MANAGING THE ABYSS: FACILITATING INFORMATION FLOW WITHIN AN INTEGRATED HEALTHCARE SYSTEM

The Abyss

The abyss is real, deep, and dangerous. The best of intentions can slip and fall off the precipice to an untimely end. The language, style and format of a medical record would lead one to believe that the primary care practitioner and the behavioral health practitioner have little in common but the name, address, DOB, and phone number of the patient. This is due in part to the different styles of operation, different purposes, and certainly different languages. Without bridging this abyss the chance of successfully integrating care is somewhere between slim and none. The bridges vary in style and structure depending on the level of integration.

Four Lane Suspension Bridge

When there is intent and structure to have a fully integrated system of care, the bridge needs to modern, useable, free of congestion, and well maintained. Full integration means that every step of the care process from health screening, to information sharing, to health services, to outcomes are in a single medical record. The ideal is an electronic health record that meets the needs of the patient and the integrated system. The reality is that it will look a lot more like a record you find in primary care than behavioral care. Gone will be the attention to the process requirements of a traditional behavioral health record. Present will be notes of diagnosis, plans of action, and sufficient information to communicate to the team providing care. Clinician's notes will need to communicate to others and be more than abbreviated reminder notes for the individual clinician. In addition the structure of the record will need to satisfy billing requirements. While the record can be pen and paper medical record, the only reason to do so would be to see if you have a system and work flow thought out so it can be computerized. Essential to building such a bridge over the abyss is an organizational structure that has mutual goals, commitment, and vision. Organizational and leadership support is a requirement so that the building and maintenance of the bridge is insured.

Two Lane Beam Bridge

Co-located primary care and behavioral health services signal intent to integrate and collaborate. They are sometimes each a part of separate organizations and sometimes a single organizations attempt to move in the direction of integration. The bridge analogy is apt because the greater the length of bridge required the greater the stress placed on the beam spanning the abyss.
If co-location is going to foster integration, information flow is critical. If there is no joint plan of care, if actions or interventions are not shared, and if the patient cannot see the plan and what is required of them, there will be no integration of care. It is imperative that the clinical leadership jointly devise a method to record and share essential information with each other and the patient. This is most likely to be a paper record of the integrated activity that can be a part of each service entities medical records.

Rope Suspended Foot Bridge

Coordinated care between a primary and behavioral health provider relies on the most tenuous and

challenging of bridges over the abyss. They are unstable, limited to pedestrians, and scary to many users. The pursuit of integrated care is dependent on the good will and interest of individual clinicians. Usually the interaction is limited to a referral or perhaps a staff supported linkage to a person they know and trust. Even with a firm organizational structure to support integration, one of the factors than can make integration take root is the free flow of information. While it will be limited as required by law, it can still be the glue that helps bind the providers and the patient to a plan of care. At a minimum there needs to be a format that can be shared on a regular basis that displays the plan of care, actions taken, and the outcomes for all involved.

Findings from the Block Grant

- The experience of the Block Grant suggests that there is a long way to go to develop sufficient information management for beneficiaries. There are numerous, differing, and frequently incompatible information systems, portals, regulatory barriers, security systems, and competencies among the many stakeholders (providers and health plans).

- There is no single EMR that addresses the full decision support and patient processing required by both primary care and behavioral health provider needs

- The Project used two EMRs (McKesson Practice Partners® for primary care providers and Streamline SmartCare® for behavioral healthcare providers. There were methods for mutual uploading of information to the respective EMRs from the other but these were “workarounds” rather than seamless solutions.

- Gaining information from Medicaid Health Plans (MHPs) and Federally Qualified Health Centers (FQHCs) was problematic and a slow process. The primary barriers came from the CMH side of the equation: there were numerous regulatory barriers; unnecessary documentation requirements; process measurements; etc. which interfered with a smooth form of information handling. It makes the PCP experience of CMHSPs annoying.

- Primary Care Physicians uniformly cringed when they had to try to get information from CMHSPs. The entire process was experienced as burdensome, “clunky,” and not collegial.

Recommendations for Exploration

- ***A Unified Statewide Medicaid Data Base***
  The easiest method for bridging the multiple Medicaid data bases and provider systems would be for the State Medicaid agency to develop a unified information/ encounter system that is uniformly available to providers for a single beneficiary. Thus a beneficiary’s provider would be able (at a minimum) to routinely access all encounters and (at a maximum) all medical evaluations, lab reports, biometrics, prescription information, etc., input by all providers.

- ***An Integrated, Web-Based Electronic Medical Record (EMR)***
  This unified EMR is the Holy Grail for integrated healthcare. Unfortunately it doesn't as yet exist—nor does there appear to be one on the horizon. Such a solution

would truly be person-centered: the evaluations, decision supports, risk management, and care coordination efforts would all be driven by where the beneficiary is at that particular moment in front of any provider. In a sense the EMR process would "follow" the prompts (i.e., information given by the beneficiary) and bring out ONLY the information and supports that would respond to the patient need *at that moment*. Such an EMR must be web-based, "meaningful use"-certified; and have HIPAA-compliant portals.

- ***Electronic Patient Registries***
  Patient registries are electronic tools for tracking and managing specific disease conditions. They include the evaluation findings; the biometrics; patient responses to interventions—and those of others covered by the specific disease condition. It allows for more targeted follow-up while assuring that patients receive the needed support to achieve health status improvement. Such registries can by available to both the provider and the beneficiary to allow better partnership in chronic care management.

- ***Use of "Smart Cards"***
  Most of the developing countries with national healthcare systems have adopted the use of "smart cards" to help with ensuring availability and correctness of patient information. These "smart cards" have an imbedded microprocessor chip in the card which operates as a read/write instrument carried by the patient and made available for input/output by authorized provider systems involved in their care. It also has the added benefit of ensuring strong patient control over protected health information. The "smart card" can hold any and all of the patient's evaluation findings; the biometrics; responses to interventions; interventions; health history; insurance demographics; and so on.

- ***Use of Networked Tablets***
  Medical Offices are currently allowing access to EMRs, patient registries, decision supports, etc., on E-Tablets. . Such tablets might also be used in Patient Education—allowing, for example, the viewing of videos explaining various necessary medical information or procedures. With the miniaturization of computers and the maximization of "cloud" technologies, we can expect the tablet to become the necessary tool for providers operating throughout an integrated system.

- ***Encrypted Email Communications***
  Providers in differing systems need to be able to communicate in a real-time HIPAA-compliant manner. Many providers are finding that use of encrypted emailing (and faxing) makes communication easier, more collegial and more given to better consultation. These are separate (at this point) from the EMR although some newer EMRs are allowing entry of emails into the medical record. We can expect more of this in the future.

Managing the Abyss

No matter the level of integration, if there is not a shared format and free information flow, the abyss will not be bridged. It has to be jointly formatted, regularly shared with consultation, monitored for needed changes in plan, and assessed for outcomes. Absent such a process the integration effort will be short lived, frustration will set in, and benign neglect of the process will take over. There is no

one format or electronic medical record to fit every situation. Start with what you want to accomplish, identify key elements of the record, test it out in your environment, and when ready, look to see which vendors can provide what you need. Integration is a team effort and so it follows that free flow of useful information is essential to support and nurture the effort.

Further Reading

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For Further Information please feel free to contact

Michael Barkey
Director, Community Development Group
Integrated Healthcare Projects
Summit Pointe
140 West Michigan Avenue
Battle Creek, Michigan 49017
Email: mfb@summitpointe.org