Integrating Behavioral Health into Team-based Person-Centered Care

Best Practices and Experience from Other States

Neal Adams MD MPH
Deputy Director
California Institute for Mental Health
Treatment Planning for Person-Centered Care

Shared Decision Making for Whole Health

Neal Adams
Diane M. Grieder
Virtual Synonyms

- Recovery
- Integrated Care
- Whole Health
- Person-Centered Care
- Collaborative Care
- Shared Decision Making
- Care Coordination
Whole Health

- We have a sick-care system
  - not a health-care system
  - fragmented
  - siloed
  - organized around disease not health

- Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity
  - there is no health without mental health
  - there is no mental health without health
The Challenge

- One of the best-known findings from epidemiologic research is that most mental disorders present in primary care and are either not recognized or remain untreated or undertreated.

- Most individuals referred to mental health specialists either do not show up for care or do not engage.

- Although a great deal of energy is currently being devoted to making the business case for integrating mental health into primary care, reimbursement alone will not improve care unless the delivery system changes.

- Merely moving mental health services into primary care, is of little value.

- It is critical to address the clinical and operational aspects of integrated care, which is very different than traditional mental health care.

Andrew S. Pomerantz, MD
VA’s National Mental Health Director for Integrated Services
On any given day...
Core goal

- Propose a framework for health care reform that focuses on supporting **integrated and person-centered care**
  - continued innovation toward more personalized care
  - not as an afterthought or as an addition to health care financing and regulation

- Improve care and health while also bending the curve of health care cost growth
My Premise...

- **Person Centered Planning** (PCP) can be the bridge between the system as it exists *now* and where we need to go in the *future*

- PCPs are a key lever of personal transformation and systems reform at all levels
  - individual and family
  - communities
  - provider
  - administrator
  - policy and oversight
  - payment/finance
Individual / Service Plan = Social Contract

- It is the “work order” created by the person and provider
- Agreement on
  - tasks
  - roles and responsibilities
  - time frames
  - deliverables
Patient-Centeredness

The concept of a medical home (practice team that coordinates a person’s care across episodes and specialties) is now reaching center stage in proposal for redesign of the US health care system.

The question remains open, however, about the degree to which medical homes will shift power and control into the hands of patients, families and communities. In this paper I argue for a radical transfer of power and bolder meaning of ‘patient-centered care, whether in a medical home or in the current cathedral of care, the hospital.’

“What ‘Patient-Centered’ Should Mean: Confessions Of An Extremist”
Don Berwick, MD, Health Affairs, May 2009
Berwick’s Three Maxims

- The needs of the patient come first
- Nothing about me without me
- Every patient is the only patient

The experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one’s person, circumstances, and relationships in health care.
Shared Decision Making is an opportunity to make recovery real. By developing and promoting shared decision-making in mental healthcare, we can advance consumer-centered care and recovery.

Kathryn Powers
July 10, 2007
Shared decision-making is an interactive and collaborative process between individuals and their health care practitioners about decisions pertinent to the individual’s treatment, services, and ultimately their personal recovery.

An optimal decision is one that is informed, consistent with personal values, and acted upon. Participants are satisfied with the process used to make the decision.
Ultimate Goal of Transformation/Reform

- A healthcare system that promotes whole health
  - Consumer and family driven
    - each adult and child has access to a full spectrum of **integrated services** needed to support their unique wellness/recovery vision
  - Focuses on wellness/recovery
    - a strengths-based approach to help each person experience health, independence, self-esteem, and a meaningful life in the community
  - Builds resilience
    - the ability to face life’s challenges and maintain health
Person-Centered Clinical Care
Guiding Principals

6th GENEVA CONFERENCE ON
PERSON-CENTERED MEDICINE

Person-centered Health Research
Core Conference on April 29 – May 1, 2013
Pre-Conference Workmeetings on April 27 and 28, 2013
Geneva University Hospital and World Health Organization
Domains of Person-Centered Care

1. Ethical Commitment
2. Cultural Sensitivity
3. Holistic Scope
4. Relational Focus
5. Individualized Care
6. Common Ground for Diagnosis and Care
7. People-centered Systems of Care
8. Person-centered Education, Training and Research
Guiding Principle Domains

- Communication
- Promotion of health and well being
- Provider responsibility
- Collaboration and partnership
- Ethics
- Research
Communication

- The narrative of the individual is the cornerstone of the communication between the patient and the doctor.
- The provider brings medical expertise as well as his own personal experience and knowledge.
- Empathic listening is central to person-centered communication
  - without reciprocal understanding, communication is undermined
Need to pay attention to the cultural, social, spiritual and educational situation of the person.

Due respect should be taken to the dynamics inside the family of the patient when appropriate.

The hopes and aspirations of the person needs to be central and defining.

The person and the provider should establish / negotiate a shared view of care.
Promotion of Health and Wellbeing

- Providers should promote health and well being—not just treat disease
  - the individual should identify what brings him/her health and lasting satisfaction

- Promotion of health / well-being and prevention being is an integrated part providers’ work
  - including individuals coping with long-standing problems/challenges
Provider Responsibility

- Habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served
- Include provision for continuity of care exemplified by the traditional role of the primary care provider
- Promote team-based services and responsibility in addition to the traditional personal professional responsibility
Collaboration and Partnership

- The provider should build a partnership with
  - the individual in their shared decision-making.
    - based on equality between the patient and the provider
  - the family to the degree the individual dictates
  - colleagues and other health care workers, preferably in an interdisciplinary team
    - aim of the team is the person-centered approach in treatment and care
The fundamental aspects of medical ethics apply as much in Person Centered Care as in medicine and healthcare generally.

Central themes:
- autonomy
- beneficience
- confidenciality
- justice
Research

- Person centered medicine needs to evolve by knowledge gained from research
  - qualitative research
  - quantitative research
Canadian Collaborative Mental Health Initiative (CCMHI)

- “there are almost as many ways of ‘doing’ collaborative mental health care as there are people writing about it”
  - wide range of strategies to achieve care collaboration and understanding
  - most models are implemented as hybrids
  - the ideal is “one team, one plan”
Not just about place...
One Team. One Plan.

- **Behavioral health and medical services are provided in one treatment plan**
  - integrated treatment plans can occur in co-location and/or in separate treatment locations
    - aided by Web-based health information technology
  - co-located care includes the elements of coordinated care
  - integrated care includes the elements of both coordinated care and co-located care
The Plan as a Road Map

Provides hope by breaking a seemingly overwhelming journey into manageable steps for both the providers and the person served

“life is a journey…not a destination”
Building the Plan

Request for services

Understanding

Assessment

Prioritization

Desired Results or Goals

Strengths/Barriers

Short term Goals or Objectives

Interventions or Action Steps

Outcomes
Importance of Understanding

- Data collected in assessment is by itself *not sufficient* for service planning
Importance of Understanding con’t

- Integration/Formulation/Understanding is essential
  - Requires skill, experience and judgment
  - Moves from “what” (data) to “what does this mean and how do we use it?”
  - Sets the stage for prioritizing needs and goals
  - The role of culture and ethnicity critical to true appreciation of the person served
DSM-5:
Cultural Formulation Interview
Integrated Narrative Guidelines

- **Identity**
  - Consider age, culture, spirituality/religious affiliation, sexual orientation, etc.

- **Explanation of Illness/Presenting Issues**
  - Why is the person here, why now
  - Stage of Change

- **BioPsychoSocial Environment**
  - Consider medical illness and/or substance use, housing, employment, support system, acute/chronic stressors, etc
  - Consider both resources / strengths—as well as barriers
Integrated Narrative Guidelines con’t

- Strengths, Preferences and Priorities
  - Summarize relevant personal talents/interests/coping skills etc. as well as natural supports & community connections.

- Summary of Priority Needs/Barriers to Goal Attainment
  - Consider how symptoms or other factors/issues may be interfering with recovery progress.

- Hypothesis
  - Consider diagnosis, central themes, insights, understandings, underpinnings, including relevance of past treatment success/failure
  - NOT a repetition of the data
  - May be an opportunity to consider any diagnostic issues
The 10 Ps

- Pertinent history (brief)
- Redisposing factors
- Recipitating factors
- Perpetuating factors
- Present condition / presenting problem
- Previous treatment and response
- Prioritization by person served
- References of person served
- Prognosis
- Possibilities
CARF’s Interpretive Summary

- Central theme of the person
- Interrelationships between sets of findings
- Needs, strengths, limitations
- Clinical judgments regarding the course of treatment
- Recommended treatments
- Level of care, length, intensity of treatment
Assessment data may have multiple references to a person not using medication effectively. The summary notes: “long history of medication non-compliance in the community has led to repeated hospitalizations”

This is NOT a formulation but rather, a re-stating of the data/facts

- The task in formulation is to try to understand WHY the person is not using meds effectively as a tool in his/her recovery
- This formulation/understanding may take the plan in very different directions.
A Chance to Put the Pieces Together

- Given the incidence of co-occurring disabilities and/or disorders, **effectively addressing co-occurring disorder is critical to successful recovery**
  - Medical concerns
  - Substance use
  - Developmental disabilities

- When the assessment identifies co-occurring needs, they are considered in the formulation
The provider shares the formulation in an emotionally safe and supportive context of caring and understanding, communicating hope and belief in the capacity of the human spirit to succeed throughout.
Being “Transparent” is Essential

- Sharing the findings from the summary and/or sharing progress notes with the consumer are receiving much publicity now in healthcare
  - Robert Wood Johnson “Open Notes” study
    - increased patient satisfaction, understand care plan better, increased medication adherence
- Collaborative documentation with the consumer is the essence of being person-centered and promotes engagement
- Acknowledging and resolving differences is critical for a partnership
Putting Together the Pieces
Pursuit of the Triple Aim

- Better Care
  - improve the overall quality, by making whole health care more integrated, reliable, accessible, and safe person-centered

- Healthy People/Healthy Communities
  - improve the overall health of the U.S. population
  - support proven interventions to address behavioral, social and, environmental determinants of positive whole health

- Affordable Care
  - increase the value (cost-effectiveness) of whole health care for individuals, families, employers, and government
Training is Necessary
...But Not Sufficient

Competency
knowledge, skills and abilities

Transformation
Change Model

Culture Management
behavior and attitude

Project Management
work / business flow
All improvement requires change...
...but not all change is an improvement.
Some California Initiatives

- System re-design
- Finance reform
  - Removal of regulatory barriers
- IHI/BTS Learning Collaboratives to promote systems change
- Transformational Care Planning
- Registries and IT
- Investment in care coordination
  - who holds the plan?
  - who is responsible for assuring care coordination?
Leading the Charge

“We don’t think ourselves into a new way of acting… we act ourselves into a new way of thinking.”

Execution, The Discipline of Getting Things Done
Larry Bossidy and Ram Charan