

# Integrated Healthcare System for Persons with Serious Mental Illnesses

## Summary of Input from Providers

### **Background Information**

In December 2011, the Arizona Health Care Cost Containment System (AHCCCS) and the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) solicited input from service providers that serve persons with Serious Mental Illness (SMI) in the public behavioral health and acute care systems, regarding the integration of physical healthcare and behavioral healthcare services (see <http://www.azdhs.gov/diro/integrated/index.htm> for more details and the latest information about this planned effort). St. Luke's Health Initiatives (SLHI) facilitated the input process. *Note: throughout this report, the term (health plan) "member" is used to refer to the person with a Serious Mental Illness and the term "provider" is used to refer to those who deliver healthcare services to the member.*

ADHS and AHCCCS engaged in a variety of outreach efforts to encourage providers to attend focus groups. In addition to posting information on the ADHS/DBHS website, a number of organizations were contacted including the Arizona Council of Human Service Providers, the Arizona Medical Association (ArMA), the Arizona Osteopathic Medical Association (AOMA), the Arizona Academy of Family Physicians (AAFP), and AHCCCS health plans. All providers who serve persons Serious Mental Illness under a contract with Magellan Health Services of Arizona were invited as well.

All focus groups were held at SLHI in Central Phoenix. For those who were unable to attend in person, SLHI offered the option for participation via teleconference or phone interview. Three focus groups for behavioral health providers were conducted on 12/9/11 and one on 12/14/11. An additional focus group with acute care providers was held on 12/12/11.

### **Participants**

Approximately 50 providers participated in the focus groups. Participants in the first four focus groups included members of the Council of Human Service Providers and other provider agencies including some that currently contract with Magellan Health Services of Arizona. Participants in the fifth focus group included primary care providers, specialists (including psychiatrists), and an emergency room physician.

Additional input was obtained via phone from a physician who was unable to attend a focus group and opportunities to be interviewed were extended to two others who have not responded to-date. An interview was conducted with a behavioral health provider who has knowledge of issues related to transition age young adults (18-21 years of age).

### **Executive Summary**

- Providers uniformly support better coordination among behavioral health and other healthcare providers in a person-centered and integrated healthcare system that promotes better health outcomes for persons with Serious Mental Illnesses.
- In developing an integrated healthcare system, the overarching principle should be the needs and preferences of the member. These, rather than rules, should drive system design.
- Providers see the value of co-location of acute care and behavioral health care but have differences of opinion on where and how this might be achieved. Concerns include impact on member choice and recruitment/retention of primary care physicians to work in the behavioral health setting.
- Providers see the value of an expanded healthcare team which includes the member, the primary care physician, and behavioral health providers, plus specialists as needed. All members should have access to a peer support specialist, a care coordinator/navigator, a wellness coach, and others, as needed and preferred. There is a need for a team leader to coordinate the work of the team. All roles should be defined functionally, rather than simply having a list of titles required for each team. There should be sufficient flexibility to allow for changes in team composition as the member's needs and preferences change over time. The team should be responsible for continuity of healthcare over time, even when there is turnover in team members.
- Communication among the team and the member would be greatly facilitated by having an electronic medical/health record that is timely, accurate, comprehensive, easily accessed, understandable, and

appropriately protected. Other forms of communication should include some face-to-face, augmented by various forms of electronic communication.

- All members and providers should receive training on integrated healthcare and related topics, so that they can participate fully and attain the greatest benefits. Ideally, information on integrated healthcare would be embedded in professional education and reinforced through ongoing training. Concerns were raised about the amount and type of training required. An alternative approach was to require certain competencies of those working in the integrated healthcare system, rather than prescribing training and education requirements.
- Establish outcomes that address improvement in both physical and behavioral health and that focus on benefits to the member. Outcomes (and payment rates) should not create disincentives to serving those with the greatest need nor to those seeking services that are truly needed. Incentives rather than penalties should be explored, but performance should be considered when making contracting decisions.
- Electronic medical and health records are essential to the success of an integrated healthcare system. Concerns focus on development of system specifications, implementation of the specifications, changes to specifications once implementation has begun, and costs.
- Payment should reflect all the requirements and be sufficient to cover the costs of planning, training, communication, coordination, implementation, evaluation, and other functions required to provide integrated and effective healthcare to adults with Serious Mental Illnesses.
- All systems that impact service delivery need to be in alignment with an integrated health care model. These include contracting, licensing, training, leadership, auditing, contract monitoring, payment, incentives, evaluation, recordkeeping, etc.

#### **Concerns (Behavioral Health Provider Focus Groups)**

Some of the major concerns expressed (when specifically asked this final question) were:

- Loss of choice for service users, impact on members
- Potential for loss of peer support
- Minimizing attention to behavioral health in an integrated healthcare system
- Losing the good things that have been built or not building on lessons learned from the carve-out model
- Integration of two disparate cultures
- Ensuring there is a focus on wellness and recovery
- Ensuring that providers are engaged in building the system
- Concern that the RFP will be too specific and not allow for the flexibility needed to develop and improve a newly integrated system; too much dictated by rules, requirements, and processes
- Need to remove silos (including funding, licensing, leadership, etc.) in order to create a truly integrated system
- Need education for all involved
- Costs and availability of adequate funding, potential for increased administrative costs and loss of service dollars
- Need for final licensing rules prior to implementation and clarity about how integrated healthcare will be licensed
- The transition process
- Resorting to brief solution-focused treatment, when more extensive or specialized treatment is indicated

#### **Concerns (Acute Care Provider Focus Group)**

Some of the major concerns expressed (when specifically asked this final question) were:

- How we will know if the pilot is working and producing the desired results
- Developing a workable model
- Concern that there are not enough acute care providers
- Ensuring that members are seen where they are, not only in the office
- Piloting the concept in Maricopa County may be too much
- Cuts in services
- Navigating the system
- Sub-specialty populations, e.g., adults with developmental disabilities

## Detailed Findings and Observations

Questions asked in the focus groups and interviews are listed in Attachment 1. Responses from behavioral health provider focus groups/interview and the acute care provider focus group/interview are reported separately below. Please note that statements in this document reflect the opinion of participants and are not the author's words.

### ***Co-location of Services***

#### Behavioral Health Provider Focus Groups:

Most participants favored bringing primary care providers into the behavioral health setting. Co-location may facilitate improved communication, coordination, and collaboration, but it is not sufficient to produce these desired benefits. It might be better to talk about *integrated services* rather than *co-located services*, as the latter still conveys a separation. Even if services are co-located, there would still be need for care coordination and system navigation assistance for the member. In order to truly integrate health care and hopefully improve health outcomes for persons with Serious Mental Illness, well functioning teams will be needed as well as shared records and competent providers.

Benefits of co-location include:

- greater and more timely access to primary care and specialty services;
- increased likelihood of getting and accepting primary care services;
- increased referral for a range of needed healthcare services;
- more timely attention to emergent health problems;
- better attendance (fewer no-shows for primary care services);
- better compliance with healthcare recommendations;
- increased efficiency benefitting both the member and the healthcare provider;
- reduced need for access to transportation;
- improved cross-consultation to address an evolving medical/psychiatric problem;
- improved provider communication, better care coordination, improved collaboration to foster wellness and address health issues (“integrated thinking”).

Concerns about co-location include:

- Reduced member choice in selecting a primary care provider or keeping a valued primary care provider;
- the philosophy that promotes active member involvement in his/her own healthcare might be diminished;
- the model of co-located services might not be feasible in rural areas.

Participants also asked if members would be able to opt-out of co-located services and which services would be made requirements for co-location.

#### Acute Care Provider Focus Group:

Some acute care providers commented, as did behavioral health providers, that co-location is likely to increase utilization of needed healthcare services and that this would benefit the member. However, regardless of whether services are co-located or not, there is a need for a shared record, better communication among providers, and continuity of care, leading hopefully to better health outcomes.

While some liked the idea of locating primary care doctors in behavioral health settings, there were concerns about recruiting and turnover of physicians. Some felt that locating behavioral health providers in a primary care setting might be a better option, but there were concerns about space, as many primary care doctors have small practices. Large medical practices are already including or considering offering behavioral health services in their practice. Another option mentioned was to regionalize so there are integrated teams but team members are not necessarily located in the same building. However, the full range of specialists needed realistically could not be co-located with either the primary care doctor or the behavioral health specialists.

Telemedicine was mentioned as an alternative or adjunct to co-location. One provider in the group (a psychiatrist) reported that she was already using this option satisfactorily and that most payors accept this model. Others disagreed that this was a good option for persons with Serious Mental Illnesses or other chronic problems.

Some commented that co-location, or others models of integration, will not address the issue of persons with Serious Mental Illnesses dying at an earlier age than the general population if there are insufficient resources for needed services. As was the case in the focus groups for behavioral health providers, having access to and using common information and functioning as a team were seen as keys to successful integration and improved healthcare for persons with Serious Mental Illnesses.

### ***Member Involvement***

#### **Behavioral Health Provider Focus Groups:**

There was strong support for member involvement in the development, implementation, and evaluation of the individual's healthcare plan. (The term "healthcare plan" is used here because focus group participants often commented on the importance of the plan addressing wellness and prevention, not only treatment of healthcare issues.) Members might need support from a trusted person of their choosing in this process and that unrealistic expectations should not be placed on the member. Members should have choice in all aspects of the healthcare plan and should receive complete and understandable information on the options available to them. Benefits of member involvement include increased buy-in and compliance with the plan.

#### **Acute Care Provider Focus Group:**

Participants in the acute care provider focus group also commented that the member should be involved in the development of the healthcare plan, but some noted that the involvement would depend on the member's preferences and competency at the time and that this might change over time. One participant commented that compliance with a healthcare plan is proportional to the member's involvement.

### ***The Team—Composition and Functioning***

#### **Behavioral Health Provider Focus Groups:**

When designing the integrated care system, the function of the team needs to be clearly defined. With respect to the composition of the team, there was agreement that those who are currently on the team should continue to serve on an integrated healthcare team. There was general agreement that a peer support specialist should be offered for each team, but some noted that the peer should be someone who is a peer in a larger sense, if possible (e.g., a person with a Serious Mental Illness and diabetes). Several participants thought that having a Pharm. D. on the team would be a major asset. Several also mentioned the inclusion of a health/wellness coach. Others mentioned inclusion of a nutritionist and employment coach, as needed. There should be consideration of natural supports when identifying critical team members, e.g., friends and family. Specialists and their role within the team need further consideration, but there should be provision for their inclusion when needed.

There were cautions about defining team composition too precisely, as each member is different and his or her situation changes over time. Composition of the team should take into account the needs and preferences of the member and some existing models, e.g., CODAC's program, could be considered.

There was general agreement that there is a need for a single point of contact for the team (a "go-to person"). The team leader would be responsible for convening the team and facilitating meetings. When specifically asked who should function as team leader, participants offered several options, including the care coordinator, the case manager, the member, the person with fiduciary responsibility, a peer support specialist (with back-up), a nurse (e.g., psychiatric LPN), a physician, or a social worker. Few felt that the position should be defined by the type of degree held. Some felt that the member should choose the team leader. Key qualifications for someone functioning as the team leader would include general knowledge of the full range of the healthcare system (behavioral health and acute care) and ability to facilitate communication among team members. It was noted that no one person can be an expert in all aspects of

integrated healthcare, but that there should be specialized training for a person filling this role so they are prepared to carry out the functions assigned and know how to obtain additional information when it is needed. One participant noted that who employs the team leader could make a difference and, therefore, this needs further consideration.

Every member should have access to a care coordinator/navigator. It was not clear if this should be the case manager or someone else, but several expressed concern that case managers not be overloaded (as they are now). Some important roles to be considered are: assisting with eligibility, ensuring appointments are made and kept, coordinating the array of services provided, following up on services and team commitments, making sure supports are in place, advocating for the member, and generally keeping everything on track. Another important function is supporting the engagement of the member and making sure the member is informed. The qualifications of the person(s) who carry out these functions will depend on the specific functions assigned to team members.

It was noted that payment must be available to support the functions of the team and all members of the team, including the team leader, care coordinator, peer support specialist, etc.

#### Acute Care Provider Focus Group:

Acute care providers also mentioned that the team composition would depend on the needs of the member. They noted the importance of having a social worker and/or case manager on the team. Specialists also need to be on the team, but they may not always be “at the table.” It was felt that having a Pharm. D. would be a major asset to the team, given concern for appropriate medication management. Care coordinators and/or system navigators were also recommended.

The team would follow the member throughout time and be familiar with the member’s longitudinal history (e.g., who saw the member for what, when, and what the results were). It was noted that the team needs to follow the person wherever they are, even if the person is living on the street. Medication monitoring was seen as a critical function, which could be aided by an electronic healthcare record.

There is a need for a team leader and the person performing this function could change over time. Sometimes it could be someone in behavioral health and at other times, an acute care provider depending on the issues at any point in time. The team leader needs to be accountable. The team leader could be a physician, a medical case manager, or someone else in a coordinating role, not the leader in a clinical sense. The team leader would need good facilitation skills and should know how to function in a team environment. One participant indicated a strong preference for this to be the primary care physician. As was the case in the focus groups for behavioral health providers, the importance of sufficient payment for this function was noted.

It was recommended that care coordination be available to each member. If the function were primarily coordinating services, it could be carried out by an experienced social worker or nurse case manager. A physician would not need to serve in this capacity.

### ***Peer Support Specialist***

#### Behavioral Health Provider Focus Groups:

Most thought that a peer support specialist should be offered to all members to perform a variety of different tasks for which he/she is qualified. In an integrated healthcare system, it would be desirable to think about peer support in a broader context, e.g., to have a peer support specialist who has personal experience both with Serious Mental Illness and the same chronic condition as the member, e.g., diabetes, cardiovascular disease.

In order to expand the role of the peer support specialist beyond the behavioral health system to the integrated healthcare system, it will be necessary to clearly define functions and communicate them to the peer support specialist, healthcare providers and members. Member choice should be paramount in determining the functions of the peer support specialist.

It would be desirable for the peer support specialist to be a neutral party, ideally a contractor rather than an employee of the agency/clinic where the member is receiving services.

Acute Care Provider Focus Group:

Some participants were not familiar with the concept and function of a peer support specialist. It was noted that there are a variety of successful models for providing peer support. There was general support for teams including a peer support specialist if the member chooses to have one. It was noted that having a peer support specialist as an “opt out” would result in higher utilization than having this as an “opt in.”

***Team Communication***

Behavioral Health Provider Focus Groups:

Communication would likely be enhanced by co-location, but there is no guarantee. Access to electronic medical/health records would contribute significantly to timely and regular communication. Remote access to the record would be essential, as would having a single repository for information. *See comments below under the heading Electronic Records for additional information.* Other forms of communication include phone, fax, email, text, teleconferences, videoconferences, etc. Some were supportive of the use of telemedicine. It was noted in all the focus groups that face-to-face communication would also be needed, although some commented that everyone who needs to be involved may not be able to be seated around the same table at the same time and that communication could take place virtually. Key team members would need to meet on a regular basis and the member should be part of the team meeting. Provision needs to be made for regular communication with specialists, too. At a minimum, the member should see at least one team member at each visit.

There is a need for improved communication among persons in the behavioral health system, in the acute care system, and between the two systems. To achieve effective communication, a common language will be needed, as will a better understanding of the disparate cultures that exist in various aspects of each system. There was a caution about stereotyping—those in the behavioral health system stereotyping the acute care system and vice versa. Cross-training would be needed, as noted below under the heading Training and Education, as would joint staffings. Communication would be aided by having clear, shared outcomes. Also, not all those involved with the member will have access to all the available information regarding the member. There needs to be clear guidelines and authorizations in place to govern this process.

The benefits of timely and regular communication include continuity of care, especially when there is turnover in team members; better treatment; and ultimately better outcomes.

The adult system needs to be developed to reflect that members are adults and have a significant role in their own healthcare.

With respect to using technology to communicate, the member might need training and/or support from a peer to utilize and feel comfortable with using technology.

The payment rate should be established to support required communication among team members. There are very different expectations in the behavioral health system and the acute care system related to number of visits per hour/day and there are very different requirements related to what needs to be done.

Acute Care Provider Focus Group:

As in the behavioral health provider focus groups, participants spoke about the critical role of the electronic record and the importance of having access to a health information exchange. They suggested that quick access to complete and timely information was critically important. They also indicated that various forms of communication would be needed, particularly through electronic means. The importance of personal communication and core team meetings was noted, although this might be aided by video chat technology, as it is not always realistic to have everyone in the same place. If teams were regionalized, it might be more feasible to have face-to-face team meetings.

Communication can be further facilitated by the use of technology, e.g., automatically turning acronyms into language all users understand, flagging critical information such as drug interactions. A major concern is medication management and technology can help with this.

Members need to be included in team communications. One participant recommended that members carry with them some form of identification that includes the name of someone on their team so that the team can be alerted in an emergency situation.

Those in the focus group for acute care providers spoke at some length about the need for better communication between providers delivering outpatient services to a member with providers delivering inpatient services. Better communication would solve problems such as a primary care physician not knowing that a member has been admitted to a hospital. Furthermore, medications may be changed while the member is hospitalized and, upon discharge, the member may not know which medication regime to follow, may not have an adequate supply to cover the time until he/she can see the primary care doctor (or specialist), or may not be able to afford the prescribed medications due to the formulary in use. Inpatient providers need to be involved with the team during the period of hospitalization.

### ***Training and Education***

#### **Behavioral Health Provider Focus Groups:**

The importance of persons within the acute care and behavioral health systems understanding each other was noted in every focus group. Some felt that there is a need for a major shift in thinking toward an integrated healthcare system—not simply two systems understanding each other. Ideally, training and education would take place with a range of provider types coming together. Some training and education would need to be made available electronically and would need to be accessible at times convenient for the providers.

Ideally, training and education should start in school, e.g., medical school, nursing school, and be carried into residencies and subsequent education and supervision for healthcare professionals. In the short term, there should be modules on key topics developed and presented to all those who will be involved in the integrated healthcare system. Messages delivered through training and education activities should be consistent. The training and education should address philosophy, culture, language, format for staffing, expectations, requirements, etc. Training and education should highlight the role of the member in his/her own healthcare. Some noted that persons in the acute care system need considerable training and education to treat persons with Serious Mental Illness and both need cross-training. Management staff in an integrated healthcare system should also be provided with proper training and education. Training should be provided by experts, e.g., certified health education specialists, primary care physicians, mental health clinicians. Shadowing might be a good approach to help facilitate understanding.

There were cautions about loading additional requirements on top of current requirements (CMEs, CEUs). Time required for participation in training and education should not be prohibitive. New requirements should not be layered on to existing requirements, but rather all requirements should be revisited in light of the integrated system. Persons in different roles may need different training and education. The payment rate should support participation in required training and education.

There were questions about licensing requirements and how these might need to change to facilitate the implementation of an integrated healthcare system in all respects, not only training and education. An alternative view was to require certain competencies, rather than specific training, and demonstrate that competencies are met.

Participants talked about the importance of providing training and education for members, too, so that they understand the integrated healthcare system. In addition, members could benefit from health education, particularly related to any chronic health conditions they might have. Members could also benefit from training on resources and how to access them, ranging from health to employment.

#### Acute Care Provider Focus Group:

The need for training and education related to integrated healthcare in medical school and residency was voiced by participants. It was noted that there is competition for students' time and space in the curriculum, but there have been some efforts to integrate training and facilitate cross-discipline interactions among those in healthcare training programs (including physicians, nurses, social workers, pharmacists, and nutritionists).

In the short term, there will be a need for a required module on integrated healthcare. This could be made available on-line with a post-test. Training and education should accommodate a variety of learning styles. The training should be provided not only to primary care and behavioral health providers but also to emergency room physicians, specialists, and hospitalists.

Training is needed on electronic medical/health records as well as the concept of integrated health care, the health home, etc. Providers need to get comfortable with using technology, and some still are not.

As in the other focus groups, there was concern that required training and education not be an add-on to other requirements, but rather that all requirements be revisited. Training and education requirements should not create a disincentive to participation in the integrated healthcare system. The payment rate should support participation in required training and education.

Some thought that there would be a need for a face-to-face, retreat-type meeting of providers within both systems to define expectations and begin the process of creating a common culture. Web-based training could be an adjunct but would not take the place of this type of team-building experience. It was noted that this would be a good investment and help to create a more functional team.

### ***Outcomes—Defining, Data, and Incentives***

#### Behavioral Health Provider Focus Groups:

Participants discussed the appropriateness of the outcomes listed in the question (i.e., reducing hospital admissions, reducing emergency room use, reducing care costs, improving the care experience, improving health outcomes). Some felt that it would be important to look at the reasons for hospitalizations, emergency room use, and high costs, so that the measures do not create a disincentive to appropriate use of services. Some did not think these were the right measures, other than health outcomes.

Many commented on the need for additional measures, particularly measures to address the effectiveness of behavioral health services and wellness/reduction of risk for medical conditions. Examples mentioned included: improved quality of life; decreased use of emergency shelters; increased ability to engage in self-advocacy; increased ability to live independently; stable housing; better relationships; greater civic engagement; employment/education; goal attainment; decreased incarcerations due to symptomatic behavior; fewer pre-petition court screenings; acuity of symptoms; ambulance use; reduced duration of hospitalization; integrating pharmacy formularies for greater cost containment and documentation of medications prescribed; and improved health indicators such as weight, blood pressure, and blood sugar. It was noted that the outcomes should focus on the entire healthcare system, including hospitals. Measures selected and targets established should be appropriate for the population of adults with Serious Mental Illness. One participant recommended adopting SAMHSA's national outcome measures.

There was some discussion about additional data that should be considered when evaluating the overall performance of the integrated healthcare system (i.e. persons going outside the health home for services).

There was a question about whether the data would be population based or member specific. If it is the latter, baseline data would be needed for each member.

Outcome data should be generated via an automated system, wherever possible. Some thought AHCCCS should be able to produce much of the outcome data. There were concerns about the burdens of data collection, analysis, and reporting. The costs of providing outcome data should be reflected in the payment rate.

In analyzing the data and drawing conclusions, it would be important to consider external factors that might affect the results obtained, e.g., policy, statutes, resource limitations, length of time to be seen in a non-emergency setting as it relates to increased emergency room use.

There was more support for incentives than for penalties. Some commented that poor performance should be addressed via the contracting process—don't contract with entities that are not performing. It was noted that attention is needed to the rate paid. The rate itself may provide an incentive to produce good outcomes. Caution should be exercised in establishing incentives for reducing care when the care is needed to produce longer term positive outcomes. Furthermore, the system should not create disincentives to serving those with the greatest need, offering choices, or holistic healthcare. There may need to be some form of risk adjustment to address acuity.

One participant suggested providing incentives for offering integrated healthcare and team work. It was noted that there may need to be some form of start-up funding at the RBHA level. Community providers cannot afford to create the new infrastructure and would need assistance.

It was suggested that members be provided with "report cards" on the providers to inform decision making.

Billing codes should also be examined. Some that are defined as administrative are essential to delivery of integrated healthcare services.

An evolutionary approach was recommended, recognizing that the integrated healthcare system will take time to develop and may not initially produce maximum benefits.

#### Acute Care Provider Focus Group:

All five measures listed in the question are important. Member and family satisfaction/perception of improved well-being should be added as a measure and there should be some health risk reduction measures, e.g., smoking cessation. Other suggestions included wait time for care, how quickly prescriptions are being filled, and measures related to poly-pharmacy. In the longer term, there should be a focus on increasing the lifespan in this population. Agreement on the outcome measures and their definitions would be needed up-front. Improving the care experience and improving health outcomes particularly need better definition. A comment was made that "simpler is better" and that the teams should have a role in deciding how to measure the outcomes.

An objective third party would be needed to collect, analyze, and report the data. Data should be shared widely. As with the provider focus group, the issue of member specific or population based data was discussed. An electronic data collection system will be essential for collecting and analyzing data.

With respect to incentives and/or penalties related to achievement of outcomes, participants preferred incentives to penalties. Some felt that incentives were more effective in changing behavior than were penalties. It would be important for the system to incentivize real desired results. One participant commented that an option would be to determine the baseline cost and then share savings resulting from integrated healthcare, taking future costs into consideration. Concern was expressed that providers do not have control over some of the proposed outcome measures.

### ***Electronic Records***

#### Behavioral Health Provider Focus Groups:

Electronic medical/health records (EMR/EHR) are seen as a major facilitator of improved communication and coordinated treatment (especially medication management), leading to better health outcomes. A certified EMR should

be required; however, the health home record is only one part, albeit an important part, of the member's overall health record.

Information needs to be up-to-date, easily retrievable, understandable (not too little and not too much), and written in respectful language. The system should be able to produce data quickly. It should facilitate recordkeeping, communication among providers, practice management, and good clinical care. It needs to work for all involved—members, funders, the health plan, and providers. It would be best if data could be entered and accessed from remote locations.

Members should have access to their record and be able to write to it, particularly to enter disputes and correct errors. There should be a consumer portal and training for them on how to use their record.

Access to an electronic Health Information Exchange (HIE) is also essential, so that there is a central repository for information from all involved providers.

Cautions were raised about requiring a particular format for EMRs given the diversity of providers who would need to be part of the integrated health plan. They should all be able and required to contribute information to the EHR. Concerns were raised about system costs and delays in implementation. There were also concerns about State-level or RBHA-level system requirements that come out after a system is in place. Modifications after implementation can be costly. Deadlines are a problem, as providers are often at the mercy of the developers. Attention is needed to the issues of EMR/EHR requirements, costs, deadlines, etc. Both AHCCCS and ADHS/DBHS need to be involved. It was noted that there would need to be dedicated funding for development of an electronic record system, as payments for service are inadequate to cover development costs. There were suggestions about who should pay for which aspects of the system; some noted that the funder should pay for the EHR and HIE, while the RBHA should pay for the EMR, especially if they mandate it. Federal incentives should be explored. There were questions about requirements for and the cost of upgrades and modifications.

Questions that would need to be resolved include data ownership and access. Some may have concerns about what they are entering, so authorizations for use need to be clearly specified. All users should have access to emergency plans, medications, the insurance plans, and demographics.

Providers would be incentivized to keep electronic information up-to-date by simply having a system that works for them and that allows for better coordination of care. It would be even more of an incentive if the system were able to produce outcome data and if the system replaced paperwork rather than duplicating it, e.g., acceptance of electronic signatures, expedited submission of prescriptions to pharmacies. There could be a contract requirement to have an EMR. Requirements for data timeliness and accuracy could be a part of contract compliance. Auditing and other reviews could be tied to the EMR. There could be a financial incentive for use of EMRs. There was a caution not to penalize small organizations and to implement requirements in a stepwise fashion.

#### Acute Care Provider Focus Group:

Some providers might not be willing or able to comply with a requirement for an EMR, at least in the short term. However, electronic records are essential for coordinated care and data sharing. Several benefits of having an EMR were mentioned, e.g., better access to useful reports, improved care and medication management, and ultimately decreased mortality.

Information in the electronic record should be relevant, coherent, sufficiently detailed to provide a complete and accurate picture of the situation, and not too stereotyped (e.g., not simply a series of check boxes). It should provide a picture of the member's history and current condition. With respect to use of flags for critical events, the standards should not be set so high as to result in providers ignoring the flags. Keeping the record simple is desirable. It should allow a provider to see quickly the medications the member has been prescribed, the other providers who are seeing them, and the hospitalizations they have had. The data needs to be "real time," comprehensive, user-friendly, and

supportive of effective care. To meet the requirement of a comprehensive record, an HIE will be needed and all providers would need to contribute data. This has already been done for some other AHCCCS populations.

The member should be able to contribute to the electronic record (e.g., in the “my chart” section).

Choosing the right system will be critical, as this is a huge expense. Flexibility will be needed in the development phase, as it will be difficult to anticipate all the issues in advance. Security issues will need attention and a balance between security and ease of use will be needed. One participant noted that it is difficult to redact an electronic record. It was noted that the perfect system is “not out there” and cost is a major concern. Maintaining the EMR could be a condition of contracting or employment.

### ***Implications for Transition Age Young Adults***

Young adults with Serious Mental Illnesses face some distinctive challenges. Those noted included the following: being placed in a setting with older adults, some of whom may have more serious and longstanding conditions; receiving SSI benefits on their own for the first time and having few skills to handle their own finances; lack of incentive to work and/or inability to find appropriate work; lack of age-appropriate social interactions, and boredom. A participant expressed that healthcare integration could have a positive impact on this age group (although this is not the answer to all the problems noted), if primary care and behavioral health providers would get to know each other and function as a true team. It was noted that it would be critical for young adults to be active participants in their own teams. They need to have teams who believe in them, focus on what is right with them, and embrace the recovery model.

As with other age groups, it was recommended that the team include not only physicians, but also the case manager, counselor, dental providers, eye care providers, prevention specialists, and others who have a role in the young adult’s recovery and wellness. It was noted that a peer support specialist should be included, as recovery is rooted in prior strengths and alliances. The peer support specialist could be an age peer or a mentor who understands and will stick with the young adult. There should be a team leader who makes sure everyone has the needed information to support the young adult. If this is the case manager, they need to have a reasonable size caseload (no more than 30). The team leader could also function as the care coordinator, if caseload sizes were reasonable. The young adult should be empowered to take charge of his/her own treatment, in order to promote adherence to the healthcare plan and reduce the probability of “learned helplessness.”

Cross training of providers serving young adults will be needed and they should be familiar with the distinctive needs and preferences of this population. Respect among the disciplines will be critical. Electronic records and joint case staffings would help promote shared understanding of the young adult and of the role of each provider in supporting the member’s recovery and wellness. All providers will need training in use of electronic records.

With respect to outcome measures and measuring systems, it was recommended that a simple participant assessment system be used, wherein young adults would rate themselves and their interactions with providers. The Client-Directed Outcome-Informed Therapy system was mentioned as an example. There should be incentives to providers for good performance and penalties for underperforming.

As noted above, an electronic record is needed for all ages, but could be particularly useful for young adults who are more accustomed to and comfortable with technology. The challenges of implementation noted were the same as in the focus groups. Data from electronic record systems could be used to track and improve performance at the individual and organizational level. It was noted that “every clinic needs a way to hold people accountable.”

## Attachment 1 Focus Group Questions

AHCCCS and the Division of Behavioral Health Services (DBHS) are seeking your input on the planned integration of behavioral health and physical health services in one health plan for Medicaid eligible persons with Serious Mental Illnesses. This would begin in October 2013 and would only be in Maricopa County initially. The input from today's focus group will be used along with that obtained from peer and family interviews and other focus groups that we have been conducting to determine what the issues are and how to best move toward integration of healthcare services and the implementation of "health home services."

Q1: Should primary care services be provided in the same physical location as behavioral health services? (For example, that might mean that a person would see their family physician at the same place that they see their psychiatrist.) Why or why not?

Q2: In an integrated healthcare system, the team would include, at a minimum, the SMI member, behavioral health and physical health professionals. Who else should be on the person's health home team? Should a peer support specialist or similar paraprofessional be offered to the member as an option on every team?

Q3: Describe how a health home team should function. Should there be a designated team leader? Who should that be? How should services or team functions be coordinated?

Q4: How much input or involvement should the member have in developing his or her treatment plan?

Q5: Should a single person be designated to coordinate services? Who should that person be?

Q6: What would help to promote timely and effective communication among team members? What would effective communication among team members look like?

Q7: Describe the training or education that is necessary for providers to effectively deliver integrated health care services. Who should provide the training?

Q8: The success of integrated health care services depends on collecting and reporting outcome data in a number of areas. What is the most efficient way to collect data and report progress in:

- Reducing hospital admissions?
- Reducing emergency room use?
- Reducing care costs?
- Improving the care experience?
- Improving health outcomes?

Are there other outcomes that should be measured and reported? What are they?

Q9: How should financial incentives and/or penalties be used to motivate providers to achieve all of the outcomes just described in Q11? How should the incentives be structured?

Q10: What do you see as the pros and cons of an Electronic Medical Record (EMR)? What potential challenges do you anticipate?

Q11: What would motivate you to consistently use an electronic medical record so it is always current and complete?

Q12: From your perspective as a provider of health care services, what is the one thing you are most concerned about with implementing an integrated health care service delivery model?