Integrated Care Action Alliance

How to Integrate Care and Prepare for Accountable Care Organizations

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Participating Organizations

Managed Care: MD Wise, Anthem, MHS

CMHCs: Centerstone, Adult & Child, Porter-Starke, Regional MHC, BHMI, IN Council

FQHCs: WindRose, Indiana Health Centers, Riggs, HealthLink, IN Primary Care Assoc.

Government: HHS, DMHA, Medicaid

Other: IN Hospital Assoc., Inspiring Transformations
Strategic Implications

Rapid changes in healthcare

ACA & parity

Integrated care

Health Homes

Accountable Care Organizations
Thriving in the New Environment

Effective Strategic Positioning Translated into Action Plans

Strong Outcomes & Fiscal Viability

Streamlining Processes

Strategic Positioning & Identity Shift
Deliverables of the IN Integrated Care Action Alliance

Clearly defined list of positive **health and cost data** that can demonstrate the impact of integrated care

**Process map** of integrated care in community mental health centers

**Process map** of integrated care in federally qualified health centers

**Un-funded steps** in the process and other issues

Training **needs assessment**

A clear **action plan with owners and due dates** indicating how the group will work to resolve critical issues
Process map of integrated care in community mental health centers
Process map of integrated care in federally qualified health centers

Integrated Care Process for Serving People with Mental Illness in IN FQHCs

Leadership from CMHC, FQHC & MO organizations:
- Make integrated care a priority and develop a clear plan.

Triage:
- Gather patient info and log it into the EMR (PHQ22), populate in the progress note automatically.
- Provider reviews the triage results & identifies people with behavioral health needs or there is a denial/self-management.
- Provider sees patient for physical health issues and tells the patient what they need.
- Provider contacts the behavioral health expert and introduces via a warm handoff (BH)
- Medical provider (MP/MID/DD)
- Important aspects: Timing, patient flow, space, more therapy somewhere else, etc.

Medical Health Consultant (BHC) - 3 - 5 staff:
- Provider contacts the behavioral health expert and introduces via a warm handoff (BH)
- Important aspects: Timing, patient flow, space, more therapy somewhere else, etc.

Behavioral Health Consultant (BHC) - 3 - 5 staff:
- Provider contacts the behavioral health expert and introduces via a warm handoff (BH)
- Important aspects: Timing, patient flow, space, more therapy somewhere else, etc.

Psychiatrist at the CMHC on call for the BHC:
- Mental Health Peer Support Specialist
- Managed Care Organization
- Labs
- Pharmacy
- Referring Support Person (family, church, etc.)

Model 1: Provides consultation to the BHC - Not billable
- Make the MIP & write prescriptions as needed
- Document in the EMR & call the psychiatrist if needed (No medication recommendation outside protocol)

Model 2: Provider puts their clients on the agenda, 20 - 35 in an hour; Treatment team meetings - transition out of therapy - BAC is documenting - Not billable - One estimate of the cost is $798/hr
- Two providers communicate in person or via the EMR, etc. and agree on a follow up plan

Does the patient need more intensive behavioral health services?
- Yes
- Refer to CMHC (How many patients will go?)
- No

Please submit changes to Suzanne Clifford at Clifford@InspiringTransformations.com
Key Issues Identified

Finding willing partners

Reimbursement/Financial Viability

Same day billing

Integrated medical record, document recognition, and information sharing

Cross-training

Credentialing, valid license in IN, Medicaid, Managed care – for both mental health & primary care
Additional Key Issues Identified

Demonstration of costs of care savings in order to influence policy and funding

Telemedicine (20 mile radius issue)

Language barrier costs

Paperwork/ Administration/ Process inefficiency

Transportation

Provider shortages (primary care, nurse practitioners, mental health, etc.)
More Issues Identified

Medicaid provider requirements, 96510 codes

Need to partner with emergency rooms to build community care collaborations

Differences in treatment plan documentation requirements between primary care and mental health (Primary care often utilizes the medical note)

Lack of access to FQHCs in certain parts of the state
Training Priorities Based on the CMHC & FQHC Needs Assessment

Financially viable models

Training medical staff on behavioral health issues & Rxs

Training behavioral health providers on chronic disease management

Moving from co-located to integrated care

Coordinating care among the CMHC, FQHC and community hospital
Accomplishments of the Integrated Care Action Alliance

Increased cross-system collaboration

HHS committed to funding training as a result of the Integrated Care Action Alliance’s training needs assessment

Created an initial business case of integrated care

Working with the Medicaid Claims Taskforce to resolve the top priority billing issues

Working to address health information sharing issues

Working on over 30 other action items