SAMHSA-HRSA
Center for Integrated Health Solutions

Clinical and Administrative Strategies of Bi-directional Integration

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July 12, 2012

Agenda

- Addressing Administrative/Cultural Barriers to Integration
- Staffing Resources and Roles
- Financial Barriers and Return on Investment

Addressing Common Barriers to Integration

- Differences between professional cultures
- Staffing Resources
- Financial Resources
- Others During Q & A

Administrative/Professional Cultures

Traditional Thinking	New Approach
The primary care provider is THE leader of the team	The patient is the leader of the team; non-medical staff can consult
Pace of work	Behavioral health adjusts to the PC pace
Documentation	BH documentation in the PC record
Privacy	HIPAA allows for disclosure for coordination of care

Function	Minimal Collaboration	Basic Collaboration from a Distance	Basic Collaboration On-Site	Close Collaboration/ Partly Integrated	Fully Integrated
Doherty, McDaniel & Baird (1995)	-Separate systems -Separate facilities -Communication is rare -Little appreciation of each other's culture "Nobody knows my name" Who are you?	-Separate systems -Separate facilities -Periodic focused communication; most written -View each other as outside resources -Little understanding of each others' culture or sharing of influence "I help your consumers"	-Separate systems -Same facilities -Regular commun., occasionally face-to-face -Some appreciation of each others role and general sense of large picture -Mental Health usually has more influence "I am your consultant'	-Some shared systems -Same facilities -Face-to-Face consultation; coordinated treatment plans -Basic appreciation of each others role and cultures -Collaborative routines difficult; time &operation barriers -Influence sharing "We are a team in the care of consumers"	-Shared systems and facilities in seamless bio-psychosocial web -Consumers & providers have same expectations of system(s) -In-depth appreciation of roles and culture -Collaborative routines are regular and smooth -Conscious influence sharing based on situation and expertise "Together we teach others how to be a team in care of consumers and design a care system

Function	Minimal Collaboration	Basic Collaboration from a Distance	Basic Collaboration On-Site	Close Collaboration/ Partly Integrated	Fully Integrated/Merged
THE CONSUMER and STAFF PERSPECTIVE/EXPERIENCE					
Access	Two front doors; consumers go to separate sites and organizations for services	Two front doors; cross system conversations on individual cases with signed releases of information	Separate reception, but accessible at same site; easier collaboration at time of service	Same reception; some joint service provided with two providers with some overlap	One reception area where appointments are scheduled; usually one health record, one visit to address all needs; integrated provider model
Services	Separate and distinct services and treatment plans; two physicians prescribing	Separate and distinct services with occasional sharing of treatment plans for Q4 consumers	Two physicians prescribing with consultation; two treatment plans but routine sharing on individual plans, probably in all quadrants;	Q1 and Q3 one physician prescribing, with consultation; Q2 & 4 two physicians prescribing some treatment plan integration, but not consistently with all consumers	One treatment plan with all consumers, one site for all services; ongoing consultation and involvement in services; one physician prescribing for Q1, 2, 3, and some 4; two physicians for some Q4: one set of lab work
Funding	Separate systems and funding sources, no sharing of resources	Separate funding systems; both may contribute to one project	Separate funding, but sharing of some on-site expenses	Separate funding with shared on-site expenses, shared staffing costs and infrastructure	Integrated funding, with resources shared across needs; maximization of billing and support staff; potential new flexibility
Governance	Separate systems with little of no collaboration; consumer is left to navigate the chasm	Two governing Boards; line staff work together on individual cases	Two governing Boards with Executive Director collaboration on services for groups of consumers, probably Q4	Two governing Boards that meet together periodically to discuss mutual issues	One Board with equal representation from each partner
EBP	Individual EBP's implemented in each system;	Two providers, some sharing of information but responsibility for care cited in one clinic or the other	Some sharing of EBP's around high utilizers (Q4) ; some sharing of knowledge across disciplines	Sharing of EBP's across systems; joint monitoring of health conditions for more quadrants	EBP's like PHQ9; IDDT, diabetes management; cardiac care provider across populations in all quadrants
Data	Separate systems, often paper based, little if any sharing of data	Separate data sets, some discussion with each other of what data shares	Separate data sets; some collaboration on individual cases	Separate data sets, some collaboration around some individual cases; maybe some aggregate data sharing on population groups	Fully integrated, (electronic) health record with information available to all practitioners on need to know basis; data collection from one source

Staffing Resources

Traditional Thinking	New Approach
There aren't enough (ANP's, MD's, LCSW's)	Who has them that we could partner with?
There's not enough time to spare to collaborate	Future Return on Investment • Improved Consumer Outcomes • Improved staff productivity • Improved retention

Role of Physicians

Primary Care Physician

Shared responsibility for consumer care

Prescribing for BH as comfort develops

One treatment plan

One record for documenting

Psychiatrist

- Consulting role
  - Curbside consults
  - Case conferences
  - Available all hours clinic is open
  - Some (fewer) evaluations
- Training
  - Support Primary Care Physician in prescribing behavioral health meds
  - Combined Grand Rounds/Training

Role of Behavioral Health Specialist

Systems Services

- Primary customers are the primary care provider
- Most breakdowns originate from a systems problem
- Address systems thinking
- Easy access to public BH system

Individual Services

- Short term solution focused therapy
- 1-3 Sessions
- Always available
- Consultation to the primary care provider
- Dually trained in MH and SA EBP's

Finances

Traditional Thinking

- We can't afford a BH Specialist - they are not reimbursable
- We can't bill two services in one day

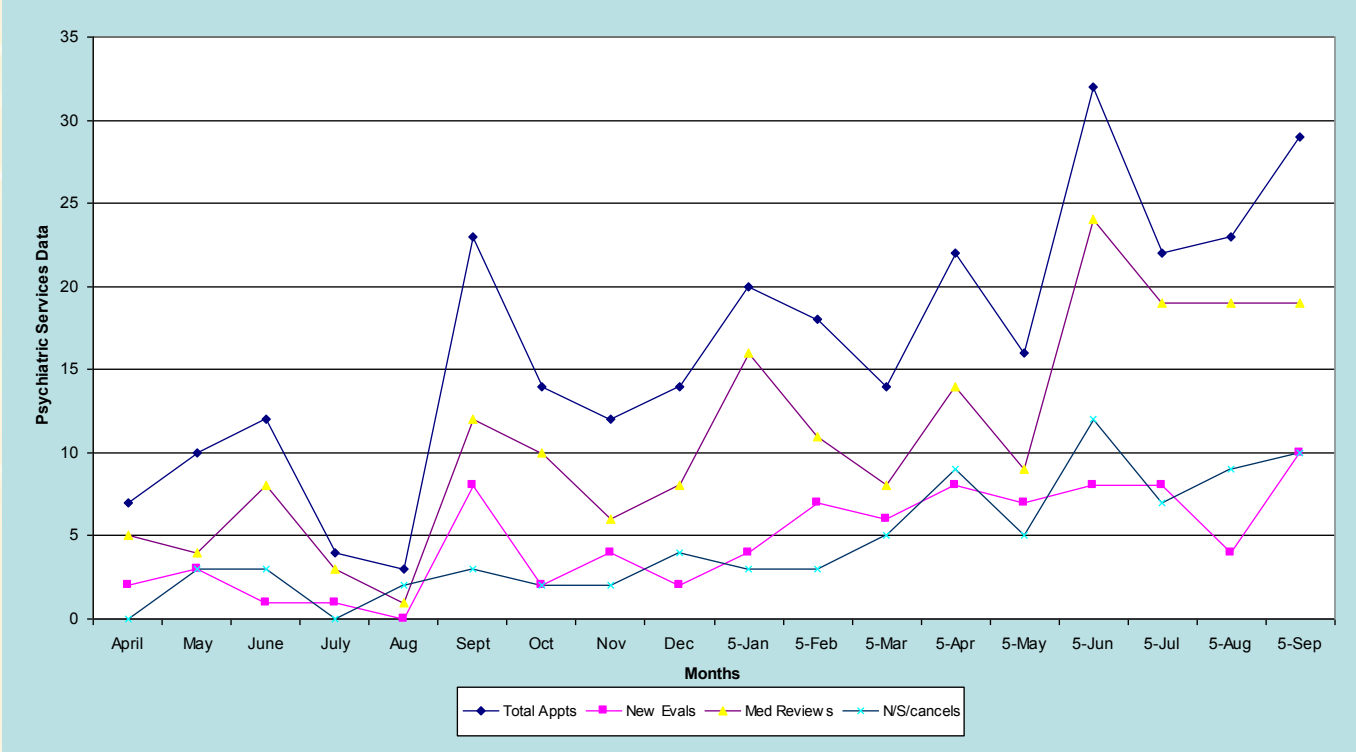
New Approach

- Who is reimbursable and how can we increase productivity to afford B
- Massachusetts Interim Billing Worksheet

Return on Investment

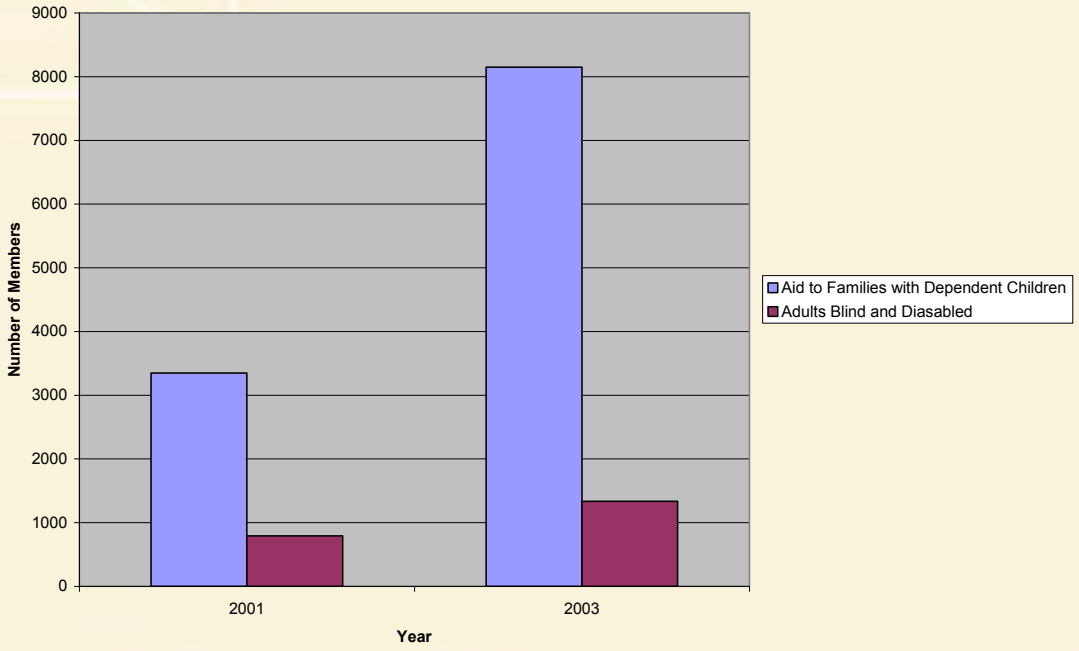
- For the consumer
- For the primary care setting
- For the behavioral health setting

Access to Care: Availability of Psychiatric Services

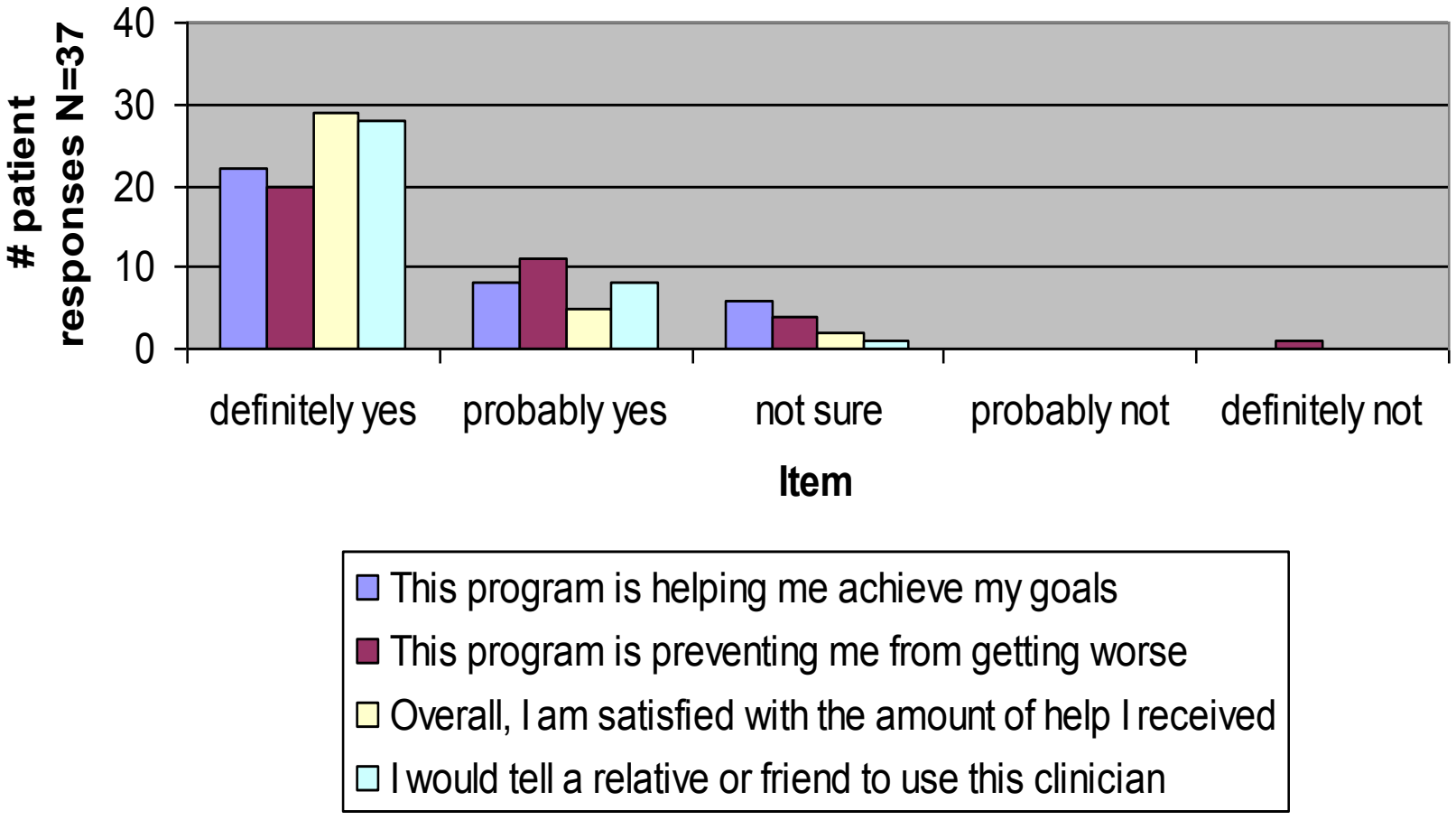


Access to Primary Care

Graph 1: Members per Month who Received Physical Health Care

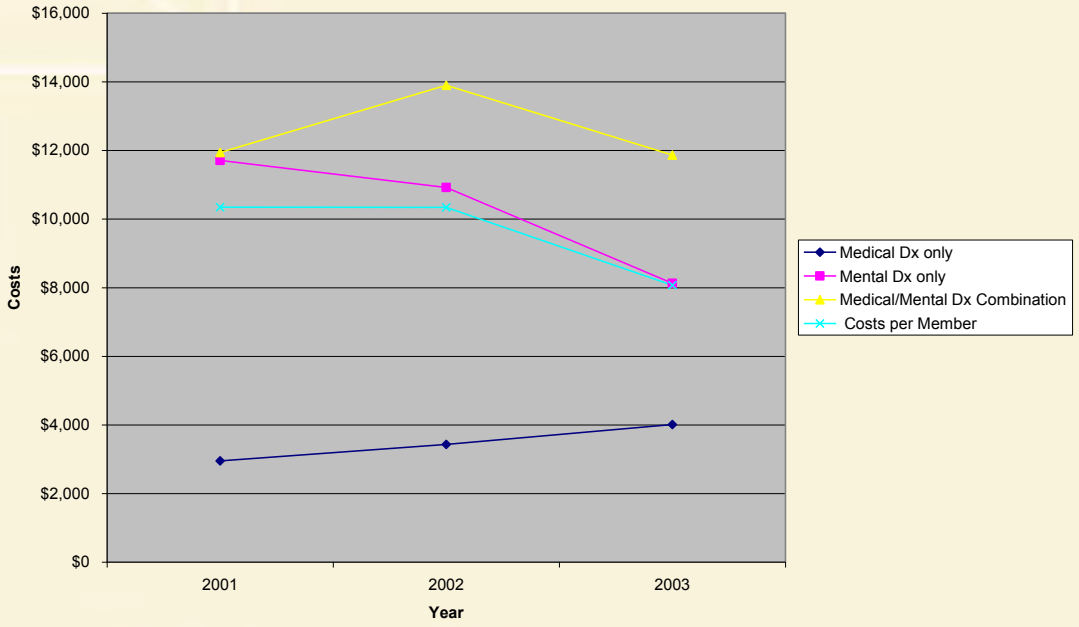


Packard Patient Satisfaction Data



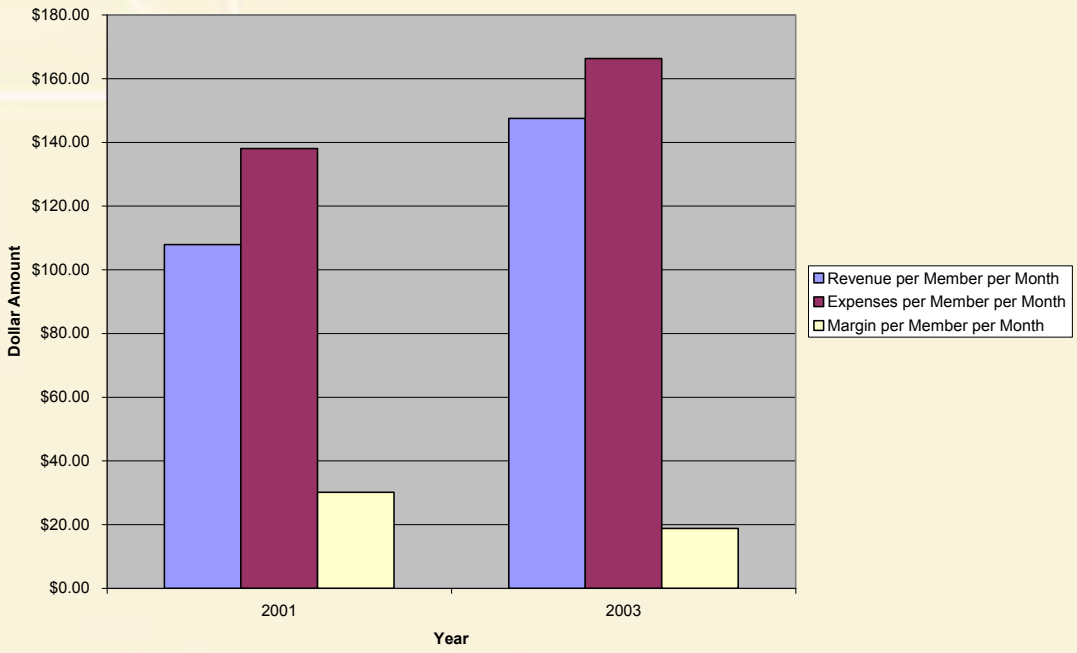
Primary Care Cost Per Case Impact

Graph 4: Costs of Services to the Medicaid Population based on Medical or Mental Health Diagnosis



Primary Care: Cost Per Case Impact

Graph 2: Comparison of Revenue to Costs for Physical Health per Member per Month



Opportunities for Return on Investment

- Disease management & early detection of health issues (primary care and behavioral health issues)
- Stronger community inclusion for clients
- Public mental health/primary care partnerships
- Better care in short run for improved, less expensive health system in long run
- Pre and post results on standardized measures