Workforce for Team Based Care – Sample Primary Care Clinic of 10,000 patients

Title	QTY
PCP - MD/DO	2
Clinical Psychologist	1
Licensed Clinical Social Worker	3
Nurse Practitioner/Physician Assistant	4
Clinical/Group Educator(s)	2
Clinical Pharmacist	0.5
Consulting Psychiatrist	0.2
Medical Assistants/Scribes	12
BH Assistants/ Scribes	3
RN Care Manager	2
BH Care Manager	1
Office Manager	1
Front Office Staff	4
IT Analyst	1
Encounter Coder/Biller	2
Community Health Workers / Patient Navigators	10
	46.7



# References

- ▶ <http://www.oregon.gov/oha/Transformation-Center/ComplexCareMeetingDocs/Ed-Wagner-slides.pdf>



# Thank you

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