How Network Routines and Practices Structure Interorganizational Collaboration in Behavioral Healthcare Settings

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Abstract

What are the barriers and channels to interorganizational collaboration, and how do they influence collaborative processes? Using the case of a hospital psychiatric service, this three-year ethnography analyzes the multiple dimensions of interorganizational collaboration surrounding the practice of patient referral. Patient referrals depend on the inter- and intra- organizational networks and behavior of pluralistic actors (patient, provider, team and administrative system) who shape the process beginning with diagnosis/assessment and environmental scan (for provider collaborators), followed by contact with those providers, and ending with patient service utilization. This study extends work on multi-dimensional interorganizational collaboration by examining the barriers and channels shaping healthcare collaboration during the referral process. I show that at various levels, resources, relationships and rules (e.g., patient resources, interprofessional relationships, and administrative policy) structure the conditions under which collaboration takes place. Findings have implications for research devoted to the question of how actors situated in diverse but interconnected environments create structures in the form of routines and practices that shape collaboration and impact organizational outcomes.

Introduction

Economic actors, both individual and collective, are embedded in networks of interconnected social, professional and exchange relationships that serve as opportunities and constraints on their behavior (Brass, Galaskiewicz, Greve& Tsai, 2004; Granovetter, 1985; Gulati Nohira & Zaheer, 2000; Gulati, 1998). Networks can be characterized in a number of ways with regard to the levels at which they connect, the types of actors they connect and the content of those linkages (Gulati, 2007).Network mechanisms by which sets of actors come together to accomplish organizational tasks are based on interorganizational, intraorganizational and interpersonal relationships—collaborative relationships involving contracts, teams and contacts (Berends, Burg &Raaij, 2011; Bruns, 2013).

Collaborative relationships provide actors with a reliable structure within which to conduct organizational activities while promoting mutual awareness and buildingtrust and commitment (Barden & Mitchell, 2007). They are important sources of contact that help partners identify and learn about each other's assets and capabilities, mitigate transaction costs and make opportunism more costly by threatening to unleash negative publicity tarnishing reputations and credibility (Falkner, 2006; Gulati, Nohria & Zaheer, 2000.

Despite their beneficial impact, a number of obstacles make collaboration both complex and difficult. The processes by which formal ties are developed are glacially slow requiring "multiple levels of internal approval, significant research to identify partners' detailed assessments of contracts and significant ongoing management attention to sustain the partnership" (Gulati, 2007:36). Informal or interpersonal/ interprofessional ties in contrast have the advantage of timeliness and flexibility since these involve fewer players. However, it is not clear exactly whose interests these contacts represent; individual, subunit or organization? Strikingly, formal ties that link organizations, and that link subunits within organizations, originate with individuals whose informal relationships may or may intersect with those of the organization (Barden & Mitchell, 2007; Berends, Burg &Raaij, 2011). This complexity suggests the importance of seeking to untangle the dynamics of interpersonal/interprofessional relationships and how they underlie interorganizational collaboration.

While much interorganizational research has been devoted to understanding interpersonal, and interorganizational linkages, most tend to juxtapose the two in binary terms:

friendship/informal versus professional/formal. Few studies attempt to untangle the multi-dimensionality of organizational collaboration (see however Barden & Mitchell, 2007; Berends, Burg &Raaij, 2011). To bridge this gap, I examine what Barden and Mitchell (2007) call nodal multiplexity (the relational experiences of pluralistic actors e.g., teams, organizations and collectivities) in the field of behavioral health. I focus on the coordination of behavioral health services among pluralistic actors in order to understand the factors that promote and the factors thathinder the cultivation of interorganizational partnerships.

Coordination of services is an important function of healthcare and tends to be highly problematic (in the U.S. especially) because service provision is highly fragmented and continuity of care lacking (Lemak, Johnson & Goodrick, 2004). Healthcare organizations enter into collaborative arrangements to improve efficiency, share resources and enhance legitimacy. They may acquire new knowledge and for public agencies, access to government resources. One strategy for understanding interorganizational relationships in the healthcare field is to analyze the mechanisms by which clients' need-for-services acts as a coordinated network of care between providers (Provan, Sebastian & Milward, 1996). Theoretically this provides a framework for examination of interorganizational collaboration at the level of service delivery rather than as strictly formal administrative linkages.

Since collaboration is not a singular event but a process that emerges from organizational practices and routines, I focus on the barriers and channels that inhibit/foster patient referrals by examining three phases of practice that healthcare organizations undertake to develop referral partners. These phases are detailed in Figure 1 below. They begin with analysis of the barriers and channels to making an appropriate diagnosis/assessment, which is essential for practitioners who must conduct an environmental scan of community services to meet the criteria of care established by the diagnosis/assessment. Next, I examine the dynamics of the phase during which identified partners become or fail to become an actual patient referral. Lastly, I explore barriers and channels to patient utilization of services during the phase from patient referral (pre-discharge) to patient service utilization (post-discharge). Factors inhibiting or promoting the success of each phase operate vis-à-vis a plurality of actors: patient, provider, team and administrative system (see Gagliardi,Dobrow & Wright, 2011).

Using a multidimensional schema of organizational processes (i.e., diagnosis/assessment, scan, referral, utilization) and levels (i.e., patient, provider, team and administration), I show that

collaboration in healthcare takes place among actors situated within their own unique environments, whose attempts to reduce their own unique uncertainties result in the production and reproduction of routines, norms and practices influencing the dynamics of interorganizational exchanges. For example; at the level of the practitioner team, diagnostic and psychosocial uncertainty (e.g., confusion over the appropriate use of administrative labels such as acute/inpatient versus nonacute/observational) may delay the process of diagnosis and then environmental scan, which can result in failure to make the actual referral, ending in a discharge that is unlikely to result in a patient pursuing the referral (Table 2 Practitioner team description - Field notes morning meeting 6/26/13; validation study 6/1/16). The reason in this case for diagnostic and psychosocial uncertainty has in part to do with administrative rules the confusion about which is compounded by lack of team cohesion, then disagreement over patient placement, followed by failure to locate a community provider who is a good fit for the patient. While another community provider may be located, transportation barriers and other obstacles may remain that make it unlikely the patient will actually pursue the referral.

In the following paper, I begin by describing the research setting (and a validation follow up site) and the sources of my empirical findings. Then I discuss Table 1which summarizes these findings as they pertain to the barriers and channels to collaboration. Tables 2-4 contain data from which Table 1 draws its conceptual summaries. Naturally, Table 2-4 contain more material than can be elaborated in the current format of the paper and will be detailed in a fuller version of the paper as it moves forward. I included them here to support claims made in Table 1.

Research Setting

This study took place on a psychiatric unit of a small hospital in the United States over the course of 30 months. The hospital (designated here as MidState Medical Center- T. Campus, or MSMC- TC) is located in a town of 16,000 not far from the state capital. It serves a wide catchment area which it shares with its parent organization (MidState Medical Center- Main Campus or MSMC- MC) in the state's capital. A follow up was conducted in a year later at a similar site in order to provide counterfactuals.

The psychiatric service on MSMC-TC (and the validation site, STM-16) provides acute inpatient mental health and substance abuse detoxification treatment services for upwards of

twenty-four patients at a time. It is a locked unit designed for individuals who are at imminent risk of harming themselves or others or who cannot take care of themselves (but not forensics patients); some of whom have been committed involuntarily, and some of whom acquiesce to commitment [Field notes interview social worker D]. The typical length of stay is upwards of 3-4 days. Many have severe mental illness which requires rapid and intensive inpatient treatment. The hospital is connected administratively to several community outpatient care services through the parent organization MSMC- MC. It is also connected contractually to at least one other organization which provides its patients with aftercare follow up services such as case management [Interview social worker N]. The remainder of its interorganizational linkages are created daily through communications between the healthcare professionals who work on the unit and other providers external to the facility.

The psychiatric service at MSMC-TC (as well as STM-16) uses a team approach of patient care whereby a combination of treatment providers assume responsibility for coordinating health care and social supports in order to assure intra organizational continuity of care (Wiersdma Mulder de Vries & Sytema, 2009). The team consists of mental health nurses, psychiatric nurse practitioners, hospitalists, psychiatrists, social workers, occupational training specialists and other providers. The teams are patient-centered but are not fixed, that is, members rotate in and out of the team depending on scheduling and staffing requirements, case load and personal preference [Fieldnotes June 2011]. The system is an open one in which referrals may be made by any member of the team not a closed system in which physicians must order services before other team members can intervene.

Ethnographic Research

The locus of behavioral health inpatient services for Mid State has shifted several times during the past decade between the parent hospital in the capital to the small town and most recently back to the capital again as the parent organization has expanded its campus to include a behavioral health wing, services which were previously delivered at MSMC-TC. Prior to the most recent move back to the capital, I conducted a prospective organizational case study of MSMC- TC based on organizational ethnography (Niccolini, 1999). It involved fieldwork that

included observations, interviews, and analysis of documents related to the behavioral health system and practices of that hospital.

A field study was optimal for getting at the question of how work practices of healthcare practitioners span organizational boundaries and create interorganizational collaboration. It addresses the question why certain relationships, routines and structures function the way they do and not some other way, and how actors affect and are affected by the structures they have created (Jinnett, Coulter & Koegel, 2002; Nicolini, 2009).

One theoretical problem is that micro-defined views of structure/ context emphasize too much individual (case) agency in the creation of structure/ context while macro-defined views of cases err on the side of assigning too much determinacy to the effects of structure/context on individuals (Berends, van Burg & Raaij 2011). Clearly the effects are mutual and necessitate a dynamic model in which interactions between individuals and contexts create a set of routines and structures that shapes organizational behavior and ultimately organizational interactions.

A qualitative study of healthcare networks such as MSMC-TC can be used to make sense of the gap between formal organizational features and actual behavior. For example, in situations where no real contract exists between healthcare providers, a formal perspective would suggest that no linkage occurs. And yet, individuals may have negotiated linkages informally in order to work around gaps in clients' care. Moreover, some linkages, either formal or informal ones, may be merely ceremonial and therefore create barriers to services rather than channels providing greater access to care. Only through close examination of relationships can we leverage the dynamic of individual and context that is essential to understanding how different levels of interact to facilitate or to hinder collaboration.

Data Sources

Observations. To address several questions related to interorganizational collaboration I spent approximately three to four hundred hours (over the course of thirty months) observing daily life on the psychiatric service of MSMC-TC. I also conducted a follow up validation study in 2015-2016 of a comparable site. Doing so generated one hundred field observations ranging in length from three single spaced pages to seven or more. These observations typically included notes

taken during the morning census meeting, a half-hour activity attended by the night nursing and psychiatric staff who reported on patients to staff taking over for the day. This handoff was held in a small room off the patient dayroom. Observations also included notes recorded during patient and family interviews which this researcher followed diligently.

Interviews. I also conducted nine interviews with social workers, mental health psychiatric nurse practitioners and psychiatrists. These were wide ranging depending on the direction taken by the interviewee, but provided information about referral practices, relationships among team members, and importantly, relationships between the hospital and community agencies to which patient were referred upon discharge.

Documents. While MSMC-TC (and STM-16) maintains extensive documentation on all its patients several documents were more salient for this study than others. These included the Patient Census, a summary of patient demographics, mental health and substance use diagnoses, psychosocial evaluation, and medical conditions; the Behavioral Treatment Plan v2, an assessment of patient behavioral, psychosocial, medical needs, resources (or lack thereof) and a tentative set of goals towards which the patient and staff direct their activities during inpatient hospitalization; the Psychiatric Evaluation, a narrative describing, diagnosing and prescribing treatment; and the Discharge Plan, a concise review of referrals, prescriptions and plans for the patient upon release.

Findings

Figure 1 provides a schema for organizing the dynamics of patient processing in the MSMC-TC system. By examining the dynamics of case-processing at several levels the features of interorganizational collaboration emerge in a way that would be impossible through analysis of the administrative apparatuses alone (Provan, Sebastian& Milward, 1996). By examining multiple functional levels of the system as they pertain to patient processing, barriers and channels to coordination and collaboration are revealed.

Diagnosis and assessment. Coordination and collaboration begins as an intraorganizational practice when a patient becomes a part of the system through triage via the emergency department of MSMC- TC or its parent organization MSMC- MC [Interview social worker N.]. There, admitting diagnoses are made and if the patient meets criteria that warrant

inpatient status, she or he is brought to the floor. Additional assessments by nursing staff are undertaken, and eventually the patient will meet with the attending psychiatrist and other team members. As noted, the MSMC system utilizes a team approach. First, before morning report or morning rounds, social workers meet to divide up cases for the day. They then join with the rest of the staff during the half hour session of morning report in which the entire professional team is present including the charge nurse, hospitalists, administrative secretary and group therapists. The team is configured and re-configured daily, and, on a large white board by the nurses' station, the name of the patient and her/his team members (nurse, social worker, psychiatric nurse practitioner and doctor) is displayed. Patient diagnostics, resources, problems with securing resources and in general, the disposition of cases are all the focus of conversation among team members during morning meeting.

Environmental scan. The team and task alignment that takes place during morning meeting, and continues throughout the patient's residence on the unit, produces an environmental scan for post-discharge resources for the patient (Aquilar, 1967). In the environmental scan phase, depicted in Figure 1, team members discuss, argue, reject, tentatively accept, challenge and dispute each other in the process of identifying and then securing community resources for patients. Again, this takes place over the course of the patient's stay. Naturally, the dynamic that generates an environmental scan is a process of trial and error, typical practice, satisfycing and other strategies in which most organizations engage. For example, everyone has their favorites in the way of a person or agency to whom they typically refer patients [Interview care management supervisor D. 2/14/12].

Referral to services. The third stage in the process is the link to community agencies that provides patients services after discharge. While a successful scan may have identified appropriate community partners for interorganizational connections with regard to a patient, there remain a number of uncertainties that will either promote or sink the process at this point. These are detailed in Tables 2-4.

Service utilization. The final stage in the process identifies the dynamic that takes place between an actual referral, an established linkage based on an agreement between professionals at a community agency and professionals at MSMC-TC, and utilization of the service.

Table 1 places the above Figure 1 schema of interorganizational collaboration into context by examining the barriers and channels that either hinder or help the process of service provision for behavioral health patients as they traverse the behavioral health system. Tables 2-4 provide evidence from interviews and field notes that support the summary categories in Table 1.

Since barriers and channels exist at multiple levels of the system, exemplified here by actors whose practices determine whether, and how, referrals take place, I have conceptualized levels in terms of characteristics which promote or inhibit collaboration. These levels are analyzed with respect to the various types of actors involved at each level: patient, provider team, hospital administration and lastly, (the targeted) community care provider. Naturally, I might have included other extra-organizational structures such as the regional/state system of health care, third-party payer systems and the like. These are relevant to this case study to the extent that my informants mention them as barriers or channels impacting on the practices of the psychiatric unit. However, the four levels documented here are the most relevant organizational features (according to my informants) in the process of interorganizational collaboration.

I examine the processes of diagnosis and assessment, environmental scan, referral to services and service utilization at each level of organizational practice. The dynamics of locating a community partner for collaboration (environmental scan), making that referral,and actual utilization of the referral, unfold at the administrative, team, patient and finally community levels (see Tables 2-4 for detail). In general, barriers to collaboration at the various levels are due to resource gaps, tenuous professional relationships and inhibiting rules. Barriers often take the form of ritualized behavior (on the part of teams and administrative apparatuses), recalcitrance on the part of the community agency due to over extended resources, and misaligned patient characteristics (including recalcitrance on the part of the patient). In contrast, successful collaboration depends on abundant resources, professional discretion/autonomy and administrative policies that encourage coordination of practices (Scott & Davis, 2010).

Conclusion

I began this study with the underlying question: what are the obstacles and what are the channels that impact collaboration and how do they do so? By investigating a hospital psychiatric unit, I am able to observe and detail the mechanisms by which interorganizational collaboration, in the

form of daily practices involving client-referrals, takes place. Since most studies examining the role of boundary spanners, focus on organization leaders such as COE and members of advisory boards, it is less well known who other boundary spanning members of organizations are, and how boundary spanning members interact within and between organizations (Klein, Palmer & Conn, 2000).

My study (and its follow up component) makes it clear who these actors are and how they behave. Observations and interviews on the psychiatric service show that to understand interorganizational collaboration it is important to consider multiple actors engaged in their daily practices. Clearly, work flow and goals shape interpersonal and cross-domain networks, vis-à-vis how teams operate, the amount of professional autonomy providers experience and so forth; however, multiple factors including resources and administrative rules play a key role in how linkages are cultivated.

While I do not observe social embeddedness directly in this study, its effects emerge throughout the course of my observations on the unit. Social embeddedness entails both relational and structural components of networks. The structural part refers to the overall pattern among actors and the relational part refers to the direct dyadic relations between actors. Both serve to facilitate as well as limit actors' practices. This is borne out in the rich detail of the tables (Tables 2-4) describing how actors at different levels in the unit succeeded or foundered in their task in providing the organization with referral partners.

That embeddedness is essential to interorganizational collaboration has implications for studies that seek to unpack the cross-level dynamics of networks (see Brass, Galaskiewicz, Greve & Tsai, 2004 for discussion), especially for organizations that provide client outcomes as a consequence of successful collaboration (e.g., healthcare, financial services and law). Although individual network research in health has focused on such outcomes (see e.g., Christakis & Fowler, 2007) organizational outcomes research has not. In that area, researchers can explore how organizational embeddedness functions at different levels and impacts outcomes such as client resources, quality of life, re-hospitalization rates and so forth. Under certain conditions collaboration may not have beneficial effects as when clients are subject to redundant and ritualized linkages(see e.g., Anthony, 2003; Granovetter, 1985), and it would be useful to detail when and how these conditions emerge. Ethnographic research in healthcare organizational

networks vis-à-vis collaboration can disclose these conditions and uncover the practices from which they arise.

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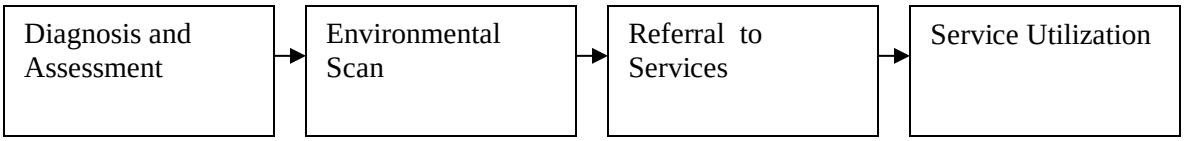

Figure 1: Interorganizational Collaboration: Behavioral Healthcare Referral Process

Table 1 : Interorganizational Collaboration: Barriers and Channels to Behavioral Health Services Utilization

		Barriers to Collaboration from…to…	
	Diagnosis and Assessment →Environmental Scan	Environmental Scan → Service Referral	Service Referral → Service Utilization
Levels			
Community Agency (targeted)	---	Resources unavailable/agency recalcitrance	Wait time for intake,/problematic location
MSMC- TC Administration	Intake protocol/ rules observation and inpatient status	Administrative rules that prevent referral	Administrative pressures to discharge
MSMC- TC Practitioner Team	Diagnostic and psychosocial uncertainty/ rotating practitioners	Lack of team cohesion/disagreement	Gap in team routines around discharge
MSMC- TC Patient	Lack of patient resources e.g., no insurance, no family supports, legal issues	Patient attribute misalignment with service/patient resistance/elopement AMA	Patients lack of resources e.g., transportation/scheduling conflicts/legal issues
		Channels to Collaboration from…to…	
	Diagnosis and Assessment →Environmental Scan	Environmental Scan → Service Referral	Service Referral → Service Utilization
Levels			
Community Agency (targeted)	---	Agency outreach program to professionals	Agency outreach to client
MSMC- TC Administration	Routines/teams/uncompensated care package/ treatment and discharge plans	In house-referral based on hospital privileges	---
MSMC- TC Practitioner Team	Professional practices and expertise, including work-arounds	Well-connected/knowledgeable/can work system, e.g., doctor-to-doctor conversations	---
MSMC- TC Patient	Bundle of pre-admission resources including insurance/med mgmt/job/CM etc.	Patient is self-advocate/engaged in treatment	Patient is motivated/compliant/help-seeking

Table 2 : Interorganizational Collaboration: Barriers and Channels to Behavioral Health Services Utilization

	Barriers to Collaboration from…to…
	Diagnosis and Assessment →Environmental Scan
Levels	
Community Agency	---
(targeted)	
MSMC- TC Administration	[Field notes morning meeting 8/16/13]. Social worker J and the director of nursing S. talk about observation status at morning meeting. I overhear that SCM (the computer program that records patients and the main system weren't communicating so that the observation status wasn't showing up (and therefore the report didn't contain patients under observation status). This is problematic because it means that the observation status patients aren't being converted with the 48 hour window they are supposed to be converted, and must therefore be discharged whether or not they are ready to go, S. notes. J. adds that it matters for Medicaid and reimbursement [Field notes morning meeting 8/16/13]. R. is a 47 year old with chemical dependency. J: he needs to meet acute criteria to be converted…but we can't because we've exceeded the 48 hour period. Charge nurse: He's on a Librium taper and seems to be hallucinating. Dr. C. notes that his doctor kicked him off rolls because he wasn't going to use again and then did. Dr. M: he has the same presentation day after day. They discuss the case and what to do with him. Where will he go? C: the methadone clinic. Social worker MR: ok yeah.
MSMC- TC Practitioner Team	[Field notes morning meeting 6/26/13]. Before the morning report occurs there is a conversation about observational status versus inpatient. The director of nursing S. and Dr. P. exchange remarks. He says he doesn't know the rule really. I note that the conversation is about a male patient who is detoxing from opiates. S. says that he should be on observational status which lasts for 48 hours. Then if the doctor wants him to stay on for a longer time, they can change the status to inpatient. She says, make them all observational status and then convert them. P. smiles and says oh really? in a way that rebuffs the presumption just slightly. Social worker J. intervenes and remarks that it is largely a moot point since the patient doesn't have insurance
MSMC- TC Patient	[Interview psychiatric nurse D 4/21/13] D: In order to make a referral you would need to know…M:…what kind of family support there is? D: right you've got the ingress and the egress. So the ingress is something severe a crisis. If it's psychiatric, if it's detox, you know what holds up a referral all those times are those psycho social things, those, ah, all those poverty indicators and the homelessness and so that's ah you know the ah thing that stops the referral in its tracks. Prior to the referral we can have all kinds of great ideas but so what? Either they're not available or if you look at the way that it's set up on the floor they rely on almost pro forma a couple things: the IOP where I'm at whether it's in Augusta or Waterville. So it is, it's almost like we don't have to think here.

	Channels to Collaboration from…to…
	Diagnosis and Assessment →Environmental Scan
Levels Community Agency	---
(targeted) MSMC- TC Administration	[Interview care management supervisor D. 2/14/12]MSMC- TC is a pretty good size institution with a large behavioral health services department both inpatient and outpatient generally because we serve everyone and almost in everyone in every behavioral health program irrespective of ability to pay, that makes all the difference in the world. For people who live in our catchment area. At the same time that tends to be true throughout the state for hospital-based services outpatient based services connected to a hospital because all hospitals receive grant monies to cover indigent patients or patients who don' t have insurance. So people who don't live in this geographic area we can usually connect folks with no insurance or who are under insured to behavioral health services connected to other hospitals throughout the state. So that is huge and makes all the difference in the world. That's how we can make a difference in setting up services for those kinds of patients
MSMC- TC Practitioner Team	[Field notes patient consult 8/16/13].Dr. C to patient R.: we have a note here from 2012 from Dr. T (one of the unit psychiatrists). You saw him and in the rehab for 3 days. Is that typical? R: Yeah, three days and I'm fine…Librium helps a lot. Dr. C. says to social worker J. that patient R.'s on observation status is it observation or inpatient? He scored a 6 on the CIWA… she remarks. Before she continues, he turns to R. and explains that he shouldn't worry, this is a real admission. We'll keep you 24 hours or if need be 72 to take care of you. J. notes again that he scored a 6, yeah, that's a real admission, she remarks. Croswell explains to R. that the issue of the observation status was about Medicare and how particular they are about reimbursement. He's quick to assure R. that he'll be taken care of…he's scored a 6 on the CIWA so they'll take that as an indication that he is an acute patient.
MSMC- TC Patient	[Field notes morning meeting 10/1/13]. Laura is a 56 year old with depression – bi polar. Dr. M: where is she going… and where has she been? Nurse K.: we're looking for placement in a shelter. M: That would be awful she'd do terrible there. Social Worker D: she has a home, she had a case manager…her daughter has been trying to get her into a shelter... Social Worker N: the case worker from Catholic Charities is expected to come today . [Field notes patient consult 9/10/13]. Social Worker M to patient: how long have you been with your therapist? Don A he moved so far…those guys you can't bullshit them, Larry …every Tuesday…M: You have a case manager at Catholic

	Charities. I just wanted to call her to let her know you are here. Does he need to see a doctor? He sees Dr. W at Cedarvilleclinic.

Table 3 : Interorganizational Collaboration: Barriers and Channels to Behavioral Health Services Utilization

	Barriers to Collaboration from…to…
	Environmental Scan → Service Referral
Levels	
Community Agency (targeted)	[Field notes observations 4/30/13] Social worker J. and I have a conversation about a call she is making. It's a provider she doesn't name but then she talks about the same issue with regard to [our] Dr. M.'s office. Apparently with both (and others as well) she makes calls and asks to set up appointments and then doesn't hear back from them. This irks her immensely. The problem as I understand it is that they have to have a patient set up with an appointment before discharge if that is part of the treatment plan. This issue has arisen even recently with the Medicare mandate that her supervisor D. remarked on last month [see notes]. So we call the provider J. tells me and they don't call back. I'll leave a message that I called twice before and will they please get back to me. I even leave the patient's name and information and still they do call. Maybe I should go work for them for a day and I'd appreciate how busy they are. But for now it really tics me off that I all and leave a voice mail with the patient's name and discharge information requesting a date and they call back and leave a message on my vmail saying give us his name and discharge date and we'll set up an appointment. She looks at me to see if I get how irksome the process can be. M.'s office is the worse, she complains (because he is one of our psychiatrists at the hospital).
MSMC- TC Administration	[Field notes observations2/2/2013] At 7:45 I arrive and care management's supervisor D. is telling everyone ASP gave us no notice…all IOP referrals need to be preauthorized. M. failed on the appeal, so the state expects preauthorization on all SA and MH IOP referrals. ASP wants all kinds of information. It's very cumbersome. SC was involved. We'll need to politely and passively resist it. The bottom line is when we have to do it we'll each do our own patients. For example, we need to enter IOP treatment plan info which of course we don't know beforehand and we can't even know if they'll go to the IOP. D. continues that this DHHS state ruling on ASP is in effect as of February [ASP is contracted with the state's Department of Health and Human Services to provide a Behavioral Health Utilization Management System]
MSMC- TC Practitioner Team	[Interview psychiatric nurse D. 4/21/13]. You know really the satisfaction on that floor from every other floor has changed dramatically…and the floor, they don't really like the docs except for Dr. C. M: Cause they're hard to work with or they have different goals… they…? D: I think they don't just take the time to get to know the folks and figure out what they need which leads into a referral. You don't just turn around and go that's just not my role. [Interview psychiatrist P. 6/27/13]. P: I do think that the leadership has to be clearly defined here because sometimes…I know [Dr. C.] is ultimately the leader, but I don't know if that is always clearly defined at the level of the attending. When I

	first got here…PM [another doctor] doesn't always take the role of the leader…you'll see [the director of nursing], who's not an MD directing him, and social workers sometimes directing him…He's… has the title of MD and the other day he was planning on keeping a patient and then a couple people said well he really needs to go and he said well maybe we can get him out…And that never would have happened…it's just strange. He did the training he went to school, he should be able to come up with a plan. So, I thinks that's *weird*…but … I think that's something I would work on if I was here really trying to make sure the tone is set, where the physicians really are the physicians…it feels like social work sometimes steps into the role of clinical management. And they're not trained to be clinicians.
MSMC- TC Patient	
	Channels to Collaboration from…to…
	Environmental Scan → Service Referral
Levels	
Community Agency (targeted)	[Interview social worker N. 11/7/13] M: Do you know who, you might not know this, but do you know who the hospital has service contracts with?N: Yeah I don't think we have service contracts with any local agencies. Ahm we do work closely with all of them but there's not a financially invested interest. As a matter of fact I think we do not intentionally have those service contracts…N: I think if we had a service contract the one I could think of would be CC because they are the only regional mobile response triage unit. They own that contract for K. and S. counties…I'm not sure how it works but our hospital needs to have a service contract with their agency to come in to our emergency room and do the evals. We make a special space for them in the emergency room. They have their own office
MSMC- TC Administration	[Field notes patient consult 5/27/13 – team visits one of the unit's psychiatric nurse C.'s patients on the unit] Dr. P:…but pills won't solve your problems, finding someone who can do the DBT, not some preppy, I went to school with a bunch, you need someone who knows their stuff… H. thoughts? H: there's a DBT group in C.'s office A: I can't do it every day, I need less intense, I hate groups… she can't do daily DBT but she can do C.'s group that meets periodically. She seems willing to do that and to stay for a few days to see if P. can stabilize her.
MSMC- TC Practitioner Team	[Field notes morning meeting 6/26/13]. Patient D. is a 56 year old with chemical dependency. Charge nurse M: Donna comes to us with chemical dependency. She is on Xanax. She drinks ½ gallon of vodka a week. Was cooperative. Is on a CIWA q2 and on CO for oxygen. She has an eating problem… and is connected with E. (the vice president of the behavioral health division of the hospital). Dr. M, is her psychiatrist. Dr. P. argues that Xanax can't be used during CINA. Why is she on

	Xanax? Pause. There is talk about how E. is connected to her…friend or something. More silence. Everyone agrees to let the director of the unit Dr. C. deal with this particular case because of her connections with the hospital VP. [Interview social worker N. 11/7/13].M: What are the easiest referrals? N: The easiest referrals, I don't know if I'd call them referrals, are just re-scheduling with their providers. The folks that are already established. Easiest referrals also…just because we are already familiar with the services of those who are in Kennebec and Somerset counties. We have strong networks with them already. Some of the services are more predictable than others. The toughest one to get is medication management. M: Oh really..why is that? N: So few providers.
MSMC- TC Patient	[Field notes patient consult 7/29/13]. Social worker M: it's about what your are committed to…a once a week session with Lisa isn't going to do it. Patient K. cries a little. I'll do anything I'm at a place where I'll do anything. They explain how she needs to be willing to do intensive care. M: what can I do to help? K: I want somewhere with a licensed alcohol counselor. M. recommends a step situation, hospitalization intensive outpatient then individual therapy.

Table 4 : Interorganizational Collaboration: Barriers and Channels to Behavioral Health Services Utilization

	Barriers to Collaboration from…to…
	Service Referral → Service Utilization
Levels	
Community Agency (targeted)	[Interview social worker MR. 11/17/13]. But I think more than anything there is no immediacy in any of the services. For example if I have a homeless person I can't always get them into a place to stay. If I have somebody that needs treatment I can get them an intake that takes them several weeks and then the treatment bed will be offered to them 6 weeks after that. The lack of immediacy …and with some of the patients it is so important to strike when the iron is hot. Because if you put people back out in the same circumstances they came from they're gonna do the same things they were doing. And then they can't or won't change
MSMC- TC Administration	[Interview psychiatric nurse D.4/21/13]. D: … our length of stay is…I mean it fluctuates it's up and down. But, I think if anything I get pressure from, well social work because I think social work has different standards on length of stay. Because they see length of stay as an indicator of how well *they're* doing. So you can see the competing contention. And you can hear it in the morning…at meeting
MSMC- TC Practitioner Team	[Interview social worker K. 1/7/12]. K: So…you find an elderly person with dementia and they're stuck on the unit and think what the hell am I going to do with this person. And you're trying to find them a place to live and you're under all this pressure to get them out. You've got… the other thing I hate about this…is that you have all this pressure to get them out. And what am I going to do with them…I feel all this pressure around E. what am I going to do with him?
MSMC- TC Patient	[Interview social worker MR. 11/17/13]. MR: And then a lot of times they don't have transportation. M: So transportation can be a problem. MR:…a huge issue, ahm, money for services is a huge issue… M: How do you deal with that? MR: Yeah so a lot of times you can't find that and with no insurance, so you send them to AA, if they need mental health treatment you send them to a counselor with a sliding fee, though those a few and far between. If you have a patient with Medicare and they are barely…they are low income…sometimes those people end up going without services. Because they can't afford the co-pay.
	Channels to Collaboration from…to…
	Service Referral → Service Utilization
Levels	
Community Agency (targeted)	[Field notes morning meeting 7/29/13]. D. is 55 with psychosis. He's voluntary no guardian. Psychiatric Nurse D: Capital Manor came to see him. Social Worker D: N. thought they might take him. T: It's right on State Street, used to be a locked facility. There is a conversation about getting him to the facility.

	[Field notes morning meeting 7/29/13]. A. Is a 39 year old male with chemical dependency who is voluntary no guardian. He's anxious and depressed. He's on a CIWA q4 when awake. T: he's leaving Thursday morning…His case manager is coming….he's going to the Manor.
MSMC- TC Administration	---
MSMC- TC Practitioner	---
Team	
MSMC- TC Patient	[Field notes morning meeting 6/26/13].Patient B. is a 56 year old female with schizoaffective disorder. She is nonacute Mike observes. Then he explains how she called someone from Old Stone Manor yesterday and they came out with paperwork to get her housing there. Everyone laughs because no one knew she was doing so at her own behest.