Behavioral and Physical Health Services Integration: The Why and How for Intellectual and Developmental Disability Providers in 2025

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Discussion Topics

- Why integration?
- How the Certified Community Behavioral Health Clinic (CCBHC) model is different than traditional community mental health service approaches ?
- What key knowledge and skills do IDD staff need to be successful in addressing their client's whole health needs?
- How the Comprehensive Health Integration Model (CHI) can be used to assess and develop a plan for health services integration?

Who do we have in the room? What is of Interest to you?

- Peers/Community Health Workers
- Aides
- Leadership
- Therapists/Psychologists
- Care Navigators/Managers/Coordinators
- Psychiatric Staff/Nurses
- OT/PT
- Finance/IT
- Anyone else?

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Defining Our Terms

- How we define a “Term” determines how we structure beliefs and ultimately our behavior

- Terms are at the core of how we think and act

- Importantly, if policy makers, clinicians &/or administrators are not clear on the definition and source of their terms it is difficult to design or implement an integrated health model

Defining Our Terms

Some Integrated Health Term Sources:

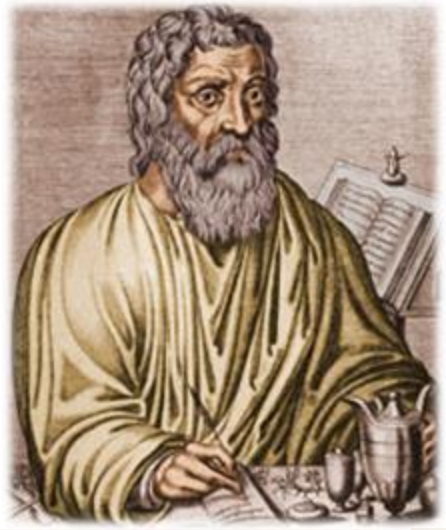
- **Research Literature-** ”Collaborative Care”
- **Policy-** “Health Home”; “Certified Community Behavioral Health Clinic (CCBHC)”
- **Accrediting Bodies-** “Patient Centered Medical Home”
- **Provider Agencies-** “Pt. Centered Healthcare Home”

Why are we still talking about Integrated Health?

Integration: A New Initiative?

“The Body must be treated as a whole and not just a series of parts.”

--Hippocrates 300 BC



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Why Consider the Whole Person?

https://www.nimh.nih.gov/health/publications/chronic-illness-mental-health

Preventable Death

- People with ID have an average life span of 58 years.
- People with Developmental Disabilities without ID, barring genetic predispositions, tend to have a life span that coincides with general population.
- Both populations have a heightened risk of Cardiovascular Disease not attributable to inherent biological differences but is largely driven by preventable and modifiable risk factors (e.g. physical inactivity, obesity, and smoking).
- Lack of accessible, inclusive, and sustained health promotion, and early screening for precursor conditions like hypertension and hyperlipidemia.
- The IDD population consistently exhibits low take-up rates for vital national screening programs, including those for breast, bowel, and cervical cancer, as well as necessary immunizations like flu vaccinations.

Source: Cause of death in adults with intellectual disability in the United States. S D Landes , J D Stevens , M A Turk J Intellect Disabil Res. 2020 Oct 12;65(1):47–59. doi: 10.1111/jir.12790

Causes of Death for People with Intellectual Disabilities

- The leading cause of Death for adults with ID (regardless of disability severity):
  - Heart disease
  - Pneumonitis, influenza/pneumonia and choking (20-30% times higher risk)
  - Cancer
- Adults with mild/moderate ID have higher risk of death from diabetes and cancer
- Constipation continues to a significant cause of death compared to the general population for people with severe ID.

Source: Cause of death in adults with intellectual disability in the United States. S D Landes , J D Stevens , M A Turk J Intellect Disabil Res. 2020 Oct 12;65(1):47–59. doi: 10.1111/jir.12790

Diagnostic Overshadowing

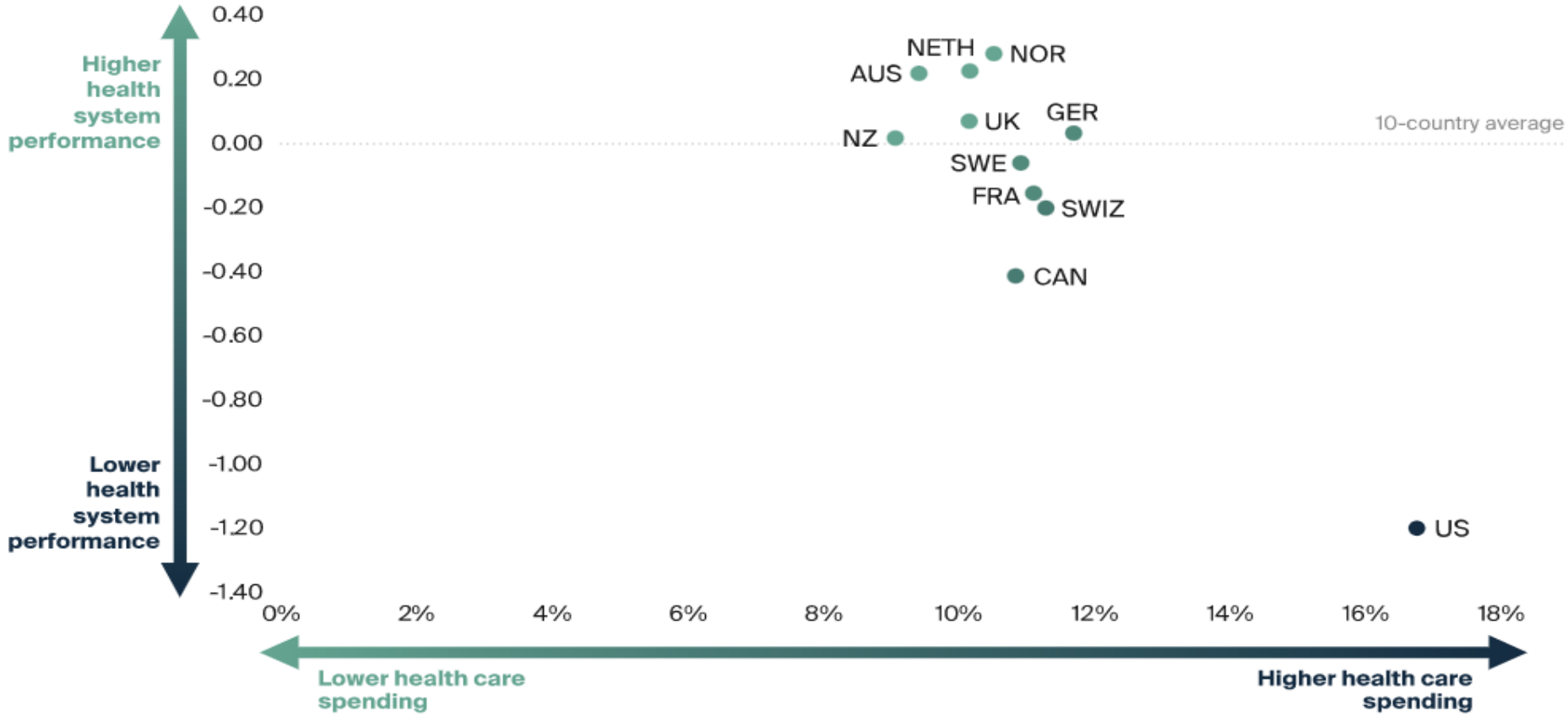
- Diagnostic overshadowing is a critical systemic failure where signs and symptoms arising from a physical or mental health problem are misattributed to the individual's intellectual or developmental disability.

- This phenomenon actively delays necessary diagnosis and treatment , resulting in an increased risk of death from causes that were otherwise medically treatable.

- This can be seen when signs and symptoms are attributed to a behavioral diagnosis when constipation is the cause. All changes in behavior should have a physical health cause ruled out.

- Resources like: Health Care Access Research and Developmental Disabilities (H-CARDD) are essential in helping health care providers design effect integrated services arrays.

Health Care System Performance Compared to Spending



Note: Health care spending as a percent of GDP. Performance scores are based on standard deviation calculated from the 10-country average that excludes the US. See How We Conducted This Study for more detail.

Data: Spending data are from OECD for the year 2019 (updated in July 2021).

Source: Eric C. Schneider et al., *Mirror, Mirror 2021 — Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries* (Commonwealth Fund, Aug. 2021). https://doi.org/10.26099/01DV-H208

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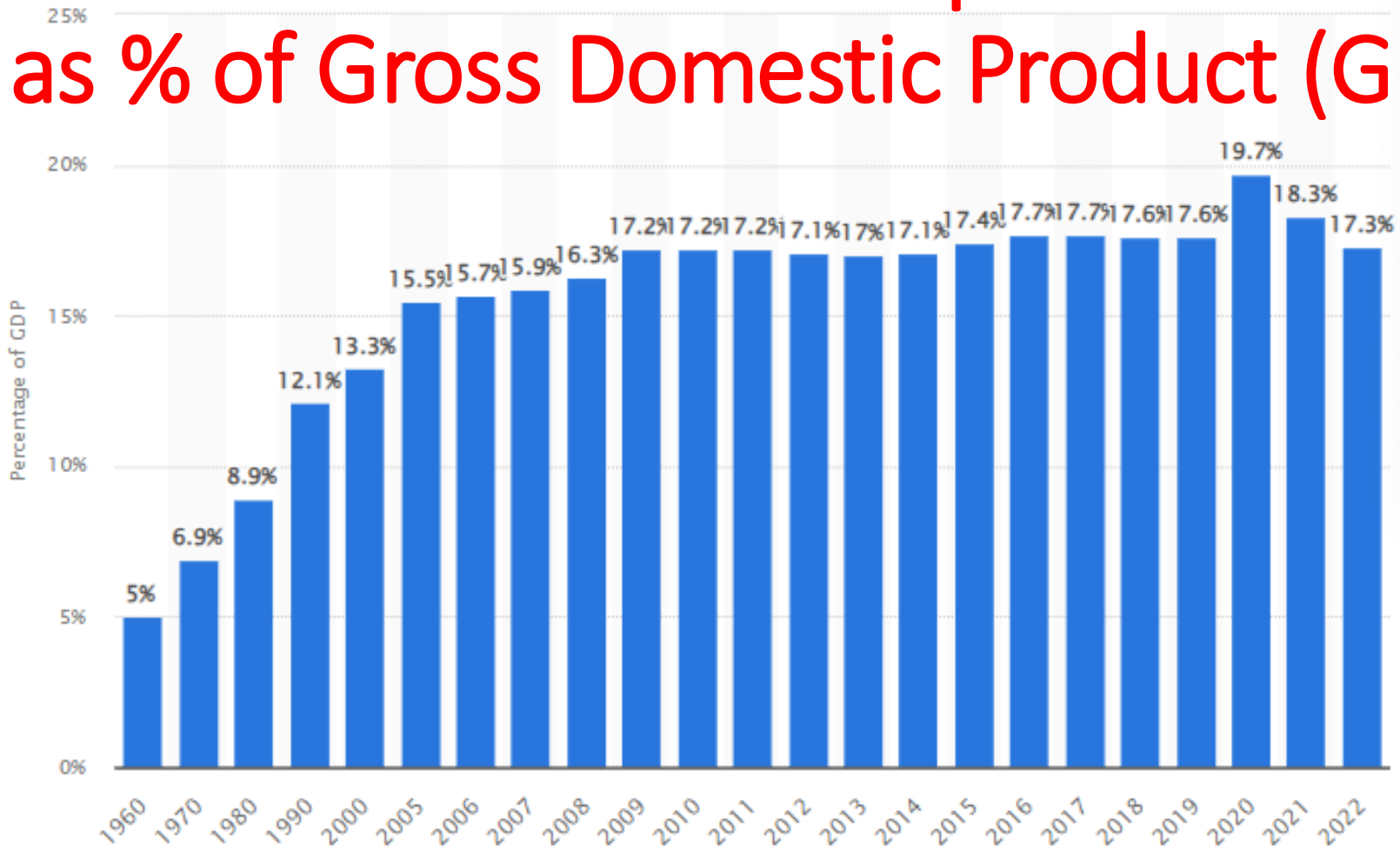
USA Healthcare Expenditure as % of Gross Domestic Product (GDP)



Additional Information

Show source

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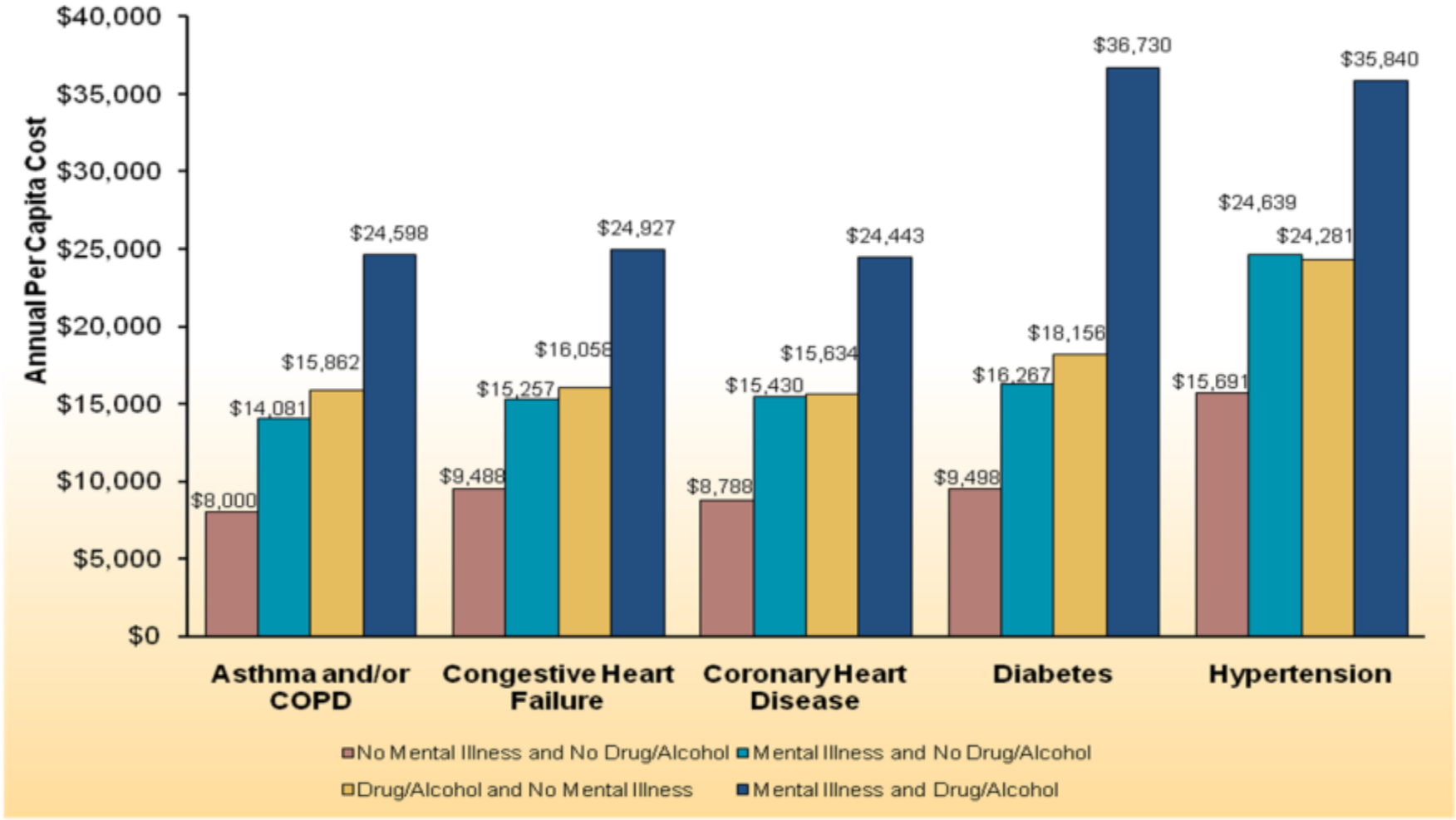
Impact of BH Co-Morbidities on Per Capita Costs (Medicaid-only beneficiaries with disabilities)



Boyd, C., Clark, R., Leff, B., Richards, T., Weiss, C., Wolff, J. (2011, August). Clarifying Multimorbidity for Medicaid Programs to Improve Targeting and Delivering Clinical Services. Presented to SAMHSA, Rockville, MD

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The Value Equation Integrates Quality Data with Dollars

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Value is closely tied to Social Determinant Needs with 70% of Health Outcomes Correlated with SDOH

Source: The Evolution of the Quintuple Aim Health Equity, Health Outcomes,and the Economy Dipti Itchhaporia, MD, FACC, President, American College of Cardiology

Wellness Graphic: SAMHSA, Adapted from Swarbrick, M. (2006). A Wellness Approach. Psychiatric Rehabilitation Journal, 29(4), 311–314.
Expenditure Graphic: National Academies of Sciences, Engineering, and Medicine 2019. Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health. Washington, DC: The National Academies Press. https://doi.org/10.17226/25467.

Value-based Healthcare

Effective Healthcare:

- Producing quality outcomes, health literacy & customer satisfaction

Efficient Healthcare:

- Clinical & administrative processes that operate within optimal time & cost specifications

Fee-for-Service/Volume Based Care =>

Focus is on Efficiency

Value Based Purchasing =>

Focuses on Both Efficiency & Effectiveness

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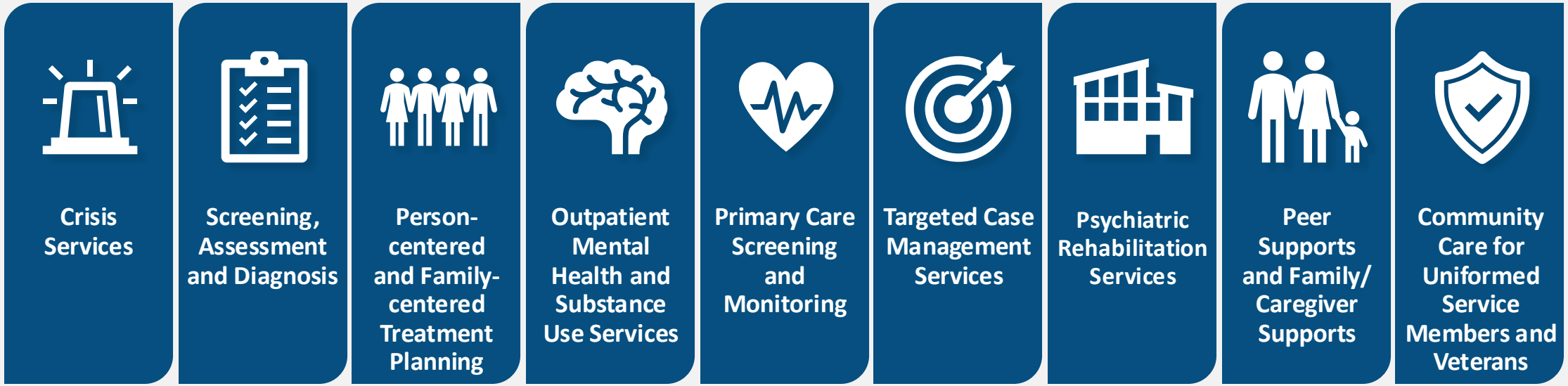
The Certified Community Behavioral Health Clinic (CCBHC) A Whole Health Approach

CCBHC Scope of Services

CCBHC

Services may be delivered directly by the CCBHC or by a Designated Collaborating Organization (DCO). CCBHCs are expected to directly deliver the majority of encounters.



Provision of all services is person- and family-centered.

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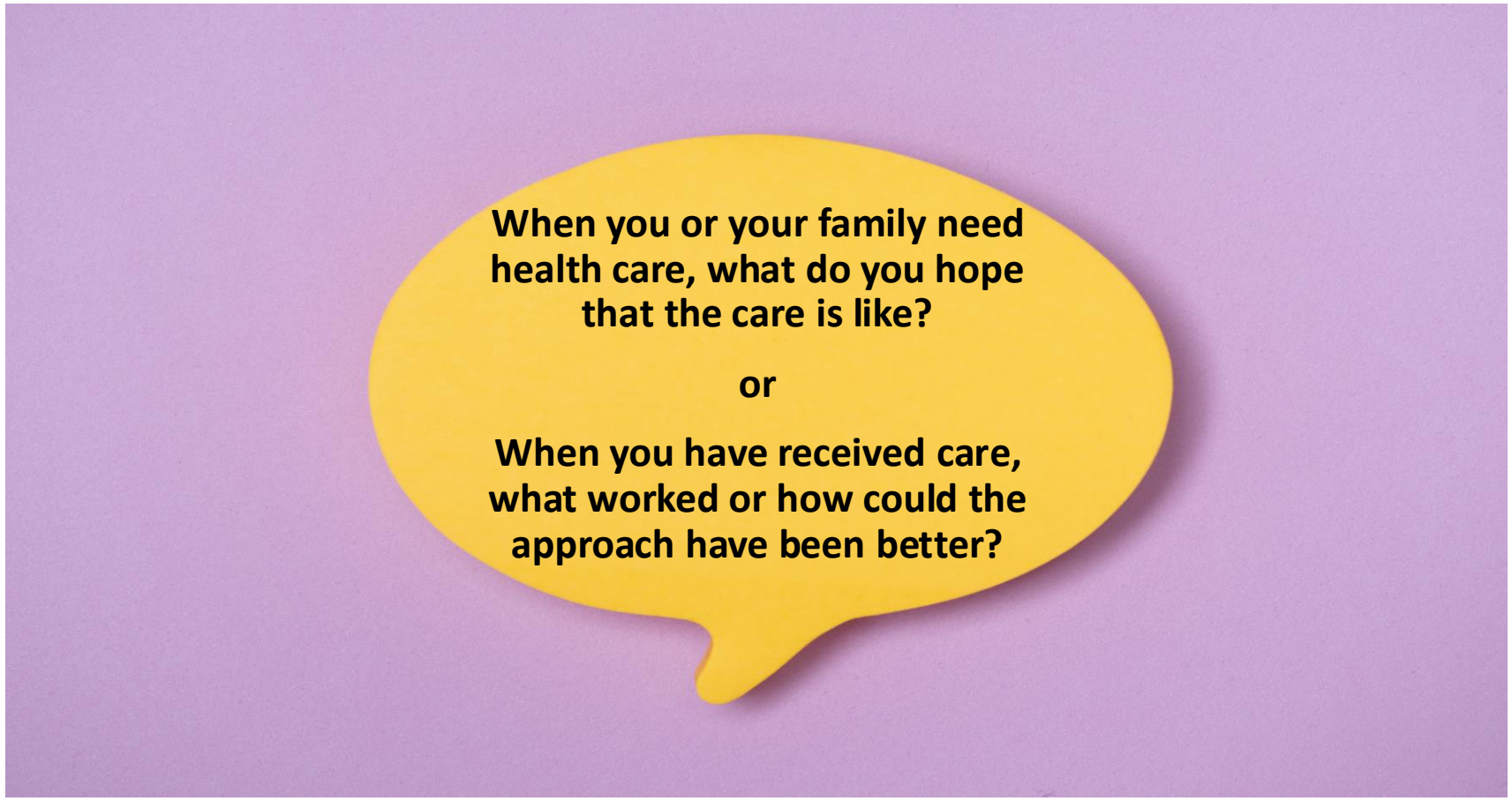
Ok Great…but what does this have to do with me?

Group Reflection



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Do the people you provide services to have their expectations met?

If Yes, what is working?

If No, what needs to be fixed?

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The Comprehensive Health Integration (CHI) Framework

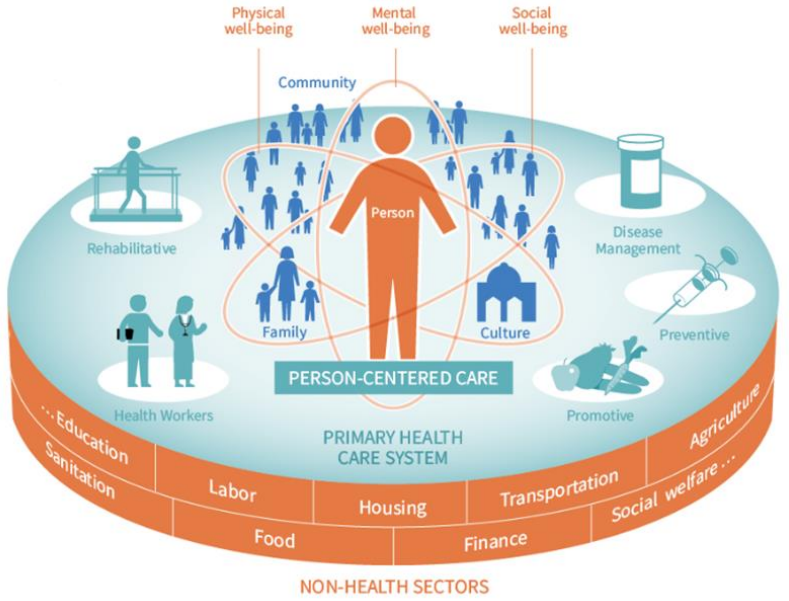
SAMHSA Standard Framework for Integration

Referral		Co-Located		Integrated	
Key Element: Communication		**Key Element: Physical Proximity**		**Key Element: Practice Change**	
Level 1 *Minimal Collaboration*	**Level 2** *Basic Collaboration at a Distance*	**Level 3** *Basic Collaboration On-Site*	**Level 4** *Close Collaboration On-Site with Some System Integration*	**Level 5** *Close Collaboration Approaching an Integrated Practice*	**Level 6** *Full Collaboration in a Transformed/ Merged Integrated Practice*
Behavioral health, primary care and other healthcare providers work:					
In separate facilities.	**In separate facilities.**	**In same facility not same offices/clinic (e.g., separate waiting areas).**	**In same space within the same facility but separate work flows/teams.**	**In same space within the same facility regular teaming & cross staffing.**	**In same space within the same facility, sharing all practice space (one clinic/one team).**

NEW!– The Comprehensive Healthcare Integration (CHI) Framework

The CHI Framework provides guidance on implementing the bidirectional integration of physical health and behavioral health to help providers, payers and population managers:

- Measure progress in organizing delivery of integrated services (“integratedness”)
- Demonstrate the value produced by progress in integrated service delivery
- Provide initial and sustainable financing for integration



Available to download now:
https://www.thenationalcouncil.org/resources/the-comprehensive-healthcare-integration-framework/

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Integrated Services

- The provision and coordination by the treatment team of appropriately matched interventions for both PH and BH conditions, along with attention to SDOH, in the setting in which the person is most naturally engaged.

Integratedness

- The degree to which programs or practices are organized to deliver integrated PH and BH prevention and treatment services to individuals or populations, as well as to address SDOH.
- A measure of both structural components (e.g., staffing) and care processes (e.g., screening) that support the extent to which “integrated services” in PH or BH settings are directly experienced by people served and delivered by service providers.

CHI Framework Domains & Subdomains

1. Screening, referral to care, and follow-up

1.1 Screening and follow-up

1.2 Facilitation of referrals

2. Evidence-based care for preventive and general medical conditions

2.1 Use of guidelines or treatment protocols

2.2 Use of targeted medications by behavioral health prescribers

2.3 Trauma informed care

3. Ongoing care management

3.1 Longitudinal clinical monitoring and engagement

4. Self-management support adapted to patient

4.1 Use of tools to promote patient activation and recovery

GHI Webinar: https://www.thenationalcouncil.org/webinars/advancing-integration-in-community-behavioral-health-using-a-new-general-health-integration-framework/

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CHI Framework Domains & Subdomains

5. Multi-disciplinary team (including patients) with dedicated time

5.1 Care team

5.2 Sharing of treatment information, case review, care plans and feedback

5.3 Integrated care team training

6. Systematic quality improvement

6.1 Use of quality metrics for physical health program improvement and/or external reporting

7. Linkages with community and social services

7.1 Linkages to housing, entitlement, other social support services

8. Sustainability

8.1 process for billing and outcome reporting

8.2 process for expanding regulatory and/or licensure opportunities

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Domain One!

1.

Screening, referral to care and follow-up

1.1 Screening and follow-up for co-occurring behavioral health, Physical health (e.g., cardiovascular disease, asthma, diabetes, obesity, cancer) conditions and preventive risk factors (e.g., wellness behaviors).

1.2 Facilitation of referrals and follow-up

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Integration Infrastructure

Staff Training:

- ✓ Staff understand the impact of physical health conditions on behavioral health conditions (and visa versa).
- ✓ Staff can provide health literacy/know how to talk to clients and their supports about the importance of physical health wellness behaviors, screening, and primary care engagement.
- ✓ Staff are expert in motivational techniques for engagement and person-centered planning.

Measurement Informed Care:

- ✓ Measurable care pathways for screening, monitoring, and coordinating care for physical health conditions
- ✓ Wellness, health promotion, and lifestyle modification programming

Care Coordination/Navigation:

- ✓ Data tracking primary care engagement/referral
- ✓ Memorandums of understanding/agreement with primary care providers

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KEY ELEMENTS of Integrated Care		PROGRESSION to Greater Integration →			
DOMAINS	**SUBDOMAINS**	**HISTORICAL PRACTICE (STAGE 0)**	**SCREENING AND ENHANCED REFERRAL (STAGE 1)**	**CARE MANAGEMENT AND CONSULTATION (STAGE 2)**	**COMPREHENSIVE TREATMENT AND POPULATION MANAGEMENT (STAGE 3)**
1. Screening, referrals and follow-up (f/u)	**1.1 Systematic screening for co-occurring conditions and risk factors.** SEE HANDBOOK FOR MORE DETAILS ON SCREENING BEST PRACTICES AND TYPES OF CONDITIONS OR RISK FACTORS TO BE CONSIDERED.	There is **no or limited** systematic screening for co-occurring conditions or risk factors that does not meet criteria for Screening and Enhanced Referral stage. **Referrals primarily are triggered by self-report** of concerns by people receiving services.	There is systematic screening for **at least one or two** high-prevalence co-occurring conditions or risk factors.	There is systematic screening for **at least two or three** high-prevalence co-occurring conditions and risk factors. **A designated team member is responsible for tracking** screening processes and results. Data on screening outcomes and f/u is **systematically collected**.	**STAGE 2, PLUS:** There is systematic screening for at **least three or four** high-prevalence co-occurring conditions or risk factors. There is **capacity for data registries** on screening, f/u processes and results. There is **capacity for using data system to stratify population stages of need** (e.g., based on screening results and PH/BH complexity).
	1.2 Systematic facilitation of referrals and f/u. SEE HANDBOOK FOR MORE DETAILS, INCLUDING DEFINITIONS OF "FORMAL ARRANGEMENT" AND "INTEGRATED TEAMWORK."	Referrals are made to external PH or BH provider **without formal arrangement**. Does **not meet threshold** for systematic tracking of referrals or method for sharing information between PH and BH providers to track f/u.	For people with no existing provider or preference, **majority of referrals** go to a partner PH or BH provider with a formal arrangement. There is **systematic tracking of referrals** to ensure connection with both PH and BH services for all in need. There is an **expectation of and method for routine information sharing** between PH and BH partners to track ongoing f/u.	**STAGE 1, PLUS:** **An integrated team member** (e.g., BH consultant or community health worker [CHW] in PH, PH care coordinator in BH) **routinely facilitates connection with and referrals** for people with positive screens. For people with no existing provider connection or preference, **majority of referrals** go to internal or partner PH or BH provider with a formal arrangement. **A designated team member** is responsible for tracking referrals and coordinating information sharing to track f/u.	**STAGE 2, PLUS:** **BH and PH providers function as an integrated team in one or more locations** and are jointly accountable for ensuring referred individuals are engaged and receive both services. For people with no existing provider connection or preference, **majority of referrals** go to an internal team partner PH or BH provider. BH and PH providers **routinely and electronically (usually via shared electronic health record [EHR]) share/receive information** about referral and f/u.

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Ok Great…but what do we do now?

Developing Your Action Plan

Based on what we have discussed, meet with your small group and identify potential action plans for your team. Right now, you are generating ideas that will be shared with your team, and your team will choose one plan.

This is a small action plan, can be done and measured in 30-60 days.

- *What will you do differently in your work?*
- *What is the change you want to take back to your team?*
- *What will be different/better for clients if you do this?*
- *Is it small enough to be doable in 30-60 days and clear enough that you will know it is done?*

Please write it down!!

Be ready to report out!

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Resources

Agency for Healthcare Research and Quality (AHRQ) https://integrationacademy.ahrq.gov/

SAMHSA – Center of Excellence for Integrated Health Solutions
https://www.thenationalcouncil.org/program/center-of-excellence/

Integrated Care Resource Center (ICRC)
(Focus is on State Level Integration Efforts)
https://www.integratedcareresourcecenter.com/state-integration-activities

Center of Excellence Oral Health Paper
https://www.thenationalcouncil.org/wp-content/uploads/2022/06/2022.06.23_NC_CoE_OralhealthMentalHealthSubstanceUseChallenges_Toolkit.pdf

Comprehensive Integrated Health (CHI)
https://www.thenationalcouncil.org/resources/the-comprehensive-healthcare-integration-framework/

Health Care Access Research and Developmental Disabilities (H-CARDD)
https://www.camh.ca/en/professionals/professionals--projects/hcardd/health-care-resources
https://www.camh.ca/en/professionals/professionals--projects/hcardd/health-care-resources/clinicians-and-service-providers