

To: Leaders of Oregon integration initiatives

RE: RESULTS OF BRIEF SURVEY OF INTEGRATION
INITIATIVES

FROM: Bob Nikkel, MSW

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Thank all of you for your responses to the survey I conducted over the past 2 months. I will distribute this within DHS, especially with AMH and DMAP as we move further into the pilot projects as well as more generally in the direction of systems of care that are truly integrated at the client/family level.

1. What's working best and why?

- Initiatives that grow out of locally identified needs and solutions
- Increased management of chronic patients with Opioid Oversight Panel established
- Co-location of our FQHC and community mental health center
- Implementation of an integrated EMR
- Changing our culture re how our programs relate to one another and readiness to eliminate remaining internal silos
- Sharing (with proper consents) of clinical information between primary care and mental health, especially medication, problem statement, diagnosis, initial treatment plan, yearly assessments and discharge summaries
- Having staff available to do some face-to-face consultation with primary care providers
- Integrated diabetes project with local FCHP; created a registry for persons with persistent mental illness in the FCHP provider database

- One county FQHC integrates health and mental health care already for 10,000 individuals in five health centers and additional sites planned along with expansion of dental care.
- This same FQHC provides culturally competent care with over 60% bilingual clinicians.
- County-based MH has a medical home for over 800 individuals, both children and adults.
- One MHO and FCHP share an consumer advisory committee
- One county organized the 100% Access initiative to develop local resources to provide health care homes to people who do not have health insurance
- At least one county-based MHO and FCHP noted strong partnerships with SPD and other Divisions of DHS.
- Several counties have implemented wellness initiatives to address smoking cessation, integrated treatment for people with co-occurring disorders of mental health and addictions; also has developed alternative care options, health lifestyle choices and nutritional supports.
- 24/7 crisis response has been increased in one county in recent years; responses times have decreased; planning toward an even more improved system when resources are increased.
- At least one county has adopted a standard referral process in collaboration with the FCHPs and MHO for its region.
- Stanford Chronic Disease Self Management program has been implemented for people with chronic mental illnesses.
- Development of new Secure Residential Treatment Facility to assist with discharge of challenging patients from OSH and Blue Mountain Recovery Center

- Reduced admissions to civil commitment units of state hospital in past year by 25% with improved case management and liaison with acute care and state hospitals.
- Jail diversion programs in multiple counties
- Improvements in children's services with Collaborative Problem Solving and Parent Child Interaction Therapy
- Youth suicide training program for community members
- At least one county reported using using a state-of-the-art EMR
- Working relationships have been established and improved in small rural county between primary care and mental health offices
- Increasing awareness of local resources available in several counties
- Quality of primary care providers and their interest in working with people who have serious mental illnesses
- Extensive knowledge of local conditions by local partners
- Several counties developed a new referral process that has increased communication with primary care and mental health/addictions
- Increasing understanding between providers about the different rules required of mental health/addictions and primary care providers
- Commitments on all parties to providing high quality of care

2. What are the biggest barriers to accomplishing what you are trying to do?

- Conflicting state OARs, especially regarding documentation requirements

- Separate funding streams for mental health and physical health care
- Balancing good patient care with revenue generation demands
- Same day billing for primary care and behavioral health consultation
- Reimbursement practices that favor shorter office visits which discourage identification of issues beyond the primary presenting disorder
- Uncompensated time for communicating and coordinating care with colleagues
- Creating staff time to establish projects like the diabetes registry; create linkages using staff time that is not billable.
- Current rules prohibit mental health staff from billing for smoking cessation and weight loss management
- Third party payment systems that give weighted value to specialty care while undervaluing primary care
- Consumer preferences regarding the setting in which all services would be provided
- Marrying the cultures of primary care and mental health service delivery
- Funding structures do not support integration; the more we integrate, the harder it is to account for the funds in an “audit proof” manner; coding billing issues are overwhelming to staff
- Difficulty getting information flow from primary care physicians to mental health and addictions staff
- Inadequate space for co-location of clinicians between mental health and health resources

- Lack of knowledge about mental health disorders among some primary care physicians
- Resources for outreach and transportation, especially in rural areas for seniors to get access to integrated care
- Unclear protocols for referrals back and forth between health and mental health providers
- Need more opportunities for mutual in-service training
- Lack of understanding the differences between “mindsets” or cultures of mental health, primary care, addictions, oral health care, etc
- Finances and time, especially when additional crisis services become available and need for followup care especially for indigent unserved individuals—increasing with the downturn in local economies
- Stigma still associated with mental health and addiction problems in most communities

3. What outcomes can you report on in summary form at this point?

- Tracking anecdotal information
- PHQ-9 for diabetic patients to show reduction in depression
- Peer wellness effectiveness measures
- Hemoglobin HA1C, last eye exam, 1st PCP visit, number getting collaborative care management (diabetes project)
- Reduction of psychiatric hospital admissions

- Reduction of acute care hospital expenditures
 - Crisis respite use
 - Crisis calls returned within 15 minutes
 - Number of clients taken to civil commitment hearings vs. diverted from
 - Number of previously homeless individuals finding housing
 - Number of persons in jail diverted to intensive case management and community supports like vocational services
 - Decreased LOS in residential care
 - Decreased negative behaviors in children/adolescents served
 - Improvement in parenting relationships
 - Number of school districts using the ASIST model of youth suicide prevention
 - Number of family advocates hired
 - Number of individuals transitioned to lower levels of care safely
 - Informal communication of increased satisfaction with integrated care
- 4. Are there resources you need (financial or other) to further your integration initiative?**
- Resources for creating Health Information exchanges, sharing of patient information through an EMR
 - More funding for additional administrative functions required for integrated care (data collection, outcome management, etc.)

- More staff to manage a structured pilot; staff for a “Health navigator team” to focus on health recovery; funding to track, monitor and document progress and outcomes measurement
- Need more flexible funding resources to support start up efforts and ongoing coordination
- Inadequate access currently to medical care
- Planning for enhanced services for transition age youth; also need resources to complete plans for seniors living in facilities or nursing homes.
- Need additional resources to implement strategies to help physicians differentiate between patients who have chronic pain, those who are primarily drug seeking, and those who are some combination of both.
- Need to expand local capacity to serve persons who are indigent and otherwise without medical insurance.
- Need to expand the presence of mental health providers in primary care clinics and explore strategies to provide integrated care through co-location, referral and communication.
- More resources to track referrals and follow up care
- Integrated EMRs

5. Do you have recommendations of regulatory changes (in addition to those that AMH is already making around amending OARs, etc) that would be helpful and/or essential?

- Change Medicaid regulations to allow payment of two different services occurring on the same day for one patient for the same diagnosis
- Make payment system more supportive of wellness, preventative, health navigators rather than procedural services
- Recommend reviewing ORS 179.505 to see if it is actually MORE restrictive than HIPAA
- Reconciliation of rules between mental health, addictions and physical/oral health care
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