Bi-Directional Care Integration Work Group Meeting

Meeting Summary, 04/24/2018

Support and Backbone Staff: Kyle Roesler – *CHOICE,* Megan Moore – *CHOICE*, Shannon Linkous – *CHOICE,* Rene Hildebrand – *CHOICE*
In Attendance: Julie Nye – *Child and Adolescent Clinic*, Pam Hedglin – *Cowlitz Family Health Center*, Andrew Hillger – *CORE*, Mike McIntosh – *Pierce County Catholic Community Services*, Christina Garcia – *Molina*, Vicky Brown – *Morton General*, DJ Lindberg, Stephanie Shushan – *Community Health Plan of WA*, Laurie Tebo – *BHR*, Christina Mitchell – *CHOICE*, Michael O'Neill – *CHOICE*, Mattie Osborn – *Amerigroup*, Terri Gushee – *Mason General*, John Lanning – *Providence*, Dr. Phyllis Cavens – *Child and Adolescent Clinic*, David Meyers – *Cowlitz Family Health Center*, Annie McGuire – *Providence*

I. Executive Summary

- Kyle reviewed some of the preliminary assessment data with the group, which suggested that most practices and organizations overall want to or plan on exploring integrated care.
- Laurie Tebo, CEO of BHR, presented to the group how her organization and Valley View Health Centers have managed to integrate care throughout the years.
- The group discussed ways to further expand relationships between behavioral health and primary care, in which the focus turned to enhancing collaboration where co-located services is not possible. There was a general consensus that whole-person care cannot be reached unless it is partially consumer-driven, with patients allowing access to information to get around HIPAA regulations. The idea is for patients to access online patient portals during their visits to medical or behavioral health. Another idea discussed focused on behavioral health and primary care dedicating meeting time to coordinate care, case consults, and discuss specific patients on a regular basis.
- The group decided that a MOU and joint-ROI would be helpful in developing partnerships and outlining mutual commitments to care.

II. Welcome and Introductions & Mention of Pre-Meeting Updates

Kyle Roesler welcomed the group and facilitated introductions. Kyle reviewed the agenda for the meeting and re-visited pre-meeting updates, which detail programmatic updates, outcomes from previous meetings, and questions to consider for the current meeting.

III. Preliminary Assessment Data

Kyle reviewed some of the preliminary assessment data. The assessment was open for about a month. There were 52 unique responses, of which 38 selected project 2A; 19 apply to Behavioral Health, and 19 apply to Primary Care. Kyle reviewed some of the data findings that apply to the 2A project frame, which can be accessed here. Below is a breakdown of the findings:

- Most organizations identified their level of integrated care in levels two through four of SAMSHA's Standard Framework for Integrated Care.
- Most people want to explore integrated care teams.
- Pertaining to behavioral health providers:
    - Most practices "somewhat" have a plan for integrating primary care. Some say "yes" while a few said "no." Numbers for this slide look lower because it was part of the skip methodology and these people selected that their organizations were interested in integrated care.
    - Providers track referrals mainly to community-based resources and social services.
    - Most practices are not tracking physical health indicators using a population-based registry, but are interested in using one.
    - Most practices do record some, if not all of the following, in a patient's record: smoking status, blood pressure, lab results, and body mass index
    - Most providers ask about some, if not all of the following routine preventative care: mammograms, immunizations, and annual checkups.
    - Most practices do not prescribe MAT.

IV. Laurie Tebo, CEO of BHR: Presentation

Kyle introduced Laurie Tebo, who talked about integrating primary care services in behavioral health. Behavioral Health Resources provides outpatient services to people with mental health issues in all age ranges. This is made up of different programs, including: New Journeys (first episode psychosis), co-occurring disorders, children and family services, pregnant women, and several others. BHR has partnered with Valley View Health Centers for over six years; it has worked well. Right now, if someone gets off the bus at the BHR location, patients can see a mental health provider, schedule a medical appointment with Valley View, and schedule a dental appointment all at the same time. Together, BHR and Valley View communicate the patient's medical records through a release of information and joint access to EHRs. They are hoping to figure out how to increase the productiveness of this union. The outstanding question is, how can we further enhance collaboration and/or integrate care between community behavioral health agencies and primary care?

V. Primary Care Integration/Enhanced Collaboration Discussion

Kyle opened the discussion to the group with the following guiding questions. Corresponding feedback from the group is listed below the relevant questions.

1. What ideas do you have to further develop these integrated relationships?
    - If providers are not co-located, integrate telehealth or develop stronger communication between primary care and behavioral health.
    - Make sure these "partnerships" really become partnerships where both parties work together to take care of the "whole" patient. The communication needs to flow bi-directionally, which could be overlaid by nurse communication. *Limited resources can be a challenge.*

- A case manager/care coordinator/navigator can be the one to make sure there's follow through on all referrals and taking ownership of case consulting. Staff from both agencies need to be identified to own this process.
- One example of enhancing collaboration is The Child and Adolescent Clinic establishing a recurring, systematic meeting with a local behavioral health agency including the following:
    - There is a designated monthly meeting set up to review patients with the psychiatrist to cycle through medication changes and lab work needs.
    - There is a person identified in each organization to increase communication and change the dynamic.
    - The meetings are a commitment, but it is worth it. The venue for these case consults is an in person lunch meeting – the MA and a psychiatrist come to the Longview building. The meeting is very structured with required information reviewed beforehand so no time is wasted.
    - They review 10-12 patients at a time, sometimes less.
    - Lab and well-child check recalls are a new endeavor and have been helpful.
    - Parents get a text about labs and appointments that are scheduled.
    - Really streamlining a point person for each organization and getting direct phone lines and in-person communication set up has been the best way to keep in touch.
    - *Attendees*: all providers, psychiatrist, his MA and the nurse manager from the psychiatrist's office.
    - Dr. Cavens said it is a requirement to call a child's psychologist directly if a child is in disarray. This should get a response right away.
- One attendee mentioned MyChart being the most useful tool he has access to. He thinks it would be smart to give providers access to MyChart in order to lower barriers and allow primary care and behavioral health providers to better understand a patient's history. If patients release information and provide their username and password, this would get around HIPAA violations. If the HIPAA regulations aren't addressed in this way, there can never truly be whole person care available.
- Providers need to allow clients better access to their own data, so they can share this with future providers. Technology will follow us – whatever apps and products people use is what patients will begin to use to make communications and access easiest for both parties.
- There needs to be a work around to allow access to mental health information due to HIPAA regulations
- There is always the extra piece of people not wanting to share information because they are sensitive about substance use disorders.
- A joint release of information could facilitate communication for organizations who have differing EHRs
- Develop a MOU template, or starter document, so both parties can start the dialogue to make the commitment to release information. This document can say what each party is willing to share (BH and PC). ROI template could be useful as well.
    - There could be an interdisciplinary team that facilitates these communications further to allow correct questions and common language amongst providers.

3. How do we move from referral sources to effective collaboration?
    - Track referrals
    - Community care centers could be a good resource for effective communication strategies.
    - Have a multi-disciplinary team on-site
        - Include community and social support agencies on collaboration teams, then every need is addressed at the same time.
        - Patients can be helpful to inform what those look like due to preference for the providers in the community. Part of the solution is to be consumer-informed.
    - How integrated is the care going to be? At what point does the patient decide? The provider? Individual identities should not be taken away. Moral and other issues have to be considered.

4. For high needs patients, what is the avenue to get them to integrated care?
    - Monthly meetings (see circle back to earlier conversation).
    - Referral and tracking systems. For example, RN care manager tracks discharges from the hospital to make contact and follow up with those patients. The process to open these lines up is to directly call or meet with the people in charge of different areas to allow access. Communication is everything to keep up with the status of patients.
        - Barrier to this system: no reimbursement for time non-face to face time.

VI. Next Steps & Closing

- Next meeting 05/29/18 from 9:00 to 10:30AM at Fairfield Marriott Inn and Suites, 6223 197th Way SW, Rochester, WA 98579
    - Dial-In: 1-872-240-3311
    - Access Code: 942-416-725
- At AIMS Center training, start conversation for collaboration agreements.
- Finalize Domain 1 Strategies
- Continue developing Logic Model
- Providers begin to think about RFP
- Start developing partnerships ASAP!