Clinical and Administrative Strategies of Bi-directional Integration

Presented by:
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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

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>The primary care provider is THE leader of the team</td>
<td>The patient is the leader of the team; non-medical staff can consult</td>
</tr>
<tr>
<td>Pace of work</td>
<td>Behavioral health adjusts to the PC pace</td>
</tr>
<tr>
<td>Documentation</td>
<td>BH documentation in the PC record</td>
</tr>
<tr>
<td>Privacy</td>
<td>HIPAA allows for disclosure for coordination of care</td>
</tr>
<tr>
<td>Function</td>
<td>Minimal Collaboration</td>
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<tr>
<td>Doherty, McDaniel &amp; Baird (1995)</td>
<td>-Separate systems -Separate facilities -Communication is rare -Little appreciation of each other’s culture</td>
</tr>
</tbody>
</table>

“Nobody knows my name” Who are you?  
“I help your consumers”  
“I am your consultant”  
“We are a team in the care of consumers”  
“Together we teach others how to be a team in care of consumers and design a care system”
<table>
<thead>
<tr>
<th>Function</th>
<th>Minimal Collaboration</th>
<th>Basic Collaboration from a Distance</th>
<th>Basic Collaboration On-Site</th>
<th>Close Collaboration/Partly Integrated</th>
<th>Fully Integrated/Merged</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access</strong></td>
<td>Two front doors; consumers go to separate sites and organizations for services</td>
<td>Two front doors; cross system conversations on individual cases with signed releases of information</td>
<td>Separate reception, but accessible at same site; easier collaboration at time of service</td>
<td>Same reception; some joint service provided with two providers with some overlap</td>
<td>One reception area where appointments are scheduled; usually one health record, one visit to address all needs; integrated provider model</td>
</tr>
<tr>
<td><strong>Services</strong></td>
<td>Separate and distinct services and treatment plans; two physicians prescribing</td>
<td>Separate and distinct services with occasional sharing of treatment plans for Q4 consumers</td>
<td>Two physicians prescribing with consultation; two treatment plans but routine sharing on individual plans, probably in all quadrants;</td>
<td>Q1 and Q3 one physician prescribing, with consultation; Q2 &amp; 4 two physicians prescribing some treatment plan integration, but not consistently with all consumers</td>
<td>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</td>
</tr>
<tr>
<td><strong>Funding</strong></td>
<td>Separate systems and funding sources, no sharing of resources</td>
<td>Separate funding systems; both may contribute to one project</td>
<td>Separate funding, but sharing of some on-site expenses</td>
<td>Separate funding with shared on-site expenses, shared staffing costs and infrastructure</td>
<td>Integrated funding, with resources shared across needs; maximization of billing and support staff; potential new flexibility</td>
</tr>
<tr>
<td><strong>Governance</strong></td>
<td>Separate systems with little of no collaboration; consumer is left to navigate the chasm</td>
<td>Two governing Boards; line staff work together on individual cases</td>
<td>Two governing Boards with Executive Director collaboration on services for groups of consumers, probably Q4</td>
<td>Two governing Boards that meet together periodically to discuss mutual issues</td>
<td>One Board with equal representation from each partner</td>
</tr>
<tr>
<td><strong>EBP</strong></td>
<td>Individual EBP’s implemented in each system;</td>
<td>Two providers, some sharing of information but responsibility for care cited in one clinic or the other</td>
<td>Some sharing of EBP’s around high utilizers (Q4) ; some sharing of knowledge across disciplines</td>
<td>Sharing of EBP’s across systems; joint monitoring of health conditions for more quadrants</td>
<td>EBP’s like PHQ9; IDDT, diabetes management; cardiac care provider across populations in all quadrants</td>
</tr>
<tr>
<td><strong>Data</strong></td>
<td>Separate systems, often paper based, little if any sharing of data</td>
<td>Separate data sets, some discussion with each other of what data shares</td>
<td>Separate data sets; some collaboration on individual cases</td>
<td>Separate data sets, some collaboration around some individual cases; maybe some aggregate data sharing on population groups</td>
<td>Fully integrated, (electronic) health record with information available to all practitioners on need to know basis; data collection from one source</td>
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</tbody>
</table>
Staffing Resources

Traditional Thinking
There aren’t enough (ANP’s, MD’s, LCSW’s)
There’s not enough time to spare to collaborate

New Approach
Who has them that we could partner with?

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

SAMHSA-HRSA Center for Integrated Health Solutions
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

- **2001**:
  - Aid to Families with Dependent Children: 3,000
  - Adults Blind and Disabled: 1,000

- **2003**:
  - Aid to Families with Dependent Children: 9,000
  - Adults Blind and Disabled: 2,000

**Year**

**Number of Members**
Packard Patient Satisfaction Data

- Definitely yes
- Probably yes
- Not sure
- Probably not
- Definitely not

<table>
<thead>
<tr>
<th>Item</th>
<th># patient responses N=37</th>
</tr>
</thead>
<tbody>
<tr>
<td>This program is helping me achieve my goals</td>
<td>30</td>
</tr>
<tr>
<td>This program is preventing me from getting worse</td>
<td>20</td>
</tr>
<tr>
<td>Overall, I am satisfied with the amount of help I received</td>
<td>10</td>
</tr>
<tr>
<td>I would tell a relative or friend to use this clinician</td>
<td>5</td>
</tr>
</tbody>
</table>

www.integration.samhsa.gov
Primary Care Cost Per Case Impact

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

- Costs: $0, $2,000, $4,000, $6,000, $8,000, $10,000, $12,000, $14,000, $16,000
- Costs per Member

Legend:
- Medical Dx only
- Mental Dx only
- Medical/Mental Dx Combination
- Costs per Member
Primary Care: Cost Per Case Impact

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

<table>
<thead>
<tr>
<th>Year</th>
<th>Revenue per Member per Month</th>
<th>Expenses per Member per Month</th>
<th>Margin per Member per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>$140.00</td>
<td>$100.00</td>
<td>$40.00</td>
</tr>
<tr>
<td>2003</td>
<td>$180.00</td>
<td>$120.00</td>
<td>$60.00</td>
</tr>
</tbody>
</table>
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