Advanced Clinical Social Work Practice in Integrated Healthcare

Module 1

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Introduction to Integrated Healthcare and the Culture of Health
Module 1: Outline

• Define integrated healthcare and review research on the need/evidence for integration

• Describe the continuum of integration of behavioral treatments into primary healthcare settings

• Discuss various "models" of integrated care, multidisciplinary practice and the different languages of healthcare

• Discuss facilitators and barriers, payment models and the implications of integrated care for social work education and practice
What is Integrated Healthcare (IC)?

• It is a coordinated system of care that provides both medical and mental/behavioral health services to address the whole person, not just one aspect of the consumer’s healthcare needs.

• Medical and mental health providers collaborate to coordinate the assessment, treatment, and follow-up of both mental and physical health conditions.

• Integrated healthcare reflects a holistic approach to social work practice that is strengths-based and person-centered. It represents an opportunity to improve care and reduce costs.
Key Elements of Integrated Healthcare

• Comprehensive screening & assessment.
• Identification of a patient-centered physical & behavioral health “home” that provides opportunities for collaboration and co-location of services.
• Shared development and communication of care plans.
• Care coordination and management to ensure care quality and provide support for consumers & providers.
• Engagement of consumers in self-management & care planning.
Additional IC Elements

• Medication algorithms and protocols, (e.g., standardized assessment/screening instruments & protocols for CBT & MI).

• Joint, standardized performance measures & feedback mechanisms, (e.g., use registries and outcome tracking).

• Mechanisms for sharing savings from reductions in high cost use & services consolidation.

• Electronic data systems capable of sharing data.
Rationale for Integrating Mental Health into Primary Care

- Skyrocketing cost of healthcare
- Fragmented health systems and unmet healthcare needs
- Persons with mental health problems often don’t get care and those with SMI die, on average, 25 years earlier \(^1\)
- Many people with mental health problems have co-morbid medical problems.
- Primary care providers manage care for 80% of persons with psychiatric disorders and are the “de facto” mental health care system \(^2\)
- Currently 20% of persons in healthcare system use about 85% of resources
- Research reveals that cost-offset is greatest when behavioral and primary healthcare are integrated \(^3\)
Rationale for Integrated Healthcare

- Primary care is often the first “port-of-call” when a person presents with a mental/behavioral health disorder.

- Patients with chronic illness frequently have co-morbid major depression, anxiety and psychosocial stressors secondary to living with their disorder.

- Because integrated care allows symptoms to be more easily recognized and treated when they emerge, it has the potential to reduce the duration and intensity of treatment required.

- Care that synchronously addresses physical, mental and behavioral health needs reduces reports of stress, improves self-care, self esteem and perceptions that illness is manageable.
Research Evidence on Integrated Healthcare

- Studies have shown that integrating mental/behavioral health services into primary care clinics
  - Improves patient satisfaction
  - Improves provider satisfaction
  - Increases adherence to medication
  - Decreases medical utilization among “high users”
  - Improves patient outcomes
  - Reduces healthcare costs
  - Improves patient quality of life
Wagner’s Chronic Care Model (CCM)

- Approaches management of mental health disorders as though they were chronic illnesses.

- This model of collaborative care involves integration of mental health specialists and care managers with oversight by primary care physicians to proactively treat mental/behavioral health problems.

- Clinical trials have revealed the effectiveness of collaborative care over general medical care in treating mental health disorders.
Other Theoretical Constructs

- Social Learning (Bandura) \(^6\)
- Self Management Theory (Deci) \(^7\)
- Four Quadrant Model \(^8\)
  - Low to moderate BH & PH care needs
  - Moderate to high BH & low to moderate PH needs
  - Low to moderate BH & moderate to high PH care needs
  - Moderate to high BH & moderate to high PH care needs
Continuum of Integration

- Consultation/Liaison C/L
- Collaborative Care
- Coordinated-Care and Care Management
- Co-located MH/BH services
- Integrated Care
- Patient Centered Medical Home (PCMH)
- Person Centered Care
- Shared Care
Consultation/Liaison C/L

- Developed in 1950s to extend mental health services to medical and surgical inpatients

- Later adopted a chronic disease management approach and began to address mental health issues in primary care

- Studies of C/L in primary care have demonstrated better treatment outcomes and decreased cost when mental health care is readily available in primary care settings \(^9-11\)
Elements of Collaborative Care

- Routine screening for mental and behavioral health conditions conducted in primary care settings.
- Referral relationship between primary care and mental health providers.
- Routine exchange of information between providers.
- Primary care providers deliver specific mental health interventions using treatment protocols and algorithms.
- Case managers facilitate communication between providers, monitor treatment outcomes and make referrals for the patient to resources in the community.
Co-located Medical and Mental/Behavioral Health Services

- Co-location describes where services are provided rather than a specific approach to care.
- Medical and mental/behavioral health services are located in the same facility.
- Referral is made for medical patients to be seen by mental health specialists.
- Consultation between medical and mental health providers is facilitated by co-location and that holds the potential to increase the skills of both groups.
Collaborative Care/Consultation/Liaison

- A overarching term reflecting an ongoing relationship between service providers (primary care and mental/behavioral health clinicians)

- Occurs when multiple healthcare providers from different professional backgrounds provide comprehensive services by working together with patients and their families to provide high quality care across care settings

- Promotes patient self-management and compliance with treatment recommendations
Integrated Care

- Comprehensive and coordinated/team-based approach to care and decision-making for medical and mental health conditions

- Ideally, integrated at one site with a unified care plan covering mental/behavioral and medical care needs

- Typically employs a multidisciplinary team working together often using a prearranged protocol and evidence-based practices (e.g. CBT, Solution Focused Therapy)

- Frequently includes close organizational integration and the monitoring and tracking of patients over time
Patient–Centered Medical Home

- A place and a model of holistic person-centered healthcare that is often team-based, comprehensive and coordinated

- Provides care through a physician-directed interprofessional care team usually composed of an MD, advanced practice nurse or physician assistant, social worker, and pharmacist

- Medical homes vary in size and provide a regular source of healthcare for individuals with a broad range of medical, mental and behavioral healthcare needs
Person-Centered Holistic/Shared Care

- Person-Centered Care: services that are responsive to individual patient preferences, needs, and values ensuring that patient preferences guide all clinical decisions

- Shared Care: primary care and mental health professionals work together in a shared system in which providers maintain one treatment plan addressing all patients’ health needs in a shared medical record (e.g. Canadian Model)
State Options for Integrating Care

- Managed Care Organizations (MCOs)
- Primary Care Case Management Programs (PCCMs)
- Behavioral Health Organizations (BHOs)
- MCO/PCCP and BHO partnerships
State Reimbursement Options

- Fee-for-service (F4S)
- Practice-based care/case management under contract to health plans
- Pay-for-performance (P4P)
- Flexible payments for chronic care and disease management
- Global capitation
- Hybrid models
State Contracting Options

- Align financial incentives across medical and behavioral health systems
- Require “real-time” information sharing across providers and for all team members
- Hold interprofessional care teams responsible for coordinating the full range of medical and behavioral healthcare
- Require competent provider networks and mechanisms for rewarding high quality care
Facilitators for Integrated Healthcare

- Co-location of behavioral health providers in primary care sites
- Routine screening strategies to increase behavioral health diagnoses
- Computer-based screening
- Co-treatment by primary care and BH providers
- Unified medical record for physical and mental health
- Use of medication algorithms for MH disorders
- Organizational support for collaborative care
- Tracking of behavioral health care outcomes
- Training of primary care providers on BH conditions
- Use of evidence-based practice protocols
Barriers in Integrated Healthcare

- Perceived loss of autonomy
- Primary care providers’ limited training in MH treatment
- Workforce shortages
- Limited time in primary care clinics
- Lack of agreement as to who is in charge
- Lack of reimbursement for screening and/or consultation between primary care and BH providers
- Same day billing restrictions
- Social Workers limited training in interprofessional team-based practice and primary care settings
Social Work Competencies for Team-Based Practice

- **Values and ethics**: Honesty and integrity in relationships with patients, families and team members. Maintaining confidentiality, dignity and privacy in delivery of care

- **Roles and responsibilities**: The knowledge and capacity to explain team members roles and responsibilities to clients

- **Interprofessional communication**: The ability to give timely instructive information and feedback to team members

- **Teamwork and team-based care**: Capacity to engage other professionals in shared patient-oriented problem solving
Implications for Social Work Education

- Didactic courses as well as pre and post-graduate level practica designed to produce competent clinicians and leaders in integrated care are suggested as a way to better prepare social workers for integrated healthcare.

- Additional macro and clinical training for social workers on medical literacy, chronic disease management, economic and business strategies, how to work in a medical team and skills for working within the primary care environment have all been recommended to ensure social work competency in integrated healthcare practice.
Impeding Factors

- **Resistance to change**: Change is often difficult and some fear a loss of status with IC

- **Absence of role models**: Many social work faculty have never been educated to work in integrated care or as part of a team

- **Logistical barriers**: Finding time and space to add to the curriculum and educate students from multiple professions is challenging
Strategies to Advance Social Work Education

• Undertake an educational campaign to establish the need for updated social work curriculum and practica to develop the competencies and skill set needed for interdisciplinary practice in integrated healthcare.

• Prepare faculty for teaching students how to work effectively as part of a team in primary care settings.

• Promote research on social work education to identify practices and curricula that are effective in changing practice behavior and prepare social worker students for successful practice and leadership in interprofessional care.
Important Questions Remain

• What is the most effective model and setting for optimal delivery of BH?

• Who should take the lead in integration?

• Does the chronic care model actually promote integration, accountability and improved outcomes for co-occurring medical and mental health disorders?

• Do financial incentives facilitate integrated care and improve healthcare outcomes?
Important Questions Remain

• What is the optimal role for regulation and legislation?

• How should integrated healthcare be financed?

• How might healthcare disparities be addressed in an integrated healthcare system?

• Who will develop practice standards and criteria that focus on holistic health, wellness and culturally competent care?
References

References


