USciences
University of the Sciences

The Blended Family: Student Health & Counseling (SHAC) A Collaborative Model

Karen Levinson, PhD

Barbara Siebert, DNP, CRNP, FNP-BC, CNE

Where healthcare and science converge.

Agenda

- Models of Integration
  - History, Benefits, Weaknesses
- Development and Description of Integrated Model at USciences
- Challenges
- Discussion- Goals? Challenges? Obstacles? Strategies?

Background History of Development of Campus Counseling Centers

- Increasing numbers of students seeking counseling services
- Increasing severity of mental health concerns
- Standards for counseling center functions include: direct services, prevention & outreach, consultation to faculty & staff, contributions to campus safety
- Mental health concerns interfere with students' ability to learn and be successful in school
- Even with high need, the majority of students do not seek professional counseling
  - Students seek help from friends, family or others
  - Most students who die from suicide never connected with counseling services

Risk Management and Campus Wide Responsibility

USciences
University of the Sciences

- Prevention- public health model to address environmental factors of a campus that impact student mental and physical health
- Coordinate campus response to provide needed resources to student AND protect the community
- Facilitate communication and coordination across a campus for quick response to struggling students and quick access to services

Reasons for Coordination of Care Between Mental Health and Medical Providers

- For Specific Health Concerns Such As, but not limited to the following:
  - Ruling out possible physical illness in the diagnosis of depression
  - Hormonal issues impacting mood
  - Physical symptoms caused or increased by anxiety
  - Disordered eating
  - Use of substances requiring medical management
- Culture –
  - More stigma for mental health, but less for medical treatment
  - Incompatible family values re: value of psychotherapy, hierarchical cultures that place higher value on medical expertise, etc.
- Public media focus on alleviation of symptoms through medication

Integrated Approach

USciences
University of the Sciences

Benefits

- Economic and social objectives- alignment of resources to save costs and meet clinical needs
- Emphasis of holistic care
- Mind-body approach
- Focus on wellness
- More effective referrals/greater continuity of care

Challenges

- Need for administrative coordination
- Merging diverse systems
- Developing staff philosophical consensus (politics!)
  - Medical Model versus Developmental Approach
- Resource management (budget, materials, staff)
- Managing confidential patient information

Models

- No consistent definition of integrated systems
  - Variations in center leadership
  - Location
  - Administrative processes
  - Shared versus separate mission statements
  - Budgets
  - Strategic planning
  - Medical record systems
  - Forms and information sharing
  - Psychiatric services

Goals of Integration

- Improved communication
- Improved quality of services
- Client/Student satisfaction
- Utilization of services
- Efficiency of administrative processes

SAMHSA's 6 Levels of Collaboration/Integration Core Descriptions

https://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf

COORDINATED KEY ELEMENT: COMMUNICATION		CO LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understanding of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet non-formal team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth understanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

SAMHSA's 6 Levels of Collaboration/Integration
Key Differentiators

USciences
University of the Sciences

COORDINATED		CO LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Key Differentiator: Clinical Delivery					
▸▸ Screening and assessment done according to separate practice models ▸▸ Separate treatment plans ▸▸ Evidenced-based practices (EBP) implemented separately	▸▸ Screening based on separate practices; information may be shared through formal requests or Health Information Exchanges ▸▸ Separate treatment plans shared based on established relationships between specific providers ▸▸ Separate responsibility for care/EBPs	▸▸ May agree on a specific screening or other criteria for more effective in-house referral ▸▸ Separate service plans with some shared information that informs them ▸▸ Some shared knowledge of each other's EBPs, especially for high utilizers	▸▸ Agree on specific screening, based on ability to respond to results ▸▸ Collaborative treatment planning for specific patients ▸▸ Some EBPs and some training shared, focused on interest or specific population needs	▸▸ Consistent set of agreed upon screenings across disciplines, which guide treatment interventions ▸▸ Collaborative treatment planning for all shared patients ▸▸ EBPs shared across system with some joint monitoring of health conditions for some patients	▸▸ Population-based medical and behavioral health screening is standard practice with results available to all and response protocols in place ▸▸ One treatment plan for all patients ▸▸ EBPs are team selected, trained and implemented across disciplines as standard practice
Key Differentiator: Patient Experience					
▸▸ Patient physical and behavioral health needs are treated as separate issues ▸▸ Patient must negotiate separate practices and sites on their own with varying degrees of success	▸▸ Patient health needs are treated separately, but records are shared, promoting better provider knowledge ▸▸ Patients may be referred, but a variety of barriers prevent many patients from accessing care	▸▸ Patient health needs are treated separately at the same location ▸▸ Close proximity allows referrals to be more successful and easier for patients, although who gets referred may vary by provider	▸▸ Patient needs are treated separately at the same site, collaboration might include warm hand-offs to other treatment providers ▸▸ Patients are internally referred with better follow-up, but collaboration may still be experienced as separate services	▸▸ Patient needs are treated as a team for shared patients (for those who screen positive on screening measures) and separately for others ▸▸ Care is responsive to identified patient needs by of a team of providers as needed, which feels like a one-stop shop	▸▸ All patient health needs are treated for all patients by a team, who function effectively together ▸▸ Patients experience a seamless response to all healthcare needs as they present, in a unified practice

Key Differentiators Continued

University of the Sciences

COORDINATED		CO LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Key Differentiator: Practice/Organization					
▸▸ No coordination or management of collaborative efforts ▸▸ Little provider buy-in to integration or even collaboration, up to individual providers to initiate as time and practice limits allow	▸▸ Some practice leadership in more systematic information sharing ▸▸ Some provider buy-into collaboration and value placed on having needed information	▸▸ Organization leaders supportive but often co-location is viewed as a project or program ▸▸ Provider buy-in to making referrals work and appreciation of onsite availability	▸▸ Organization leaders support integration through mutual problem-solving of some system barriers ▸▸ More buy-in to concept of integration but not consistent across providers, not all providers using opportunities for integration or components	▸▸ Organization leaders support integration, if funding allows and efforts placed in solving as many system issues as possible, without changing fundamentally how disciplines are practiced ▸▸ Nearly all providers engaged in integrated model. Buy-in may not include change in practice strategy for individual providers	▸▸ Organization leaders strongly support integration as practice model with expected change in service delivery, and resources provided for development ▸▸ Integrated care and all components embraced by all providers and active involvement in practice change
Key Differentiator: Business Model					
▸▸ Separate funding ▸▸ No sharing of resources ▸▸ Separate billing practices	▸▸ Separate funding ▸▸ May share resources for single projects ▸▸ Separate billing practices	▸▸ Separate funding ▸▸ May share facility expenses ▸▸ Separate billing practices	▸▸ Separate funding, but may share grants ▸▸ May share office expenses, staffing costs, or infrastructure ▸▸ Separate billing due to system barriers	▸▸ Blended funding based on contracts, grants or agreements ▸▸ Variety of ways to structure the sharing of all expenses ▸▸ Billing function combined or agreed upon process	▸▸ Integrated funding, based on multiple sources of revenue ▸▸ Resources shared and allocated across whole practice ▸▸ Billing maximized for integrated model and single billing structure

Advantages & Weaknesses

USciences
University of the Sciences

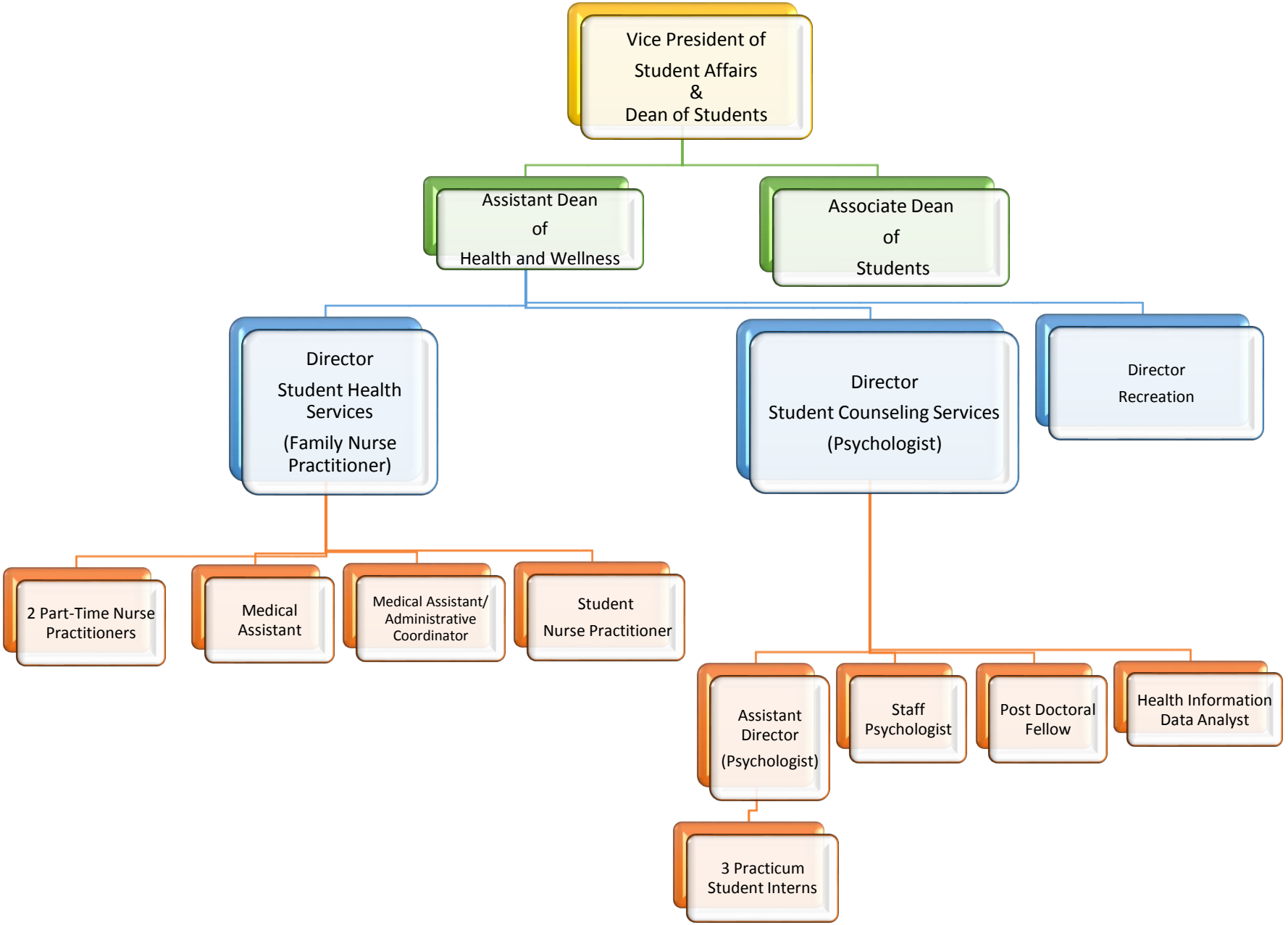
COORDINATED		CO LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Advantages					
▸▸ Each practice can make timely and autonomous decisions about care ▸▸ Readily understood as a practice model by patients and providers	▸▸ Maintains each practice's basic operating structure, so change is not a disruptive factor ▸▸ Provides some coordination and information-sharing that is helpful to both patients and providers	▸▸ Colocation allows for more direct interaction and communication among professionals to impact patient care ▸▸ Referrals more successful due to proximity ▸▸ Opportunity to develop closer professional relationships	▸▸ Removal of some system barriers, like separate records, allows closer collaboration to occur ▸▸ Both behavioral health and medical providers can become more well-informed about what each can provide ▸▸ Patients are viewed as shared which facilitates more complete treatment plans	▸▸ High level of collaboration leads to more responsive patient care, increasing engagement and adherence to treatment plans ▸▸ Provider flexibility increases as system issues and barriers are resolved ▸▸ Both provider and patient satisfaction may increase	▸▸ Opportunity to truly treat whole person ▸▸ All or almost all system barriers resolved, allowing providers to practice as high functioning team ▸▸ All patient needs addressed as they occur ▸▸ Shared knowledge base of providers increases and allows each professional to respond more broadly and adequately to any issue
Weaknesses					
▸▸ Services may overlap, be duplicated or even work against each other ▸▸ Important aspects of care may not be addressed or take a long time to be diagnosed	▸▸ Sharing of information may not be systematic enough to effect overall patient care ▸▸ No guarantee that information will change plan or strategy of each provider ▸▸ Referrals may fail due to barriers, leading to patient and provider frustration	▸▸ Proximity may not lead to greater collaboration, limiting value ▸▸ Effort is required to develop relationships ▸▸ Limited flexibility, if traditional roles are maintained	▸▸ System issues may limit collaboration ▸▸ Potential for tension and conflicting agendas among providers as practice boundaries loosen	▸▸ Practice changes may create lack of fit for some established providers ▸▸ Time is needed to collaborate at this high level and may affect practice productivity or cadence of care	▸▸ Sustainability issues may stress the practice ▸▸ Few models at this level with enough experience to support value ▸▸ Outcome expectations not yet established

Questions to Ask/Answer (from ACHA White paper)

- To what extent will services be integrated and merged? What will the administrative and clinical care structure look like?
- Will reception areas and staff be shared or separate?
- How will consent for treatment and release of information be handled?
- How will clinical records be kept, and who will have access to which parts?
- Will there be joint or separate staff meetings and in-service training?
- What will be the mission and goals of the new service?
- Will the name reflect a more holistic/wellness approach?
- Will advertising and outreach be integrated or separate?
- How will finances/funding be handled? Shared or separate budgets?

An ACHA White Paper, Journal of American College Health, 2010, Vol. 58, NO. 6

SHAC Administrative/Clinical Care Structure



Consent to Treatment (Counseling)

Client Information and Consent Form

Welcome to Student Health & Counseling (SHAC)! This screen summarizes important information that you should know about our services. If you have any questions after reading this information, please be sure to discuss them with your intake counselor. By actively addressing your concerns with your counselor, you will ensure that you get the most of these services.

COUNSELING SERVICES OFFERED: Our office is open between the hours of 9:00a.m. - 5:00p.m., Monday through Friday. We offer short-term, developmentally oriented counseling and prevention services to currently registered university undergraduate and graduate students. These services include: crisis intervention; psychological and psychiatric assessments; individual and couples therapy; and psychological consultation. In situations requiring intensive treatment beyond the scope of the services we are able to provide, we will discuss any necessary referral and treatment recommendations with you, and assist in obtaining appropriate resources to the best of our abilities.

INTAKE AND FOLLOW-UP: At your initial appointment, you and your intake counselor will discuss which services best fit your needs. Please keep in mind that if counseling services at SHAC are recommended, the intake counselor may not be the individual with whom you continue to meet. Your intake counselor may consult with other staff to determine the best possible recommendation for you. Sometimes the recommendation will be referral to outside (non-University) programs or therapists when these seem advantageous to your care. In such cases, you will be responsible for the payment of off-campus treatment; your personal health insurance may cover a portion of your expenses for those services.

EMERGENCIES: If you experience a psychological emergency before your next appointment (for example, if you are feeling suicidal, experiencing psychotic symptoms, or having a substance related crisis), please go to the nearest emergency room for immediate evaluation. Call Public Safety at 215-596-7000 to help transport you, or call 911. If you are unsure what to do and it is during normal business hours, you may call the Counseling Center at 215-596-8536. If you are unsure what to do and it is after normal business hours you can call the Philadelphia Suicide and Crisis Center at 215-686-4420. Under any circumstance, if you or someone you know are in danger, call 911 immediately.

GENERAL APPOINTMENT POLICIES: We experience a heavy demand for individual counseling appointments. If you find that you cannot keep a scheduled appointment, it is your responsibility to contact SHAC as soon as possible to cancel or reschedule (215-596-8536). This gives us an opportunity to use the time for another student. If a counselor cannot keep a scheduled appointment, every effort will be made to contact you in advance of your appointment to reschedule.

PROCESS AND EFFECTS OF COUNSELING: The purpose of working with a counselor is to help clients identify and improve areas in their life that are causing problems or distress, or that are interfering with their ability to succeed in one or more areas of their life. The counselor and client will work collaboratively to develop a plan for improving these problem areas. The counselor may suggest strategies for making changes or alleviating problem areas, but the client must be invested and put effort toward their own progress in therapy. Most clients can expect to benefit from counseling, making positive changes in their thoughts, feelings, and behaviors. You should remember, however, that psychotherapy may stir up uncomfortable feelings and that as part of the normal treatment process you may experience a degree of distress. You are encouraged to discuss with your counselor how you are doing throughout the therapeutic process so issues can be worked through collaboratively.

PSYCHIATRIC APPOINTMENTS: SHAC employs a part-time consulting psychiatrist. Appointments with the consulting psychiatrist can only be initiated by your counselor. If you are interested in meeting with our psychiatric consultant, you will need to discuss this with your counselor to arrange an appointment. SHAC does not provide psychiatric services to individuals seeking medication only. Due to limited psychiatric time, it is very important that students be on time for their appointments and that they notify SHAC as soon as possible if they will not be able to attend an appointment.

TRAINING: SHAC is a practicum placement for graduate programs in the field of mental health. Practicum clinicians are supervised closely by licensed professional staff and meet regularly to review their clinical work. Our practicum clinicians are required to audio-record their counseling sessions. Prior to recording, the process will be discussed and your written permission obtained. Recordings will be kept confidential, are only to be used for educational and supervision purposes, and will be deleted after being utilized for those purposes.

CONFIDENTIALITY: Information shared by you in counseling sessions will be treated with the strictest confidentiality. While information will not be released by SHAC staff outside of SHAC without your written permission, SHAC professional staff may confer with each other to be sure to make appropriate referrals and to improve the quality of services to you. The rare exceptions to this rule of confidentiality, as required by state law, include the following situations:

1) if there is a reason to believe you might be in imminent danger of seriously harming yourself or others;
2) if there is reason to believe that a child or vulnerable adult has been, or is likely to be, abused or neglected;
3) if there is a valid court order which requires disclosure of information.

COUNSELING RECORDS: Counseling files are stored either on paper in locked files or electronically on a secure server. Only SHAC staff members have access to these records. These records are held for a seven year period and then destroyed.

PHONE AND ELECTRONIC COMMUNICATION: Because confidentiality cannot be insured when communicating via email, and because of our belief in the importance of face-to-face contact, we discourage clients from communicating with their counselors about therapy material through email. Changes in appointment can be made by phone and with your permission by email. However, general therapy concerns should be discussed in person with your counselor. Please be aware that counselors may not respond quickly to email messages, and this should never be a method of communicating information that requires an immediate response. As always, if you are having a mental health crisis, please call 911 immediately or go to your nearest emergency room. Please also be aware that counseling staff will not accept or respond to any social media requests from current or former clients.

GENERAL CONSENT AND ACKNOWLEDGMENT OF RECEIPT OF THE SERVICES, POLICIES, AND INFORMED CONSENT:
I hereby give my consent to SHAC to provide assessment, treatment, and/or other services determined to be appropriate. I have read and understand the information on this client information and consent form, and am aware of the limitations to services, and the exceptions to confidentiality. I am also aware that I have the right to refuse treatment at any time.

ACKNOWLEDGMENT SIGNATURE
By providing my full name and student ID below, I acknowledge that I have read the services, policies, and informed consent information provided to me. I consent to receiving services at SHAC based on these rights and responsibilities.

Full Name: _____ Student ID: _____

Thank you for acknowledging the receipt of information about SHAC policies, procedures, and services. Please be sure to raise any questions or concerns you may have about any of these issues with your counselor or any SHAC staff member. We want to ensure that you fully understand how our center functions so that we can better serve your needs.

SHAC Mission Statement

USciences
University of the Sciences

Student Health and Counseling (SHAC) provides high-quality physical and mental health care in a safe, respectful and confidential environment, while promoting healthy behaviors and lifestyle choices. We work collaboratively with the University community toward the goal of improving the academic, personal, and professional experiences of our students through the provision of individual services, consultation, referral, education, and outreach.

Health Objectives

- Provide students with quality healthcare services that integrate individual health needs, health education, prevention, and appropriate, evidence-based clinical treatment for illness and injury
- Enhance students' knowledge about healthy lifestyle choices
- Educate students' about appropriate Self-Care measures
- Support the personal and academic development of all USciences students by promoting and supporting their health and well-being.

Health Goals:

- Meet the demand for student health services on campus to support student retention and engagement (Measured by Student Satisfaction Survey results & PyraMed utilization reports)
- Increase students' awareness of health services (Measured by Student Satisfaction Survey results & PyraMed utilization reports)
- Increase students' utilization of health services through PyraMed Self-Scheduling & extended Wednesday hours
- Increase students' overall satisfaction with health services (Measured by Student Satisfaction Survey results and Daily Health Service Survey results)
- Establish a Student Peer Mentor Program comprised of undergraduates and MPH students providing supervised campus-wide health education outreach
- Augment health education communication & SHAC website information providing students with Self-Care measures and Health Promotion modalities.
- Establish a Medical Triage System utilizing SHAC Medical Assistants and Health Care Providers
- Provide on-site vaccination clinic to facilitate student compliance completing immunization requirements and annual flu vaccine
- SHAC will be regarded as a Center of Excellence for student health services and health education (Measured by Student Satisfaction Surveys & Health Education Presentation evaluations)

Counseling Objectives

- Provide students with quality mental health services that integrate appropriate clinical treatment of individual mental health needs with education, prevention, outreach, consultation and referrals.
- Enhance students' knowledge about healthy lifestyle choices.
- Support students in the development and maintenance of effective self-care behaviors.
- Support the personal, professional and academic development of all USciences students by promoting and supporting their emotional health and well-being.

Counseling Goals:

- Patient Care: Meet the demand for clinical services of students on campus for support of student retention and engagement (Measured by utilization stats)
- Increase awareness of services (Measured by satisfaction survey results)
- Crisis Management: Increase awareness and access to other resources to support after hours or alternate sources of care (Measured by number of new resources added, e.g. stress management website, self-help materials, social media, other website content, after hours hotlines/ text lines, local referral sources, etc.)
- Increase staff participation in regional and national higher education suicide prevention efforts (Measured by Jed & Clinton health matters self-assessment and subsequent feedback)
- Health Promotion: Increase collaboration on outreach and health promotion programs e.g. with Greek Life, ARC, etc. (Measured by number of programs and attendees)
- Increase student knowledge and skills around healthy relationships through provision of revised healthy relationship workshop to first year students through collaboration with Athletics department (measured by workshop evaluation data)

USciences
University of the Sciences

Discussion

- How are your student health and counseling centers structured?
- Have you experienced benefits, hindrances, or integration?
- What are your goals related to integration? What benefits do you anticipate?
- What are your concerns regarding your current model/structure?

Conclusions

- Importance of Establishing Professional Relationships
  - Mutual Trust and Respect
- Importance of Professionalism
- Value for Interprofessional Collaboration Practice Model
- Importance of Communication
- Importance of Boundaries
- Importance of Ongoing Discussion, Debriefing, Case by Case Consultation

???Questions???

Contact us:

Karen Levinson

k.levins@usciences.edu

Barbara Siebert

B.siebert@usciences.edu