Interprofessional Care in Primary Care Settings: Key Components and Implications for Improving Outcomes for Transitional Age

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State System of Care Collaboration
Creating a Culture of Care
From Cradle to Career Conference
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Workshop Overview

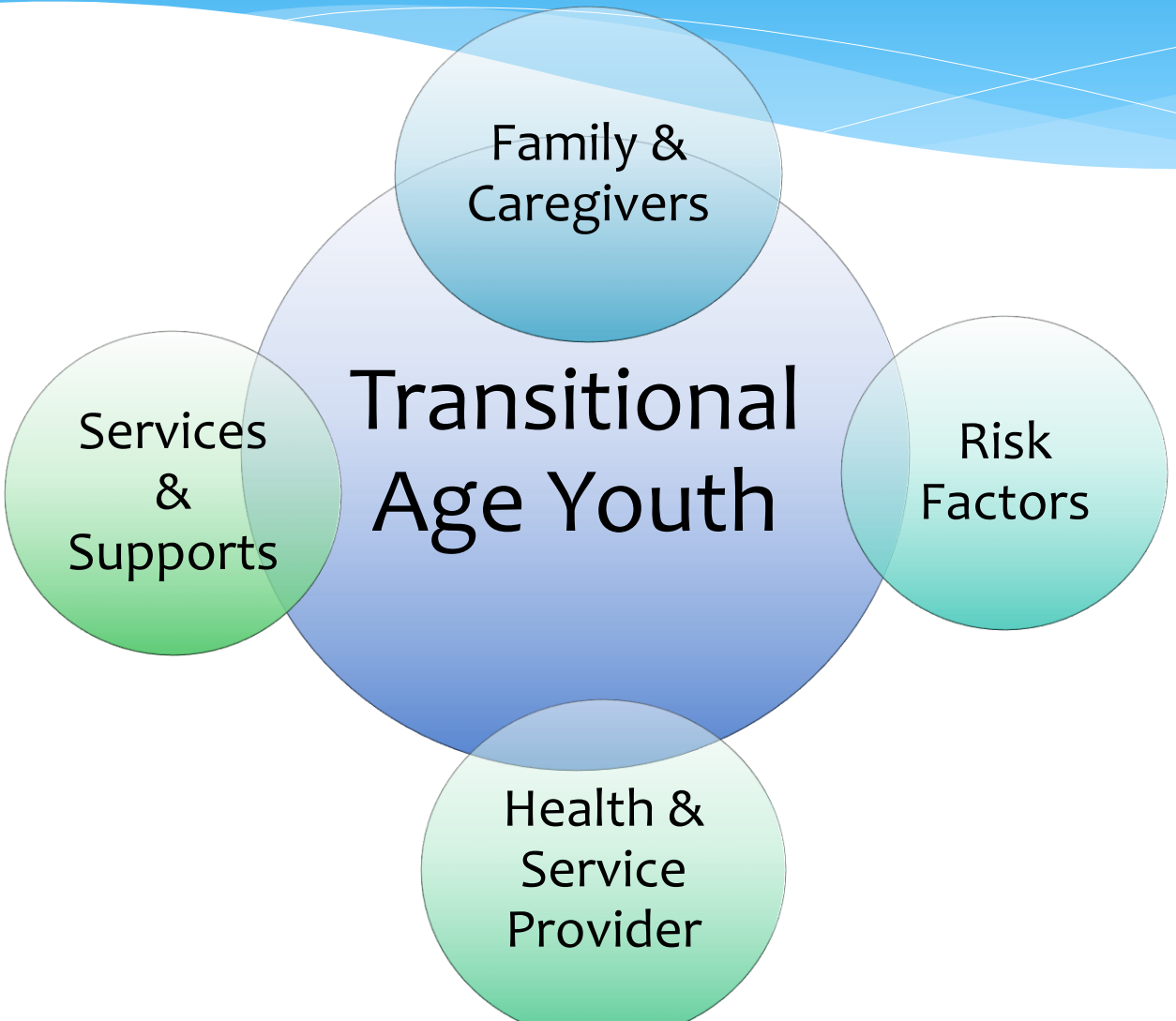
I. Introductions

II. Key components and characteristics of interprofessional Care

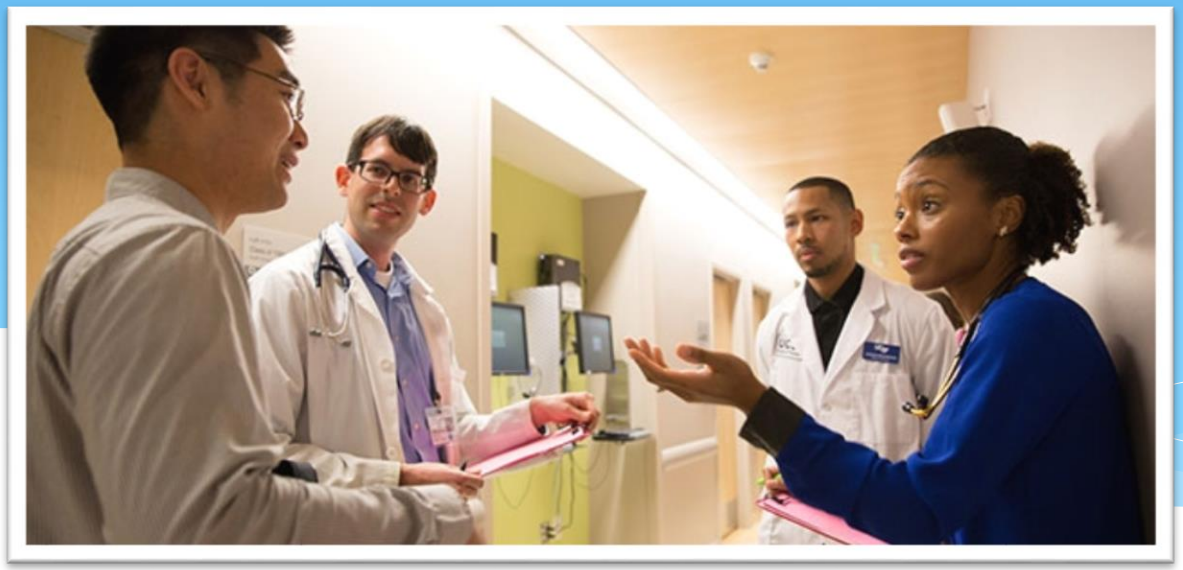
III. UNC School of Social Work & training for work in integrated care

IV. Meeting the behavioral health needs of transitional- age youth (TAY) and families

Introductions– How are you Involved?



What is Interprofessional Care and How is it Different from Traditional Care?



Interprofessional Care

Interprofessional Practice

Multiple health workers from different professional backgrounds providing comprehensive health services, working with patients, their families, caregivers, and communities to deliver the highest quality of care across settings.

WHO, 2010

Interprofessional Team-Based Care

Interprofessional Team-based Care

Care delivered by *intentionally* created, usually small work groups in health care who are recognized by others as well as themselves as having a collective identity and shared responsibility for a patient or group of patients, e.g. rapid response team, palliative care team, primary care team, operating room team

WHO, 2010

Key Characteristics of IP Care

- Patient/family centered
- Relationship focused
- Shared work location
- Consistent communication among team members
- Shared decision-making
- Use of language common *across* professions
- Mutual understanding of and respect for team members' roles
- Outcome driven

IP Educational Collaborative Expert Panel, 2011

Differences in Communication and Collaboration Based on Levels of Integration

Traditional Care Model
Minimal Collaboration
Separate Facilities

* Separate systems
* Communicate about cases only about compelling situations
* Communication driven by provider need
* May never meet in person
* Have limited understanding about each other's roles
* Separate treatment plans
* Patient's physical & behavioral health needs treated separately

Integrated Health Care Model
Full collaboration/Integration
In same shared practice space

* Function as one integrated system
* Communicate consistently at system, team and individual level
* Collaboration driven by shared concept of team care
* Formal and informal meetings
* Have roles and culture that blur or blend
* One shared treatment plan
* All patients health needs are treated by a team who function effectively together

SAMSHA, HRSA, Center for Integrated Health Solutions

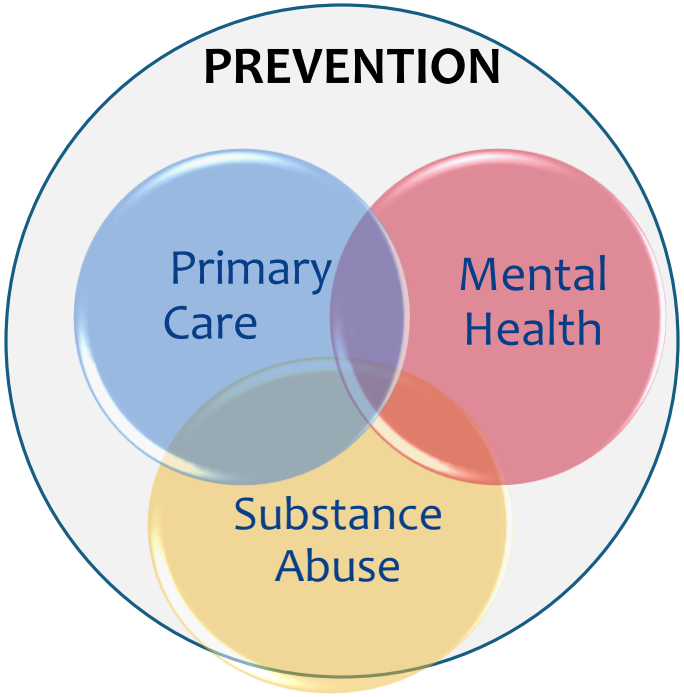
Benefits of Interprofessional Team Work on Patient Care

- Improves access to care
- Improves continuity of care
- Reduces duplication and fragmentation of care
- Improves communication, coordination and safety
- Improves patient outcomes
- Improves patient and provider satisfaction

Shaw, 1979; Gregson, 1991; Farooqi, Azhar; Stevenson et al., 2001; Schmitt, 2001; Onyett, 2002

Relationship between Interprofessional Teams and Integrated Health Care

- Integrated care is " **the systematic coordination of general and behavioral healthcare.**
- Key Characteristics include:
  - Patients have one Person-centered medical home where they receive all or most of their care.
  - Providers are in same facility and space.
  - Providers share medical records and other electronic systems.
  - Health care and mental health care providers work closely together in teams.



Background Context: Behavioral Health in NC Impacting Transitional-Age Youth

Why focus on transition-age youth and behavioral health?

- The health and well-being of adolescents sets the course for health trajectories into adulthood. [37]
- Time of transition and opportunity
  - Typically defined in U.S. as the developmental period between 14–24 years old wherein profound physical, cognitive, emotional, and social changes occur.
- Transitional-aged youth (TAY) are at high risk of developing behavioral health problems and many mental health disorders present during this time period.

Why focus on transition-age youth and behavioral health?

- Of youth in the juvenile justice system, 70% have a mental health condition and 20% have a serious mental illness.
- Over 1/3 (37%) of students with a mental health condition aged 14-21 or older who are served by special education drop out, the highest drop out rate of any disability group.
- Suicide is the third leading cause of death for youth aged 10-24 and the second leading cause of death for youth aged 15-24.
- More than 90% of adults with a substance use disorder began using before they were 18.

National Center Mental Health & Juvenile Justice, 2007for U.S Department of Education, 2014; American Association of Suicidology, 2014; Trust for America's Health, 2013.

Transitional-Age Youth in NC

- Adolescents (ages 10 to 19) and young adults (ages 20 to 24) make up 21% of the U.S. population [35]
- In NC, 23.1% of the population are under the age of 18.
- 8.1 % of children are enrolled in special education.

U.S. Census Bureau, 2014; U.S. Department of Education; 2014

Background Context: Behavioral Health Needs of TAY

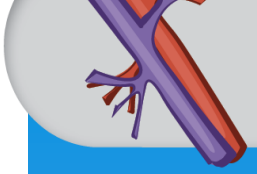
- 23 million individuals, 9% of U.S. pop ≥ 12 years meets criteria for SUD; and 1 out of 10 15-17 year old meets the criteria for a Major Depressive Disorder.[6]
- NC leads the country in illicit drug use:
  - 11% of the NC youth ≥ 12 years and older (ever used)
  - 14.3% used alcohol past month
  - NC ranks in the bottom 10 for all states in meeting substance use treatment needs for youth
- Number of NC youth who die from unintentional overdose exceeds national rate,[17,18] and increased by nearly 300% between 1999 and 2013.[19]

Healthcare Reform: Setting the Stage for Integrated Care Models

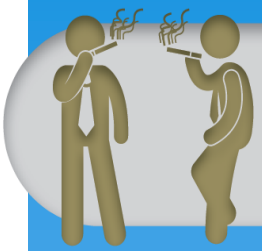
- ACA (2010) Expansion of insurance coverage [6,]
  - Medicaid (not in NC) [9,10]
  - Private Insurance through health care exchanges
- Reforms directly impacting young people and their families[6, 10]
  - Can not discriminate against pre-existing conditions
  - Youth aging out of foster can remain on Medicaid up through age 26
  - Youth may remain on parents' insurance until age 26
- Emphasis on prevention [5]
- Reforms in reimbursement

Rationale for Changes in Healthcare

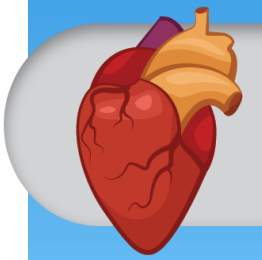
- Skyrocketing cost of health care + fragmented systems of care + unmet needs
  - Stigma around seeking mental/behavioral health care[2,5]
- Accessing treatment and disparities in MH problems [2, 8,9]
- Co-occurring needs of individuals [5,6,8]
  - Primary care providers manage care for 70-80% of persons with psychiatric disorders and are the "de facto" mental health care system [3, 7]
  - 20% of persons in healthcare system use ~85% of resources [3]
  - Cost-offset is greatest when behavioral and primary healthcare are integrated [4,5,12]



Mental Illness 21.9%
No Mental Illness 18.8%
High Blood Pressure

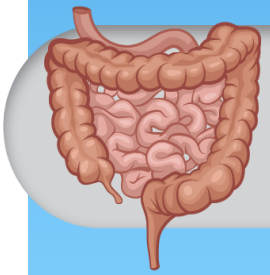


Mental Illness 36%
No Mental Illness 21%
Smoking

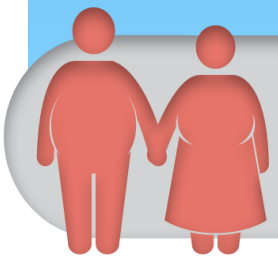


Mental Illness 5.9%
No Mental Illness 4.2%
Heart Disease

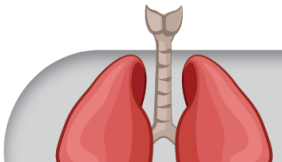
Co-occurrence between mental illness and other chronic conditions



Mental Illness 7.9%
No Mental Illness 6.6%
Diabetes



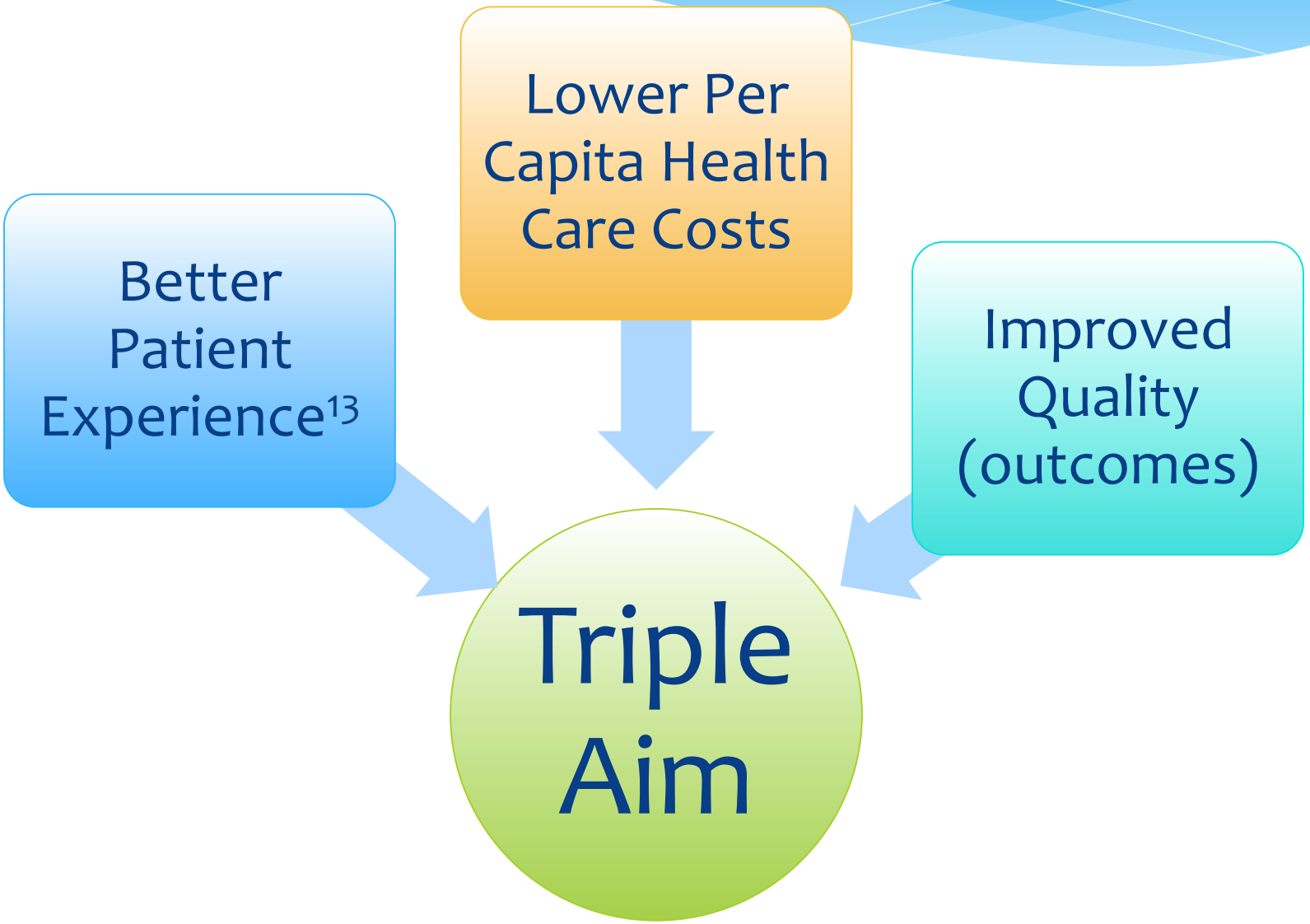
Mental Illness 42%
No Mental Illness 35%
Obesity



Mental Illness 15.7%
Asthma

Graphics used with permission [6]

Triple Aim Objectives



Center of Excellence for Integrated Care, 2014

Biological Realm: Common Problems Influenced by Social/Psychological Factors

- Motor vehicle injuries and deaths
- Obesity – 20.5% of teens age 12-19 are obese
  - Lack of physical activity
    - Lack of safe places to play
    - Sedentary life styles
  - Dietary habits
    - Availability and marketing of high caloric foods
    - Limited access to healthy, affordable food
- Sexually transmitted diseases including HIV
  - Risky sexual behavior

Psychological Realm: Common Problems Influenced by Biological and Social Factors

- **Mood disorders –** genetic disposition; lack of friends; social rejection; micro-aggressions; bullying; overt discrimination
- **ADHD** – genetic factors; complications or exposure to toxins during pregnancy
- **Substance use** - genetic vulnerability, peer pressure, maladaptive coping; experimentation
- **Medication misuse** –poor coping skills; thrill seeking; peer pressure
- **Body image and self-esteem issues/eating disorders** - feel pressure from family, friends, media to fit "ideal" beauty type; physical disability; appearance/body type different from peers or "ideal"

Social Realm: Common Problems Influenced by Biological/Psychological Factors

- **Lack of family support** – substance use; mental health problems; illness
- **Social rejection/isolation** – physical/mental illness; physical or cognitive disability; member of social/cultural/racial minority group
- **Poverty or economic hardship** - substance use; mental health problems; physical illness
- **Lack of social and human capital (job & life skills, education)** impacted by physical, cognitive or psychological impairment

Addressing the Behavioral (Psychosocial) Needs of TAY

- Careful screening and assessments
- Use of motivational interviewing, CBT, TI-CBT, Interpersonal therapy, Solution-focused therapy
- Screening, brief intervention and referral to treatment (SBIRTs)
- Consultation with team and/or medical providers
- Pschyoeducation re stress management and alternative, positive forms of coping; risky behaviors
- Referrals to community, school, neighborhood resources

Addressing the Behavioral (Psychosocial) Needs of TAY

- Parents/Families
  - Educate and encourage parents to communicate with their children, remain involved with teen activities and provide appropriate supervision
  - Psychoeducation around establishing appropriate boundaries; reasonable expectations; and household rules
  - Link parents/care-givers to community sources of support
  - Crisis Intervention
  - Family therapy
  - Cultural sensitivity and humility

Addressing the Behavioral (Psychosocial) Needs of TAY

* Social (Systems)
  * Promoting healthy and safe school environments
  * Use of school or community-based youth development interventions
  * Advocacy for state/community/school policies”
    * Teen pregnancy prevention programs
    * Violence/IPV prevention programs
    * Anti-bullying programs
    * Underage drinking prevention programs
    * Graduated driving programs

Challenges: The Real World of Practice

- Hierarchical nature of medical model
- Role modeling and understanding
- “Cart before the horse”
- Billing and reimbursement mechanisms
- Lack of space for

Opportunities

* Focus on prevention with ACA
* Evidence-Based Brief Interventions (i.e, SBIRT, Solution Focused Therapy, Motivational Interviewing)
* Interprofessional education shifting acculturation in medical settings
* Trends across systems (i.e., VA, HMOs, FQHCs, RHCs)
* Billing and reimbursement mechanisms for behavioral health specialists
* Health beyond doctors office (i.e., schools-based health clinics, wrap-around supports)

Conclusions

* Social workers can be a natural lynchpin on interprofessional health care teams.
* By providing early screening and services that address the needs of the whole person, social workers can help to improve the quality of patient care.
* Although not currently demonstrated, we hope that a more holistic and integrated approach to health care will be shown to prevent problems from becoming chronic and reduce costly forms of care (i.e., ER utilization; readmissions).

Thank you!

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