Coordination of Care

Physical and Behavioral Health/ Dr. Richard F. Dalton/ January 21, 2015

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Why it matters

- Mental or substance use problems and physical illnesses seldom occur in isolation. Approximately 15-43% of the time they occur together (SAMHSA, 2004).
- Depression, schizophrenia and other common mental disorders are disabling and their treatment is associated with endocrine, cardiovascular and neurologic risks. Specific mental health and substance abuse diagnoses are associated with increased risk for physical illness (IOM 2006).
- Various physical disorders as associated with mental illness (MI): 1/5 patients hospitalized for a heart attack suffers from depression. Patients with post-heart attack depression are 3x more likely to die (Bush et al, 2005).
- People with chronic mental illness die 25 to 30 years earlier than their peers who do not have a mental health condition, often due to unaddressed physical conditions.
- Healthcare costs are 75% greater for individuals with MI; co-occurring MI and substance abuse (SA) increase costs 2 – 3 fold (IOM, 2006).

2013. Health Home Information Resource. "The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes" http://medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-IRC-Collaborative-5-13.pdf
2006. National Association of State Mental Health Program Directors. "Morbidity and Mortality in People with Serious Mental Illness." Alexandria, VA. http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Technical%20Report%20on%20Morbidity%20and%20Mortaility%20-%20Final%2011-06.pdf.

Why it matters

- Cooperation and effective communication (shared knowledge) between physical healthcare providers and behavioral healthcare providers are key elements for the integration of healthcare. Lack of coordination, miscommunication and redundancy lead to increased patient suffering (IOM, 2001).

If we know collaboration and coordination are so important, why aren't we doing it?

- 12% of PCPs don't ask new patients about alcohol use and less than 20% use formal screening instruments to identify alcohol use/abuse (Friedmann et al, 2000). 45% of MH/SA providers do not inquire about physical health issues (Miller et al, 2003).
- Why?
  - Failure to appreciate how behavioral health and physical health are interconnected (actually, how they are the same)
  - Lack of options for those who screen positive
  - Silo thinking in a busy world where the rules are constantly changing
  - Disease management with individuals with chronic mental illness and/or chronic substance abuse

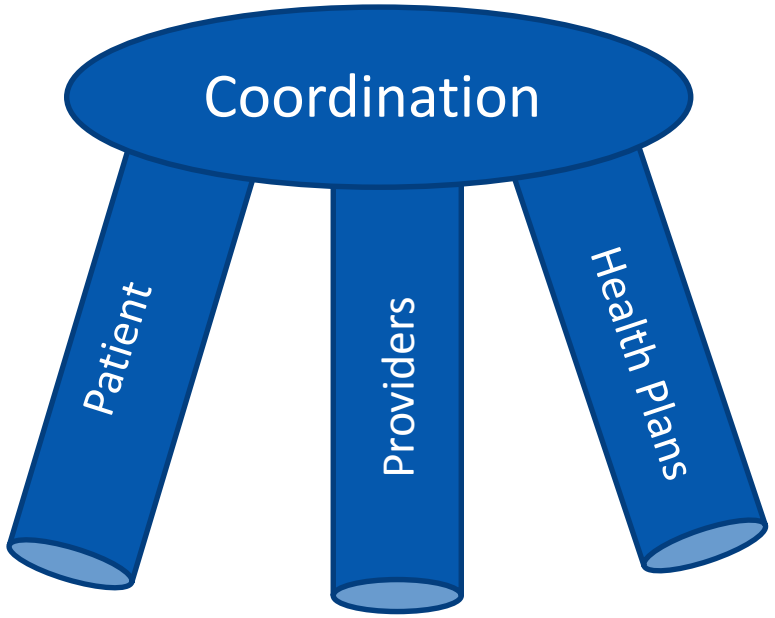
Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite 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, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understanding of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet ill-defined team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth understanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013

What it takes

- Coordination is not easy
- Dedicated time, effort necessary
- Patient involvement/voice is key
- Health plans can help
- Willing providers critical



Transforming the system

Our efforts in coordination of care

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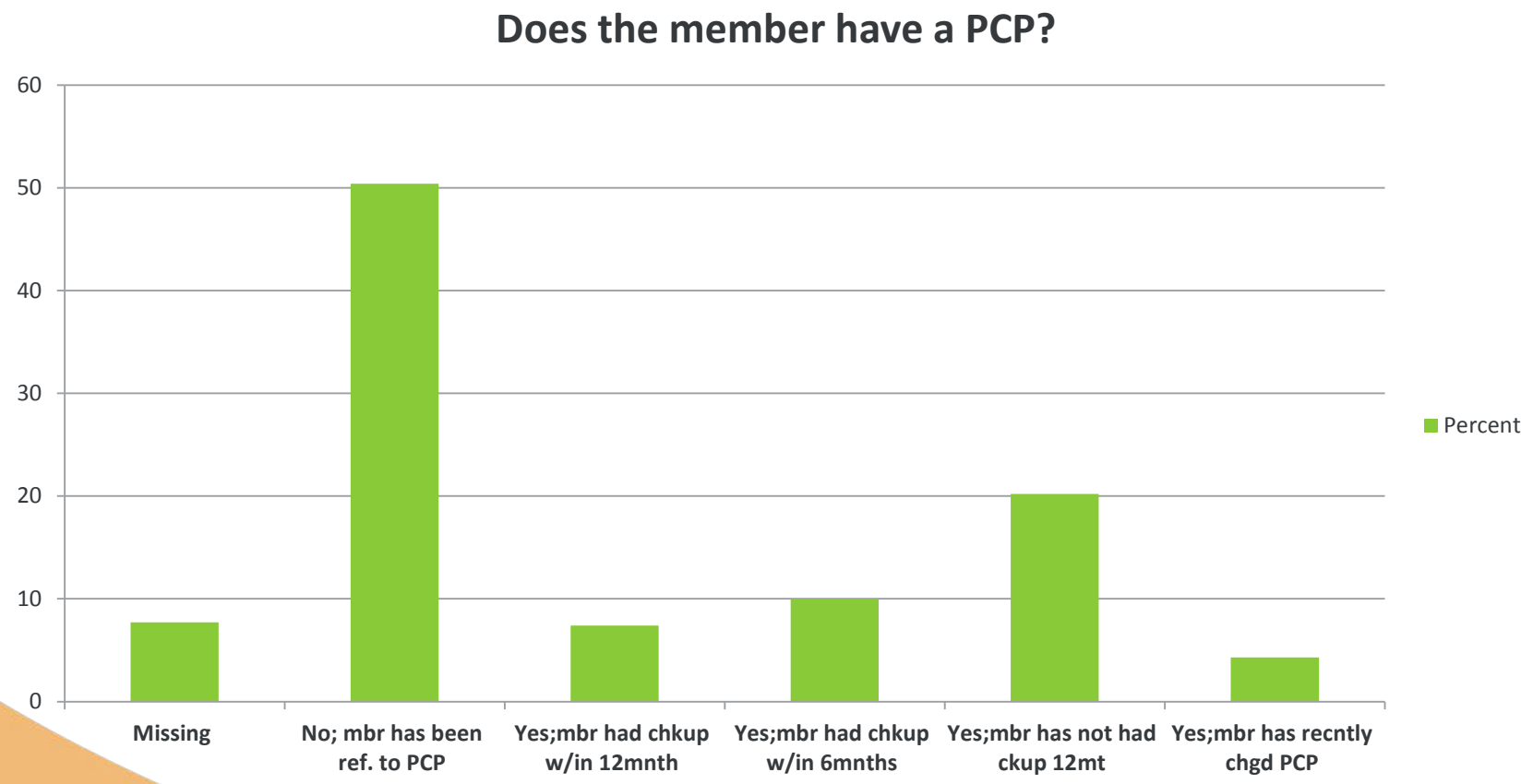
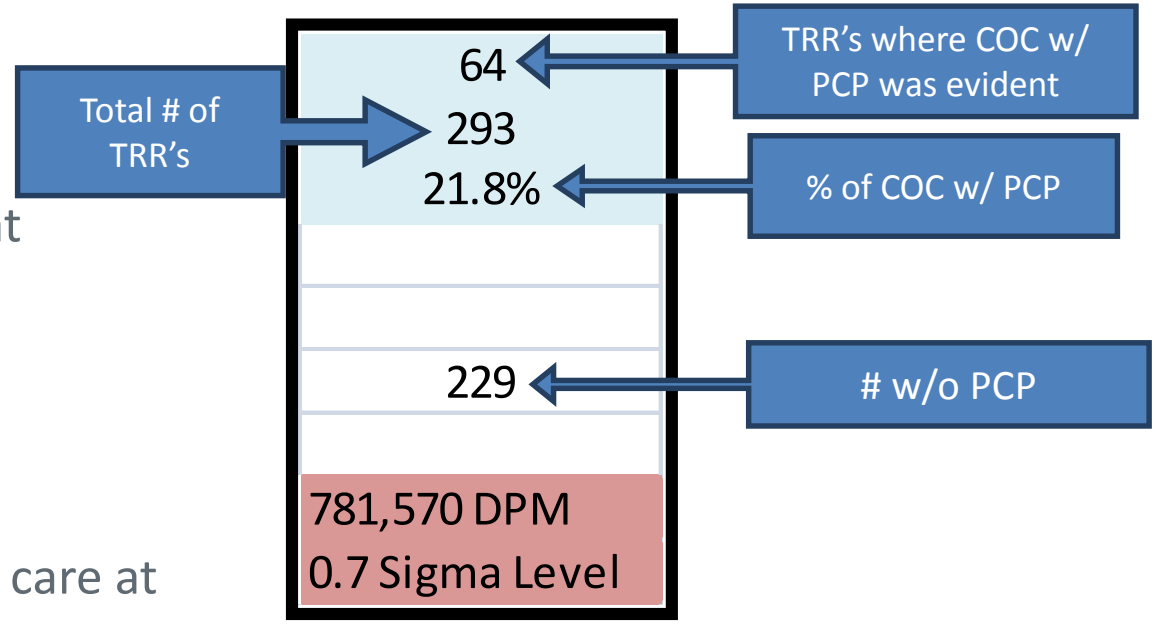
The starting point

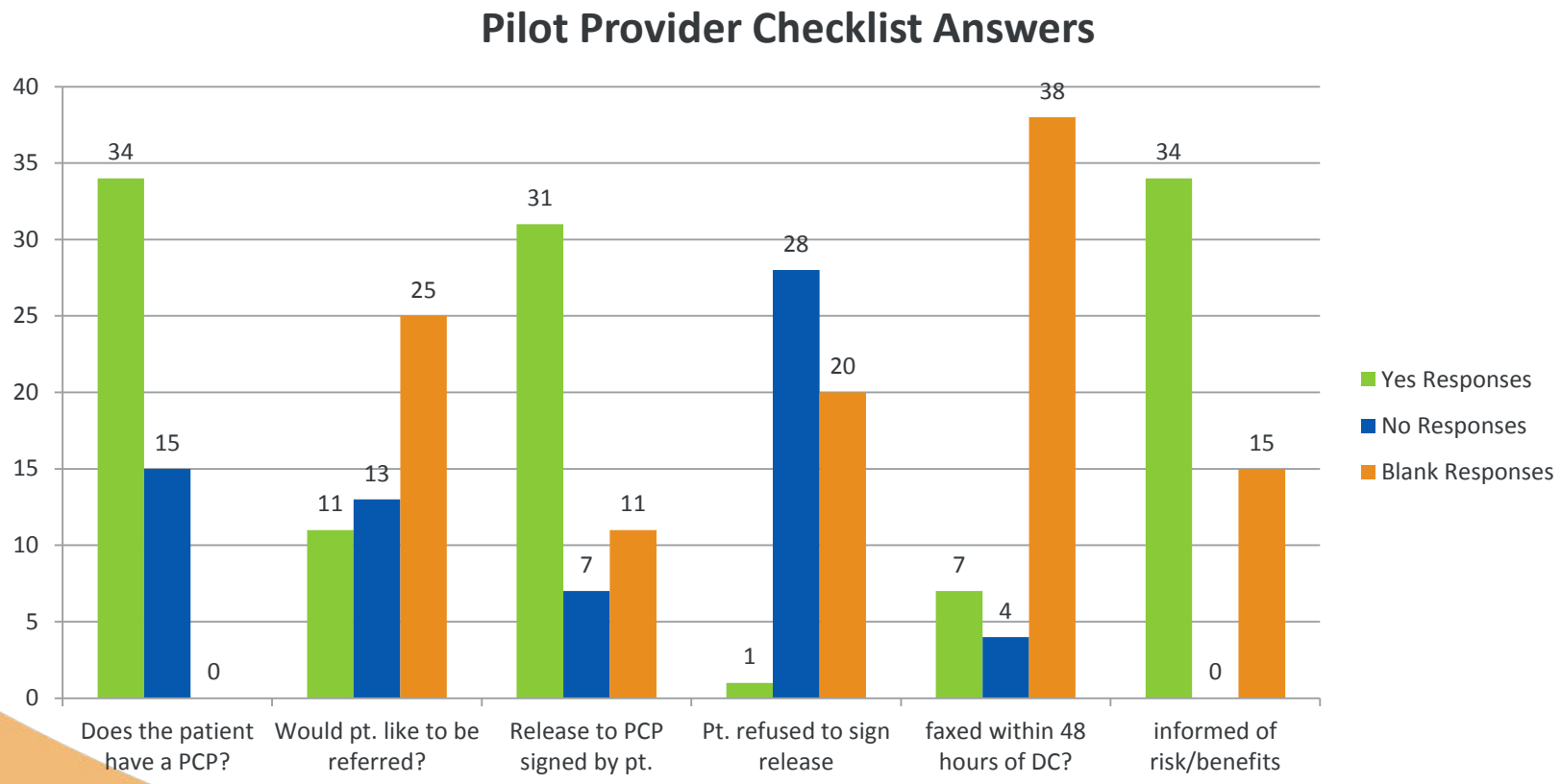


The starting point

- Identifying opportunities for improvement
- Treatment record review at inpatient hospitals
- 229 records review
- Only 64 (22%) included coordination with primary care at the time of discharge as an coordination of care element



Working with providers

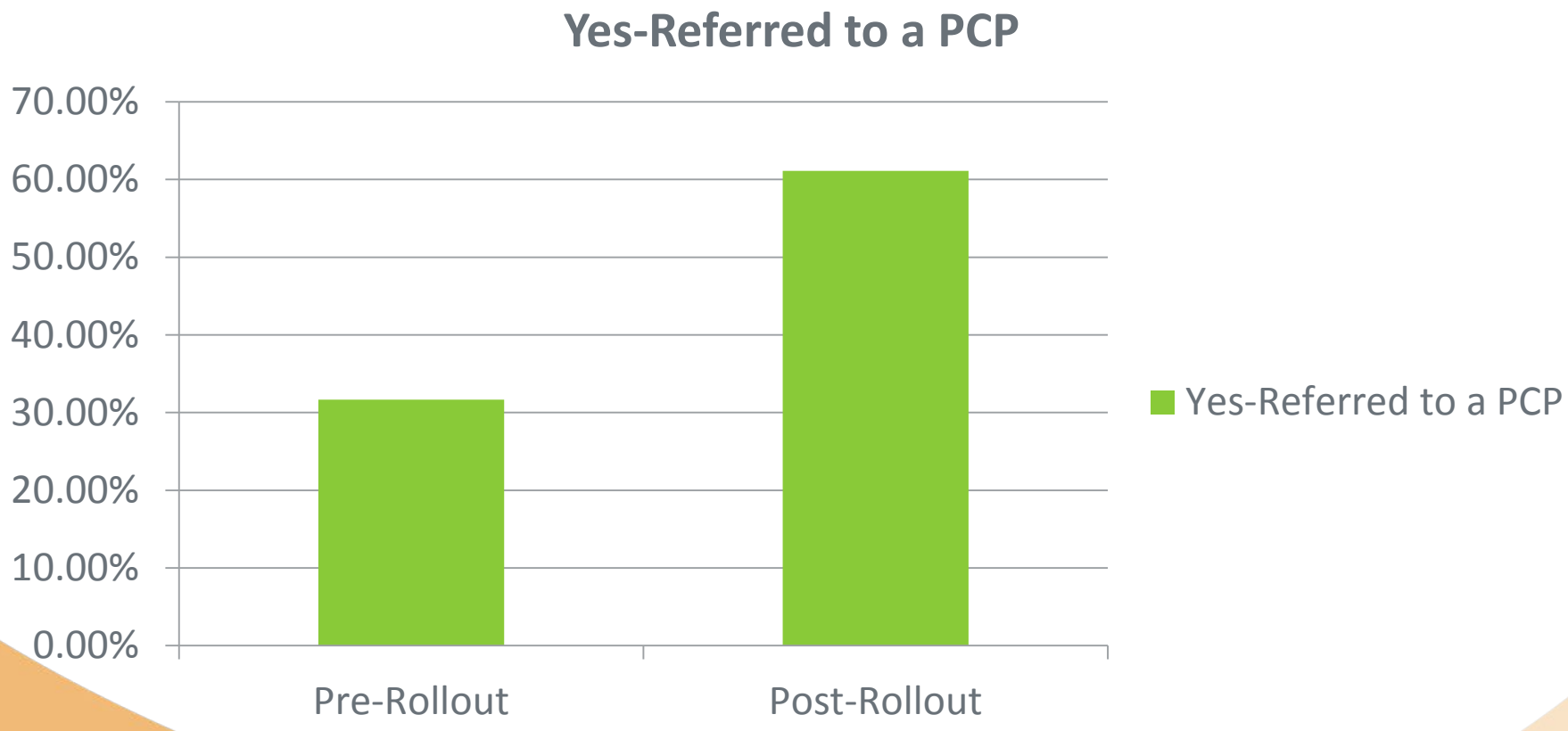


Working with providers

The sub-processes involved in coordinating care with PCP's include:

- Buy-in from facility executives & physicians regarding the importance of this process, so social services staff has direction to make appointment
- Obtain consent from members to schedule PCP appointments (found to be a barrier since the hospital reported many children are hospitalized without a guardian present to sign consent forms)
- Determine the member's PCP (found to be a barrier since many members do not know their PCP and it is difficult for psychiatric hospitals to obtain this information from the Bayou Health Plans)
- Need for attending physician to write discharge order for follow-up appointments with PCP
- Need for social service or nurse to schedule the appointment with the PCP
- Providing the member with appointment details such as time and location at discharge
- Need to verify through claims data that member has attended appointment

Early Results



The role of health plans

- Sharing data to focus efforts and improve results, particularly among highest utilizers
- Work in collaboration on difficult cases
- Give providers a better view of their patient across various levels of care when allowed
- Work with members directly to ensure they are following up with appointments
- Work together to ensure appropriate referral to care (both physical and behavioral)
- Share expertise through consult and training opportunities

The patient factor

Magellan's Peer Support Whole Health Program

- Focuses on key lessons on helping people navigate the health system and focus on healthier habits
- Works with certified peer specialist to help them assist members with chronic disease management; stress reduction; healthier eating choices and tobacco cessation
- Free to providers and members
- Webinars
- Trainings
- Newsletters
- In Louisiana, Peer Support Whole Health and Resilience Groups have been formed in Houma, Baton Rouge and Lafayette with more in development
- Second whole health training for peers is being held in Alexandria today.

2.5 years after the inception of managed care in LA for Medicaid recipients, where are we RE coordination?

- Level 2: Basic coordination at a distance
- Actual barriers to integration that must be addressed
  - Medicaid billing for 2 encounters on the same day
  - Structure of the current LA system
  - Importance of the FQHC model
- Plan for moving to co-location
  - Pilot project: imbedding behavioral health providers in physical health clinics

Your continued role

Coordination to integration to health homes

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A new thought process

New Attitude

- Patient-centered – Focus is on mobilizing services and supports based solely on the individual's health and wellness needs
- Integration of physical, behavioral, and other social supports
- Proactive, preventative efforts to improve/maintain health
- Access to services available
- Information and guidance
- Plants and lamps campaign – creating warm, inviting places for health care delivery
- It is a *privilege to serve this population*

Old Attitude

- Practice-centered - Patient needs to fit into available service array
- Silo approach to care, lack of integrative efforts
- Reactive efforts to manage crisis, illness
- Waiting lists, poor access, missed appointments
- Confusion within system, no designed guidance
- Sterile, low focus on environmental setting
- Population should feel privileged to be served

Steps you can take and how we can help

- Ask for help – you can ask the Bayou Health plan to make a referral to Magellan or call and make one yourself
- Learn, learn and learn more
  - Participate in webinars and trainings
  - Check out Magellan's resources to learn about such things as the use of psychotropic drugs in children or whole health initiatives
- Engage patients in all aspects of their care
  - If you are a behavioral health provider, ask about their PCP connections; assist in connecting with PCP
  - If you are a physical health provider, get to know the patient's behavioral health providers, discuss their behavioral health needs

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DISCUSSION and Q and A

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