

UNDERSTANDING INTEGRATION FROM THE GROUND UP

**OHP QUALITY AND HEALTH OUTCOMES
COMMITTEE, OCTOBER 13, 2014**

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PRESENTATION OUTLINE

- About ACT and WORKFORCE
- Methods and Data
- Data and stories related to screening and delivery of integrated care

METHODS AND DATA

Sample – about ACT and WORKFORCE

Data Collection

- Documentation
- Practice Information Form
- Online diaries (ACT only)
- Phone calls
- Site visits
- Reach and patient tracking (ACT only)

Establishing outcomes (ACT only)

- Patient outcomes
- Expenditures
- Utilization



REACH

The ACT program included:

Over a 12 month period:

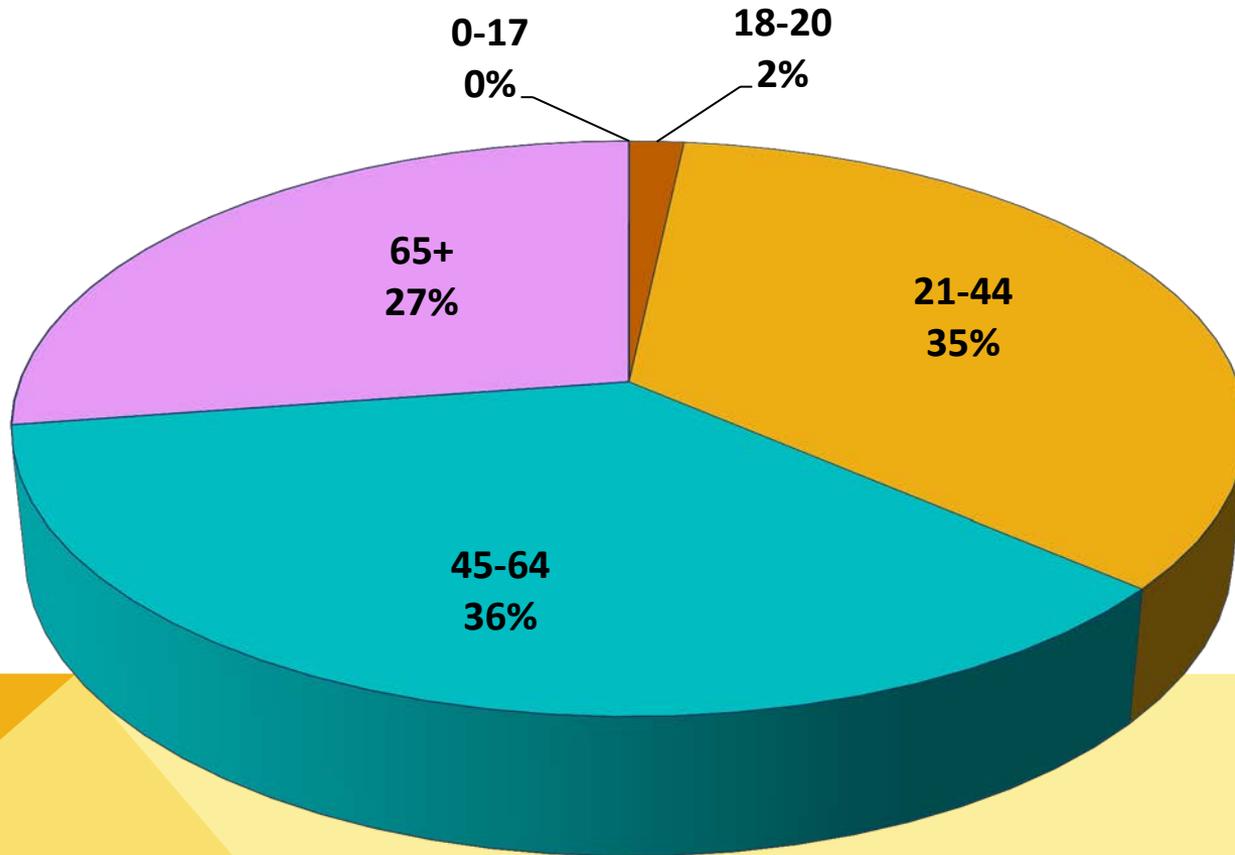
- 84,645 target patients
- 13,168 were screened
- 6,845 screened positive

Over a three month period,
on average:

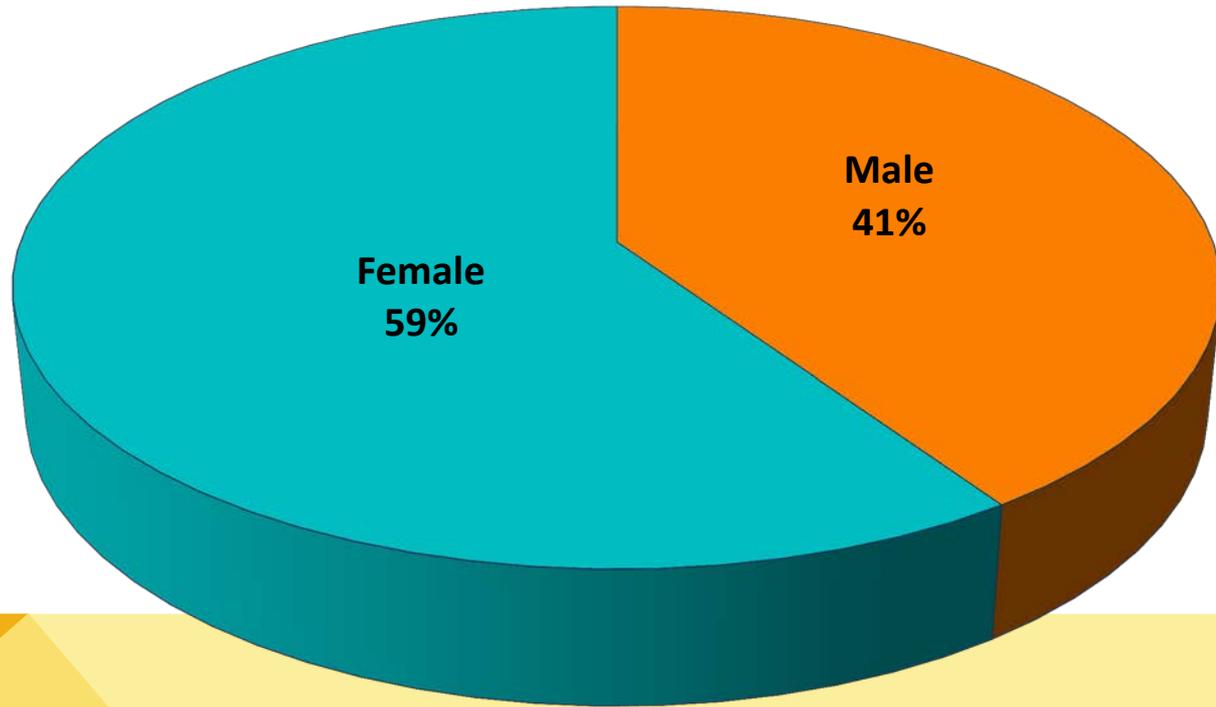
- 21,149 target patients
- 3,292 were screened
- 1,711 screened positive

15.5% screened
52% of those screened, screened positive

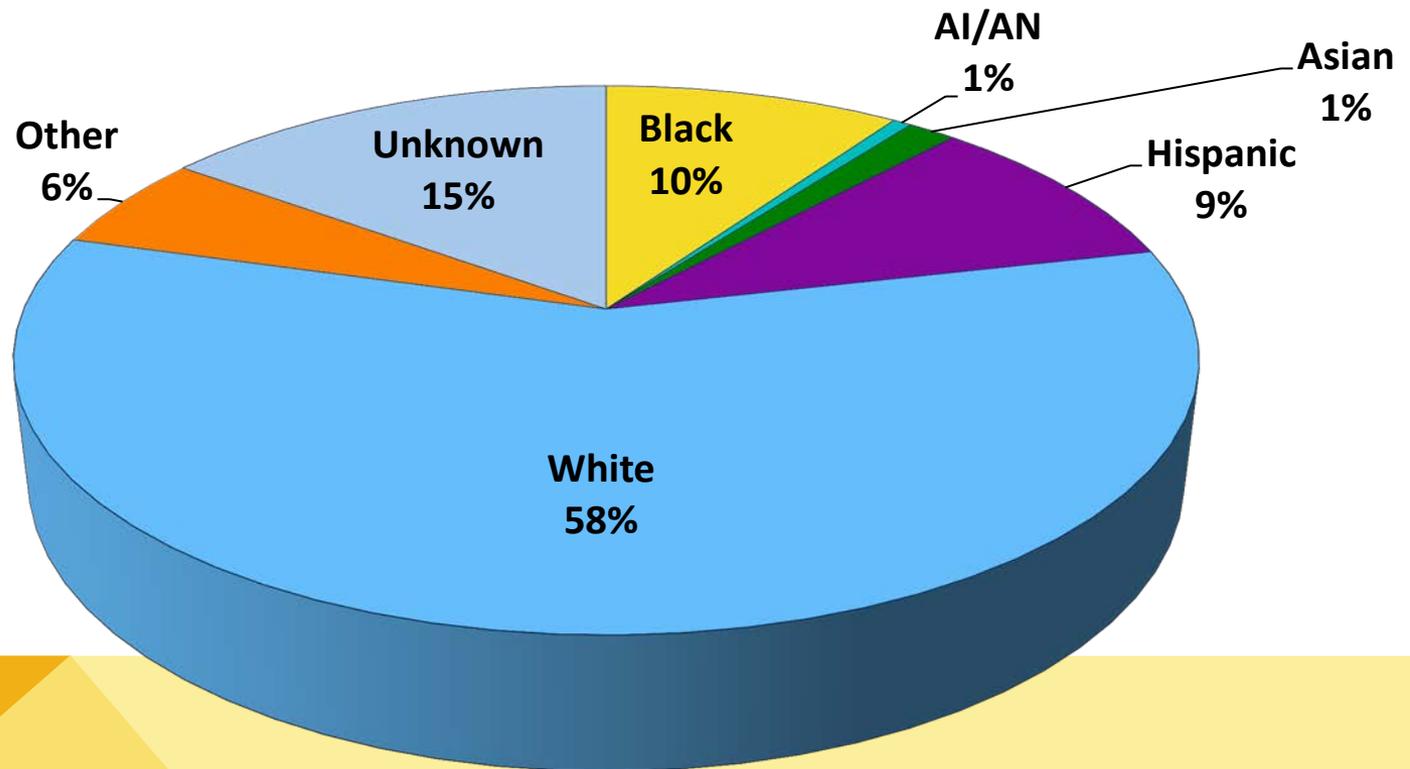
DEMOGRAPHICS - AGE



SEX

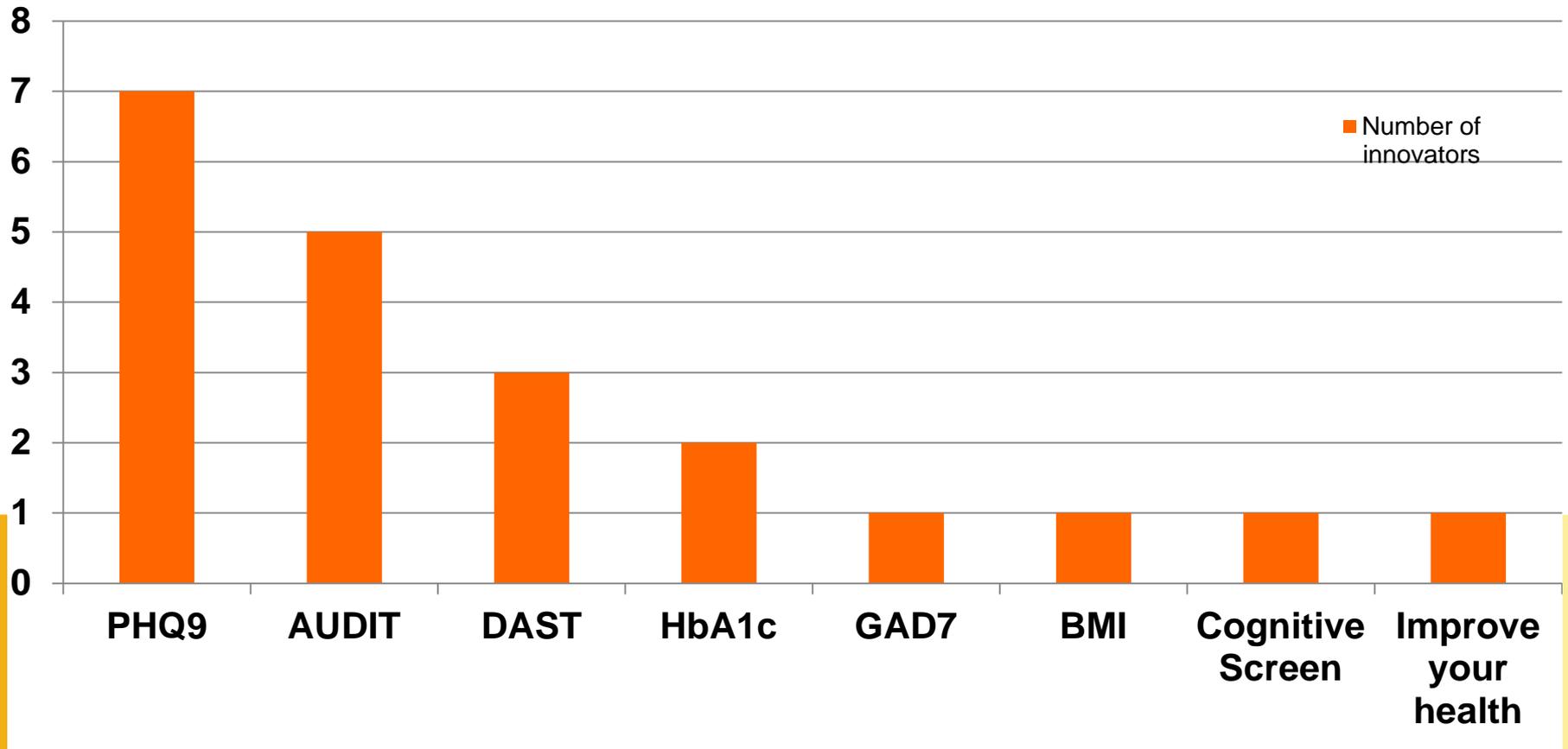


RACE/ETHNICITY



SCREENING TOOLS USED BY ACT INNOVATORS

Screening Measures



TYPES OF INTERVENTIONS PROVIDED TO PATIENTS

Brief counseling in primary care

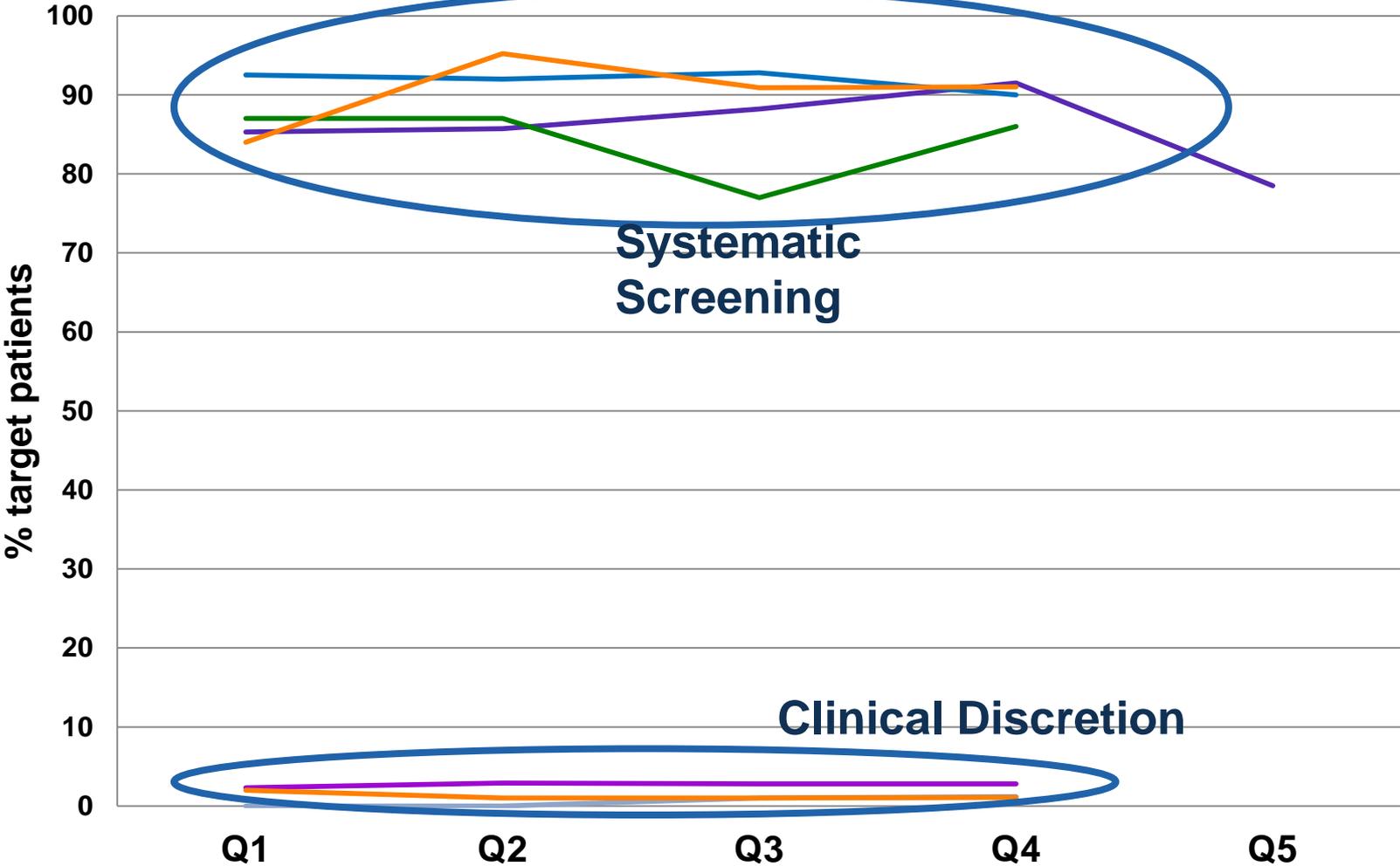
Referrals for traditional long-term counseling

- Within clinic
- From partner clinic
- Outside clinic

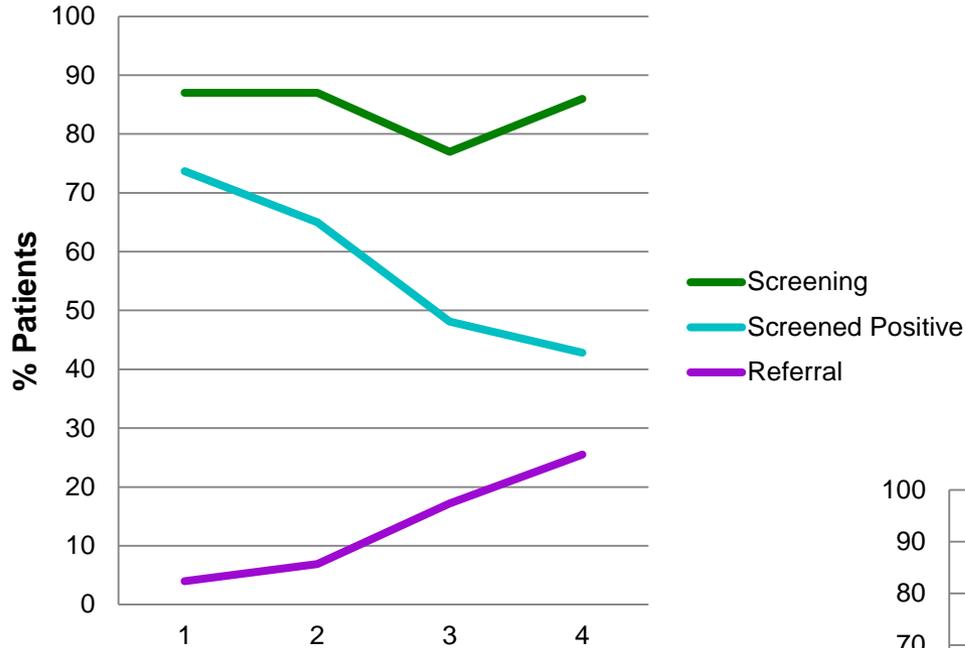
Warm hand-off

Joint PC and BH counseling

SCREENING

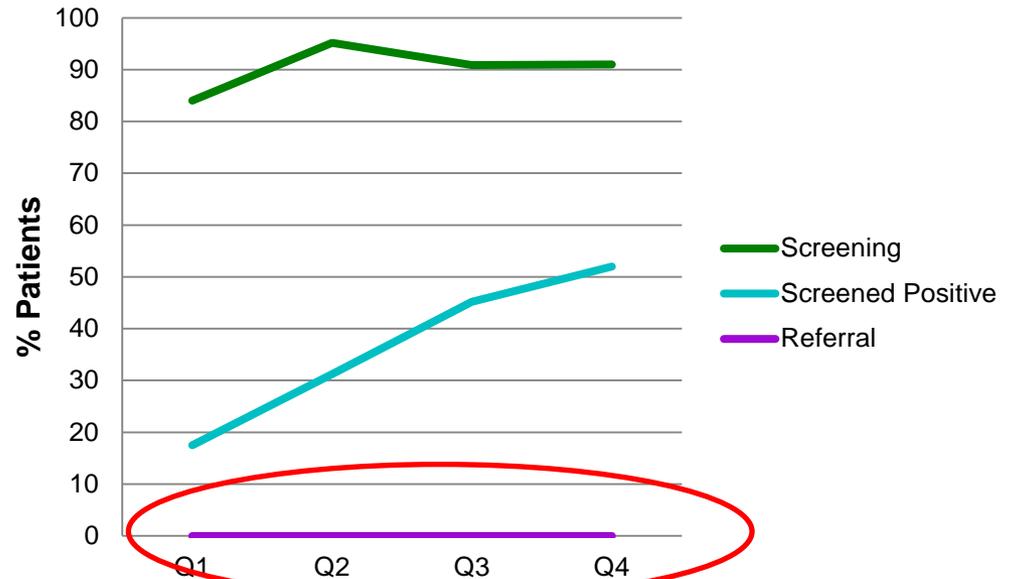


TWO STORIES



Documenting referral or receipt of further counseling for patients who screened positive

Mental model for how data is used in quality improvement process



THE WORK BEYOND SCREENING

Change is needed to integrate behavioral health and primary care

Developing expertise / culture needed to deliver integrated care

- Leadership
- Hiring and staffing – balancing access and financing
- Training / Mentoring

Developing structures that facilitate integration

- Structuring for sequential and reciprocal tasks
- Defining roles and responsibilities
- Health IT infrastructure
- Physical space

THE WORK BEYOND SCREENING

Change is needed to integrate behavioral health and primary care

Developing processes that facilitate integration

- Documentation and information sharing
- Workflows
- 3Cs: Consulting, Coordinating and Collaborating
- Recruiting, coaching, modeling

EXAMPLE 1: CMHC-FQHC HYBRID

Characteristics	Practice 1	Practice 2
Breadth / Depth of Integration Reach		
ID of Problem	Systematic Screening	Systematic Screening
Provision of Services	Limited	Broad
Relevant Workforce Location		
In Practice	Yes	Yes
Embedded in Team	No	Yes
Path Identified for Other Services	Yes	Yes
Shared Mental Model for Integration	No	No

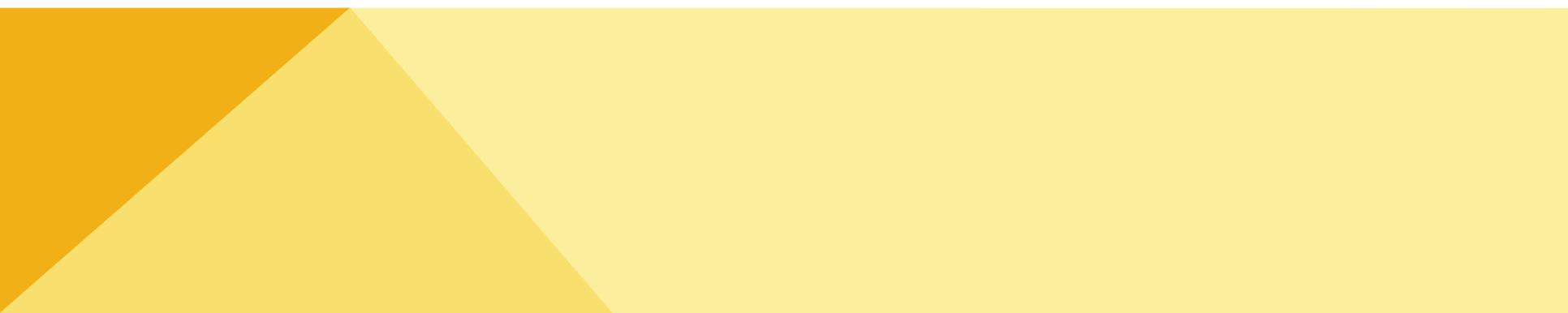
EXAMPLE 2: BH IN PC

Characteristics	Practice 3	Practice 4	Practice 5
Breadth / Depth of Integration Reach			
ID of Problem	Systematic Screening	Systematic Screening	Clinical Discretion
Provision of Services	Limited	Limited	Limited
Relevant Workforce Location			
In Practice	Yes	Yes	Yes
Embedded in Team	No	No	Yes
Path Identified for Other Services	Yes	Yes	Yes
Shared Mental Model for Integration	No	Yes	Yes

EXAMPLE 3: PC IN BH

Characteristics	Practice 6	Practice 7	Practice 8
Breadth / Depth of Integration Reach			
ID of Problem	Systematic Screening	Clinical Discretion	Clinical Discretion
Provision of Services	Limited	Limited	Limited
Relevant Workforce Location			
In Practice	Yes	Yes	Yes
Embedded in Team	No	No	No
Path Identified for Other Services	Yes	Yes	Yes
Shared Mental Model for Integration	No	Yes	Yes

KEY TAKE HOME POINTS

- Systematic screening is the first step (and a must) for thinking about integration at the level of clinic populations
 - Practices that used systematic screening and had the capacity to provide integrated services to the most patients in need, are comparable to FQHC-CMHC hybrids
 - Systematic screening with limited capacity to provide services – there are a wide range of reasons for this limited capacity; these need to be identified and addressed
 - Clinical Discretion may be an active choice particularly when resources are limited
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My collaborators on this project include:

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THANK YOU