

Summary of “Sharing Patients” Recommendations

The following is the list of items recommended at our Sept. 22nd “Sharing Patients” meeting. During our Jan. 17th meeting we will identify three items on which to take action during 2006. A few issues were excluded from the list because they are being addressed elsewhere (e.g. stigma). The items in italics were left in for your information but are believed to be outside the scope of this initiative either because they are much too broad for us to take on (e.g., cultural competence) or they don’t relate specifically to primary care (e.g., improving mental health/substance abuse reimbursement).

1. Insurance Reimbursement

- Reimbursement to PCP's for screening
- Work to reimburse depression care management
- Move psychiatrist to medical side of reimbursement
- Develop means to extend psychiatry consultation with PCP/Medicaid and Medicare reimbursement: remove barriers about two professionals billing to promote consultation and team-based care, remove barriers about same day service provisions
- Design payment system to reflect value they place on integration
- Payment models: paying for service vs. paying for outcomes, paying for performance
- *Reimbursement available for care managers in mental health settings*
- *Improved reimbursement for Mental Health/ SA Services*
- *Outlaw behavioral health carve-outs - no reimbursement in PCP for behavioral health/ SA; single provider network*

2. Education of providers on skills necessary to integrated care

- Early training, education, skill building (medical school). To increase the ability to provide care to the whole person.
 - Increase ability of primary care providers to feel comfortable with mental health screening and management
 - Need to promote symptom recognition of mental disorders
 - When to hand off to mental health provider
 - Communication and empathy
 - *Cultural competence, making care acceptable*
- Educate PCPs and staff on behavioral medicine
- Have students in training develop and provide in-service training (with mentors) to the facilities they are interning re: MH & AODA screening, intervention & referral
- Educate and promote services to patients
- Consider pre-serve professional training programs (nursing, social work, occupational therapy) to stimulate basic skills in holistic medicine

3. Access to Behavioral Health Providers

- Access available resources in all areas of the state (regional, rural, urban)
- Resources: telemedicine equipment funding, identification of partners/ collaborations,
- MH Provider/ Time Co-Located
- Create/allocate new "care manager" role

4. Medical Records/ Confidentiality/ Data Management

- Confidentiality issues between primary care and behavioral health
- Access to medical records
- Single medical record
- Clarify HIPAA to reduce/eliminate communication barriers
- Need to stress importance of consent forms for release of info
- Coordination of care or exchange of information between PCPs and mental health providers. Key info to exchange: diagnosis, meds
- Data about what is happening with screening, intervention, other than QI studies
- Standardization of depression outcomes - patient-level
- *System-wide implementation of electronic medical records*

5. Buy-In From Key Stakeholders:

- Educate state legislators and administrators about rationale for integrated care
- Buy in by the PCP's-- specific changes that would need to happen (not as bad as they think); Openness to new models of care, address threats
- Employers and insurance COS/MCO/Public agencies
- Educate at all levels about the efficiency and cost effectiveness of MH/SA vs. other medical care
- Get WI payers together to agree on common depression guidelines and outcomes
- Change employer goals in terms of health for their employees
- Bring together stakeholders (MDs, health plans, employers, patients, M.H. professionals) to educate need for integration to establish "buy in"/ build relationships

6. Attitude Changes that need to be addressed

- Patient is approached as a partner in care "compliance to alliance"
- Holistic approach to care, mind & body, quality of life vs. quantity of life
- Integration is positive for patient. Bottom line.
- Interest and ability to cross over expertise in profession
- Attitude shift from M.D.'s and Administration
- Willingness of behavioral health to give up its independent identity

7. Identify and Support Champions

- Identify and facilitate support for innovators in integrated care who have the motivation and stamina to overcome systemic change
- *Create a mini-model pilot to prove success/ sustainability*

8. Promote Networking

- Promote networking through regular and semi-annual meetings on integrated care