Center for Health Care Strategies: Coordination with Primary Care

Katherine E. Grimes, MD, MPH
Associate Professor, Dept. of Psychiatry
Harvard Medical School

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Brief History

- 1982, child welfare, Jane Knitzer, Unclaimed Children ("fragmented care")
- 1986, Stroul and Friedman published "CASSP Principles"; least restrictive setting, over-use of (FFS) hospitals a lever to pull
- 1992, federal funds for "systems of care"; large multi-year grants with state match requirements; flexible funds for wraparound; no financial outcome reporting
- Physical health not included; mental health treatment and $ (docs/meds/hosp) paid for outside the "system of care"

“For Results to be Different, Something has to Change”

- In SOC’s, “clinical” became negative term, outcome evaluations consistently showed lack of clinical improvement; Bickman (1996): “More is not always better”
- RWJF sought to add strengths of managed care to CASSP principles
- 1997, RWJF/WBGH,“MHSPY-Replication” one year planning grants to 12 states (including Massachusetts)

Shared Risks, Goals and Outcomes

- 1998, MA MHSPY unique in country: *global cap*; All physical health, mental health, meds, hospital, wrap dollars; $ accountability to five state agencies
- Everybody gave up a little control, gained flexibility for *individualized service plan*
- Comprehensive identification of *needs* and *strengths* includes physical health
- Successful *coordination with primary care* required for improved outcomes under cap

"Does Integrated Care Matter?"

- Mental health and substance abuse needs may go unrecognized in primary care
- Serious medical conditions, such as asthma or diabetes, may require community-based monitoring
- Delayed PH or BH treatment leads to greater *morbidity*
- Interactive impact of physical and psychiatric diagnoses, treatments and meds on *clinical* and *financial outcomes*

Culture Change

- All providers are part of child and family team
- Team creates single plan of care with treatment goals and measurement points
- Intervention pathways on behalf of specified goals should include health care provider input and role
- Overall health status and service use (and expense) monitored along with other indicators

How Does Integration Work?

- Primary care is hurting; grateful for help
- Engage system leadership to sponsor introductory activities (and lunch!) between Care Management Entity and Primary Care
- Follow-up 1:1 brief face-to-face introductory meetings to explain goals, leave contact info
- Clarify roles (i.e. med management or communication with school nurse)
- Pay for time; if provider can attend a child and family team meeting or phone call; share information/notes in real time

Vignettes

- 10 year old boy, some learning disabilities, more irritable than 12 year old brother; sometimes “loses it” in physical fights and won’t stop
- 8 year old girl with terminal lung disease; parents divorcing; having trouble in school, few friends, cries, doesn’t pay attention
- 14 year old boy, court involved, refuses to attend school, runs away

Barriers

- Differences in training mean communication requires more effort
- Lack of time within primary care to drive to community-based meetings or spend 1-2 hrs. with one family
- No insurance reimbursement for time spent on phone or in travel; can't have two services same day (i.e. peds and psychiatry)
- Most records are not integrated, so mental health notes not accessible to primary care
- Confusion re: HIPAA; "business partner", "need to know" and "QI" all relevant for integrated care processes

Opportunities

- EPSDT: Not only screening, but better access to *diagnosis* and *treatment* for vulnerable populations when care is coordinated
- Enhanced recognition and treatment, in both physical health and psychiatric areas, results in use of *fewer medications*, and/or *reduced hospitalization* and *ER expense*
- *Overflow relationship building* creates processes for greater communication around routine care; also guards against confusion re: *follow-up steps* (labs, med change, etc.)

Questions?/Comments?

DISCUSSION

Contact Information

Katherine E. Grimes, MD, MPH

katherine_grimes@hms.harvard.edu

Children's Health Initiative
Cambridge Health Alliance
120 Beacon St., 4th fl.
Somerville, MA 02143

Ph: 617-503-8454