RESOURCES FOR INTEGRATED CARE

Resources for Plans and Providers for Medicare-Medicaid Integration

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Integrating Behavioral Health Competency within Disability-Competent Teams

Disability-Competent Care Webinar Roundtable Series

Behavioral health (BH) and primary care (PC) services are typically delivered by different providers in separate settings, often with little coordination or integration. This fragmented delivery of care can be particularly problematic for individuals requiring a wide variety of services to address physical, emotional, and behavioral challenges.

Integrating BH and PC services may improve the care delivered to individuals with disabilities, or "participants," while increasing the efficiency of care delivery. The relationship between BH and PC services can be defined using the following dimensions of collaborative care:

- **Coordination**, where services exist in different setting. Routine screening for BH problems conducted in PC setting is an example;
- **Co-location**, where services exist in the same location and are facilitated by enhanced informal communications and processes for referral between BH and PC providers; and
- **Integration**, where elements of both medical and behavioral health services are included within a given plan of care for a patient

The **Courage Kenny Rehabilitation Institute's Advanced Primary Care Clinic** *(see insert for profile)* implemented a person-centered and recovery-oriented approach that co-locates BH and PC services within the same center and assigns integrated care teams to its participants.

It notes the following **challenges and lessons learned** in integrating care for individuals with disabilities:

Challenges:

- Gathering information about long-term care services and supports;
- Addressing the impacts of social determinants of health – especially on individuals who acquired their disabilities during the course of their lives and thus experienced a change in the way they go about their daily lives;
- Connecting participants with community resources, which may be limited;
- Overcoming data privacy concerns that present barriers to coordinating care; and
- Redirecting care from the more familiar and traditional medical approach to the person-centered and recovery-based approaches.

Lesson Learned:

- Partnering with the participant and his or her support network is valuable to successful integration of services;

Profile: Courage Kenny Rehabilitation Institute Advanced Primary Care Clinic

- Certified health care home in Minnesota that started in 2010
- Serves 200 patients
- Staffed with primary care and psychiatric physicians who are co-located with physiatrists, nurse practitioners, nurses, social work care coordinators, and certified medical assistants
- Staff partners with individuals with disabilities and their support network to provide comprehensive and integrated care

- Social determinants of health such as, living and work conditions, can be responsible for health inequalities and must be considered when developing an integrated plan of care;
- Communication is key, both within the BH-PC partnership and with other involved providers;
- Care pathways for common causes of hospitalization and emergency department visits need to be developed; and
- Motivational interviewing, where care team and participant discuss the medical and behavioral diagnoses and what changes the participant feels ready to begin making, is very important for behavior change.

Additional Resources

Please visit the *Resources for Integrated Care* website (www.resourcesforintegratedcare.com) for the "Training in Disability-Competent Care and Supports" webinar series, which served as the basis for this brief and for other Disability-Competent Care-related resources including an interactive self-assessment tool.