NATIONAL REGISTER

OF HEALTH SERVICE PSYCHOLOGISTS

Integrated Care:
Models, Screening & Financing

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Models

Why Language & Behavior Matter

- The lexicon (AHRQ) gave us a start to knowing how to talk about integrated care, but now we need to move on towards behavior in describing integrated care
- Models give us the key behaviors which exemplify evidence-based integrated care and specify our use of language
- This allows us to coalesce concepts such as “level of integration,” “population reach,” alongside our use of terminology related to the defined “models.”

Center of Excellence for Integrated Care

What Is Integrated Care? Definitions and Terms.

Integrated care is defined by the effort to treat the physical health of patients alongside the mental health of patients. How integrated care is delivered varies by setting and by providers, however, well defined *Models* of integrated care have emerged in the last decade for integrating behavioral health services into primary care clinics. Some clinics choose to create their own ways of integrating services outside of these models, and these are then called *Programs*. Programs are specific to clinics and do not generalize to other situations. More recently programs have emerged to integrate primary medical care into behavioral health settings. These are still emerging and being studied. Both programs and models can also be described as having a certain reach or *Population Penetration* into the population. Some models, such as the PCBH model have broad penetration in that almost any patient of a clinic can be impacted by the model whereas the other models by their focus only impact a subset of the clinic population.

MeHAF Score	1 Usual Care	2	3	4	5	6	7	8	9	10 Full Integration
Program or Model Typology	-	Program				SBIRT Model/ Collaborative Care Model			PCBH Model	
Six Levels Crosswalk	1 Minimal Collaboration	2 Basic Collaboration at a Distance			3 Basic Collaboration Onsite	4 Close Collaboration Onsite/Some System Integration		5-6 Full Collaboration/ Transformed practice		
Population Penetration (Four Quadrants)	Variable					I Low BH/ Low PH	I & III Low BH/ Low PH and/ or Low BH/ High PH		I-IV All Quadrants	

Key & Definitions:
MeHAF Level: refers to the degree of integration of physical and mental/behavioral health at a particular site *compared to usual care* as defined by the domains of the MeHAF tool (**http://www.mehaf.org/content/uploaded/images/tools-materials/ssa%20surveyjanuary2015.pdf**).
Program: refers to a site- specific effort to increase the *level* of integration (that is *not* defined by a model) compared to usual care. This effort is not generalizable to other sites and is not evidence-based.
Model: refers to a discrete, well defined, empirically validated, replicable set of characteristics and pathways which systematically apply studied strategies using a defined workforce to achieve integrated care.
Population Penetration: refers to the extent to which a model reaches the population of a site and is represented by the Four Quadrant metric (**http://www.integration.samhsa.gov/resource/four-quadrant-model**).
Six Levels: refers to another commonly used framework of levels of integration (**http://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf**)

The Models

PCBH	A Behavioral Health Consultant works alongside a primary care provider providing real-time support to patients and the medical team to any patients with need in the clinic that day.
SBIRT	A bachelor's or master's level worker screens patients for substance abuse conditions and provides brief intervention to those patients who screen positive.
Collaborative Care	A consulting psychiatrist and care manager provides support for prescribing practices of primary care providers for the care of depression.

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Models

- Have a clear definition of practice, personnel roles
- Have an evidence base
- Three exist: Collaborative Care, SBIRT & PCBH
- These models are not mutually exclusive and can run simultaneously in a practice setting given that two are vertical models (CC, SBIRT) and one is a horizontal model (PCBH)
- The models, when run with some degree of fidelity, will usually score 6 or above on the MeHAF
- The models differ in which populations they are applicable to (Four Quadrants)

Programs

- Are unique efforts to make improvements compared to “usual care” that are site specific
- No evidence base is present specific to the effort but there may be some general rationale for the effort that links to research
- Are not generalizable since the boundaries of the effort are not portable; all sites have some “programmatic” aspects to their work
- Sites that primarily run programs typically score between 1 and 5 on the MeHAF on average
- Example: A therapist is contracted by a site to provide care in a primary care clinic in a co-located fashion

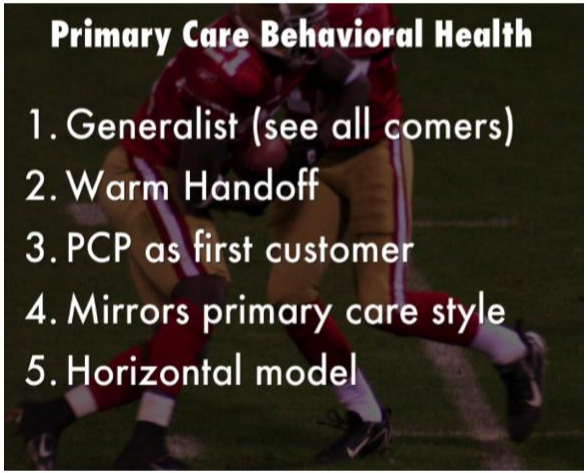
Population Reach or Penetration

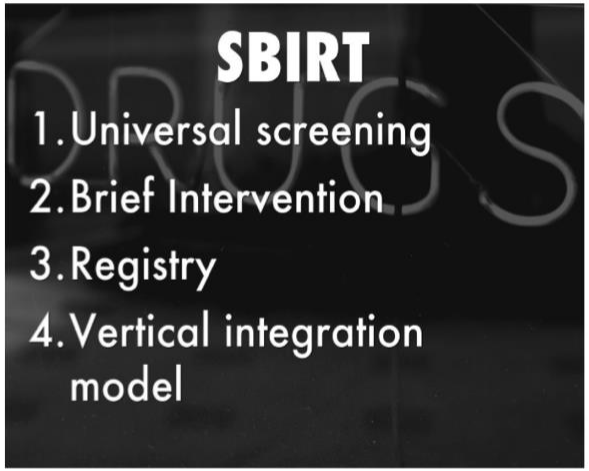
- Four Quadrants: Low to High Medical & Behavioral Health complexity
- Alternative definition for population reach: Number of unique patients seen by the integrated care service as compared to the total number of unique patients in the served population
- The models differ in their “population reach” potential by design

Level of Integration

- This is an emerging area, but most tools coalesce around the same concepts
- MeHAF is one tool which describes 18 domains and can be used by a site to survey itself
- The Six-Levels continuum proposed by SAMHSA is descriptive only
- “Models” score higher on the levels of integration by definition

Side-By-Side Comparison





Implementation Basics

- Models are not mutually exclusive and can be run side-by-side
- Model selection is done based on target need/ population and available personnel
- Implementation of any of the models requires organizational effort thus an implementation team is needed and external guidance is frequently needed for success

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