Applying Integrated Health Care Principles In Indian Country

May 2013
• “Powerful elements of historic conclusion in areas of workforce planning, payment, delivery, research and health promotion”.

• “It focuses on prevention, wellness, health promotional practices, the public health system and integrative medicine.

• “Integrative care has to be proven to be cost-effective.”

• “Evidenced-based integrated care needs comparative research to evaluate its effectiveness.”

• “For insured patients using services like acupuncture, chiropractic, naturopathy and massage therapy, the future looks brighter.”
Coordinated Care

Level 1-Minimal Collaboration

Behavioral health and primary care providers (PCP) work at separate facilities and have separate systems. Communication usually occurs when a provider needs specific information about a mutual patient.

Level 2-Basic Collaboration at a Distance

Behavioral health and PCP maintain separate facilities and separate systems. Providers view each other as resources and periodically discuss shared patients. For example, a primary care physician may request a copy of a psychiatric evaluation to confirm a diagnosis. In this model, behavioral health is viewed as specialty care.

From SAMHSA-HRSA Center for Integrated Health Solutions. April 2013. A Standard Framework for Levels of Integrated Healthcare
Co-Located Care

• Co-Located Care

Level 3– Basic Collaboration Onsite

Behavioral health and primary care providers are located in the same facility but use separate systems. Providers may or may not share the same space, communication becomes more regular due to close proximity, especially by phone or by email with occasional meetings to discuss patient care; Patient movement is through a referral process. Most of patient care is done independently by individual providers. Team concept exists but is not fully experienced.

Level 4- Close Collaboration with Some System Integration

There is closer collaboration among PCP and behavioral health providers due to co-location in the same practice space and some shared systems. Front desk schedules all appointments and the behavioral health provider has access and enters notes in the medical record. Consultations occur through personal communications which leads to more opportunity to share patients and to have a better understanding of each others role.

From SAMHSA-HRSA Center for Integrated Health Solutions. April 2013. A Standard Framework for Levels of Integrated Healthcare
Level 5-Close Collaboration Approaching an Integrated Practice

High levels of collaboration and integration. Providers begin to function as a true team, with frequent personal communication. Team actively seeks system solutions as they recognize barriers to integrated care. However, some issues, like the availability of an integrated medical record may not be readily resolved. All providers understand the different roles team members need to play and they have started to change their practice and the structure of care to better achieve patient goals.

Level 6-Full Collaboration in a Transformed/Merged Practice

This model involves the greatest amount of practice change. Fuller collaboration between providers has allowed the system to transform into a single health system treating the whole person. The principle of treating the whole person is applied to all patients, not just targeted groups.

From SAMHSA-HRSA Center for Integrated Health Solutions. April 2013. A Standard Framework for Levels of Integrated Health Care
Some Benefits of Integrated Care

• Integrated care treats the whole person. Everyone on the treatment team gets the “full picture” of the patient’s health care needs.
• Integration increases the likelihood of better health care outcomes through greater collaboration and coordination of care which can lead to efficacious care.
• Indian Country has some of the worst health disparities in the U.S. for Diabetes, cardio vascular disease, depression and alcoholism. All can be addressed in an integrated health care system by treating the whole person in a coordinated manner.
• Integrated health care helps to reduce the stigma associated with receiving mental health services.
• Prevention features such as PCP screening for depression and suicide.
• Enhances access to care.
• ACA expanded covered services can enhance integrated approach, e.g., acupuncture.
Barriers to Integration

1. **Compartmentalization and “Turf Issues”**
   Some staff just do not want to integrate care and will rationalize that there is no value to integration.

2. **Separate software**
   Accessing Records can be problematic.

3. **Different confidentiality laws**
   Substance abuse confidentiality laws (state and federal) and mental health confidentiality laws (state) are typically more restrictive.

4. **Different record keeping regulations**

5. **Resources needed for integration**
   Transition to single systems and training requires additional resources.
Characteristics of Our System

- Gila River Health Care (GRHC) began co-location in 1996 when their Behavioral Health unit was moved from Tribal Social Services to GRHC.
- 2006 through 2010 a series of mergers and acquisitions created a seamless community based behavioral health system managed by GRHC and made integration more attainable.
- Community system consists of a reservation-based state funded behavioral health program and a number of 638 outpatient facilities, a 638 adult RTC drug and alcohol program and one home that is being renovated for mental health clients.
- Full integration exist in specialty programs such as our Diabetes Clinical Pathways and Dialysis programs.
- Due to program growth, space limitations and site locations, Behavioral Health Services (BHS) is between the “Basic Collaboration at a Distance and Basic Collaboration on Site” models, e.g., primarily use of emails and phone calls to collaborate.
- There are two PCP facilities within the Community and 5 BHS facilities in the Community. Some BHS facilities are 200 yards away from PCP services and some BHS facilities are 10 miles away from PCP.
- The two PCP facilities are about 31 miles apart, each of these facilities contain pharmacies and have behavioral health buildings located 200 yards away and 400 yards away. This allows for in person consultations as needed, and evaluations for acute inpatient admissions to occur.
- Partial integration has separate electronic health records and providers have look-up capability. Full integration has single medical record, which we are pursuing.
- Drug and alcohol continuum will have a full time Internal Medicine physician beginning June, 1, 2013. Physician is American Society of Addiction Medicine certified. This will be a fully integrated model, sometimes referred to as “reverse integration.”
- Traditional healing services are also provided by BHS.
How Our Systems Work

GRHC Integration is a Hybrid Model

- GRHC is beginning to develop outcome measures.
- Full integration works well, show rates for care is good.
- Partial integration is primarily done through emails and phone calls, PCPs use their own EHR and our BHS use a different EHR, but we scan our behavioral health notes into the PCPs EHR.
- PCP conduct depression screenings on patients who are 12 years old and older. For those patients who score high on the depression screening an electronic referral is made to BHS from the PCP.
- Depression Screenings from Family Practice accounts for 39.6% of the screenings, Internal Medicine accounts for 36.1%, General Medicine accounts for 14.6%, and Diabetes accounts for 7.1%. Of interest, the low percentage of depression screenings in our Diabetic programs may mean that the fully integrated model of care is treating and managing depression more effectively than our partially integrated programs.
- Show rate for depression referrals to BHS are low, we are evaluating the need for co-location with PCP.
- ICARE is a software package that allows all providers to look up the patient’s previous, current and future appointments. For instance, this allows the mental health therapist to point out to the diabetic patient that they missed their eye exam last week which permits the therapist to discuss the importance of the exam with the patient and to reschedule the needed exam; promotes continuity and efficacy.
- Psychiatrists and other physicians make electronic referrals for prescriptions to our 2 pharmacies, look up capability also allows for the coordination of care and the ability to identify drug seeking patients.
- Behavioral health case managers can be present in the exam room when the patient is receiving primary care.
Lessons Learned

What Have We Learned So Far

• Indian Country healthcare systems treat the “body, mind and spirit” (the whole person). Subsequently the principles of integrated care are consistent with Indian Country approaches to care.

• Co-location model has been used by Indian Health Services for several years. Historically this model has created easy access to care.

• Outcome measures are essential to evaluating the effectiveness of integrated care.

• Be committed to addressing all barriers to effective collaboration regardless of the degree of service integration that you are working with.

• Implementing integrated health care in “frontier country” can be difficult.

• Transitioning to integrated care requires additional resources.
The Need to Maximize Federal Funding

- Indian Country falls off the Fiscal Cliff every year.
- Indian Health Services Annual Funding Agreements (AFA) remain relatively flat which means “Direct Care” and “Contract Health Service” funds also remain flat.
- “The dismal statistics of American Indian healthcare are well documented. President Obama cites a couple of the more startling ones on this website, including that men living on South Dakota’s Pine Ridge and Rosebud reservations have the second-lowest life expectancy in the western hemisphere. The health disparities are, as Sebelius says, ‘unconscionable’. But so are the funding disparities”.
- Some per capita comparisons to healthcare programs that are federally funded: federal prisoners, $3725, American Indians, $1600 per person.

Federal Mandates That are Unfunded

1. Tribal Law and Order Act
   Potentially expands tribal behavioral health programs to address competency evaluations, competency restoration services and reintegration to the community.

2. Tribal Action Plan
   Requires a comprehensive assessment of the substance abuse service needs in tribal communities. Requirements include addressing service gaps and reporting to SAMHSA every two years.
SAMHSA’s Funding Opportunities for Tribal Programs

SAMHSA’s Tribal Affairs

Mission: To develop, coordinate and communicate SAMHSA’s polices and resources to improve behavioral health in Tribal/Village communities.

• SAMHSA’s Tribal Affairs has a special focus on AI/AN youth suicide and substance abuse prevention.

• SAMHSA Tribal Portfolio includes:

  FY 2010 = 104 Grants Awards to Tribes/Tribal Organizations = $68,120,563
  FY 2011 = 103 Grants Awards to Tribes/Tribal Organizations = $71,065,895

• Tribal Affairs Website: http://www.samhsa.gov/obhe/tribal-affairs.aspx.
Types of Block Grants

• Prevention and Treatment of Substance Abuse (SAPT)
  GRHC Behavioral Health Services uses SAPT Substance Abuse General Services funding category to pay for traditional counseling and traditional healing services.

• Community Mental Health Services (CMHS)
2014 Block Grant Requirements

- State Health Departments must consult with tribes regarding the SAPT allocations. Allocations to be made for FY 2015.

- Allocation considerations must be based on documented need and resources.

- SAMHSA must approve state Block Grant plans.
The Institute for Mental Disease Issue (IMD)

- Any BH facility that has 17 or more beds does not qualify for the OMB rate under certain circumstances, as the facility is classified as an IMD.

- Individuals between 21 to 64 who are in IMDs are not eligible for the OMB rate.

- Likewise, these individuals are not eligible for the inpatient OMB rate nor is the facility eligible for a special negotiated contracted rate.
Working with Arizona’s State Medicaid Agency

Accomplishments

• GRHC’s RTC is classified as an IMD. Non-OMB rate made it difficult for us to balance out bottom-line.

• GRHC worked closely with AHCCCS to address various OMB rate issues.

• RTC campus of care consists of 5 dormitories, 4 having 17 or more beds, the remaining 1 was used for intake evaluation.

• AHCCCS reclassified our intake building as an outpatient program which qualifies for the OMB rate. As a result, our clients walk about 100 yards or so to these services.

• We worked on and off with AHCCCS for a 3 year period to get a firm determination from CMS that our home-based therapy would be reimbursed at the OMB rate. Establishing the OMB rate was critical as the Tribe is building an 80 bed campus of care for a youth RTC. We will hire outreach therapists at our central office to provide RTC services if the youth facility does not qualify for the OMB rate.

• Medicaid State Plan Amendment (SPA) was amended to allow all AZ tribes to be reimburse for up to 5 services per day, prior approval was for 3 times per day.

• Inter-Tribal Council of Arizona worked with AHCCCS to obtain a waiver from the Childless Adult benefit reduction.
Questions?