Care Management and Behavioral Health Integration

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Statewide Healthcare Innovation Plan

PCMH Transformation Team – *Learning Collaborative*
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Step Ladder of Care

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Care Management (CM)

Access

Care Management Program

Time

Technology

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Elements of Best Practice

- The following are CM/Care Coordination (CC) elements of best practice:
  - Evidence-based elements:
    - Risk stratification
    - CMs in the primary care practice or at least connected to the team and patient record
    - Face-to-face interactions with CMs and their patients on a regular basis
  - Health Information Technology (HIT) to support clinical team and interact with patients

Elements of Best Practice (continued)

- The following are also CM/Care Coordination (CC) elements of best practice:
  - Strong link between behavioral and physical health
  - Emphasis on medication management
  - Comprehensive, planned, and evidence-based programs for transitions of care involving multi-disciplinary teams
  - Recognition of the impact of social determinants of health and not solely using clinical health assessments
  - Efficient use of the “right staff” at the top of their license
  - Having a team approach

Elements of Success: The Process

1. Identification of patients with the most complex medical needs through some type of risk stratification:

- By disease:
  - Chronic Heart Failure (CHF), Coronary Artery Disease (CAD), diabetes, Chronic Obstructive Pulmonary Disease (COPD), Serious Mental Illness (SMI) , Hypertension (HTN)*

  **Can be managed through evidence-based guidelines*
- By utilization:
  - Prior hospital and emergency department (ED) use
- By other risk/social determinates**

  ***Important to not just look at past utilization, but also at current social factors and live situation as well as disease management*

Elements of Success: The Process (continued)

2. Individualized care plans (and eventually integrated care plans):

- Patients and their families involved in the development of individualized plans
- Plans should address the following:
  - Medical
  - Behavioral health (BH)
  - Environmental
  - Functional needs
  - Goal setting

Elements of Success: The Process (continued)

3. Care managers' face-to-face interactions with their patients on a regular basis:

- At least monthly
- Can be augmented by telephonic contacts occurring between face-to-face meetings

Note: Telephonic interventions unlikely to move the dial

Elements of Success: The Process (continued)

4. Care managers' direct interaction, development of a strong rapport with their providers, and team-based approach to patient care:

- Should act as a communications hub across providers and between patients and their providers
- Should also ensure that Primary Care Providers (PCPs) have all relevant external data on their patients

Elements of Success: The Process (continued)

5. Care managers *embedded in – or staff members of* – primary care practices and have access to patients' Electronic Medical Records (EMRs):

- Hospitals should notify CM when patients visit the ED or are hospitalized
- CMs should interact directly with patients during their hospital stays and physician office visits and have access to the discharge planner and a pharmacist who can assist with medication management

Elements of Success: The Process (continued)

6. Strong emphasis on medication management:
    - Two components:
        - Evidence-based
        - Electronic physician medication orders with care to avoid drug-drug and other dangerous interactions
    - Using behavior change techniques and patient education to improve adherence

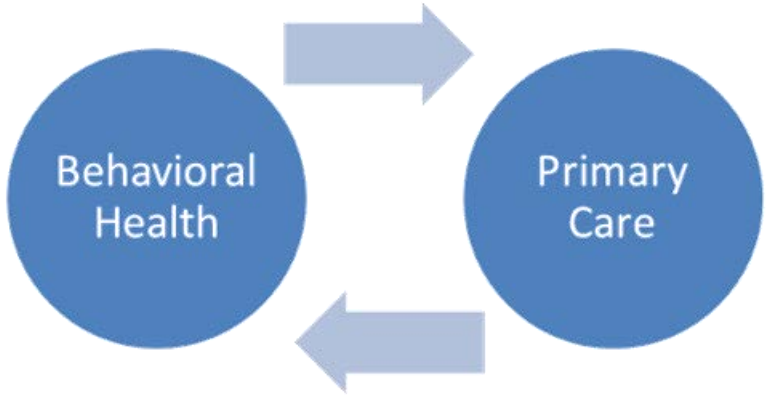
Elements of Success: The Process (continued)

7. Transitions of care are carefully and comprehensively planned:

- Discharge planning should start well before discharge
- Follow-up should include educating patients about early symptom spotting, dietary advice, medications, social services, and self-management
- Intense home assessment for patients with asthma to identify triggers and avert flare-ups

Elements of Success: The Process (continued)

8. Strong linkages between behavioral and somatic health:
   - Emphasis on making PCPs aware of danger signals and the need for referrals to BH specialists
   - Encouragement for BH providers to ensure that their patients are getting proper treatment for physical conditions that are prevalent in individuals with SMI



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Elements of Success: The Process (continued)

9. Assessment and recognition of impact of social determinants of health. Also, incorporation of social services into the healthcare delivery model:

- Health Risk Assessments (HRAs) should include the following:
  - Transportation assistance
  - Transitional housing
  - Language services
  - Family preservation for young parents
  - Employment assistance, where appropriate

Elements of Success: The Process (continued)

10. Health Information Technology:

- Provides registries for population management and care management tools
- Facilitates contact with clinicians and provides information support to clinicians in real time as they see patients
- Provides patient-accessible portals

Elements of Success: The Process (continued)

11. Care management fees that are at risk, depending on outcomes:

- Payment incentives for the whole care team when outcomes are achieved (moving towards global payment and risk/gain sharing)
- Care management costs controlled to the extent possible
- Strategies include ensuring that staff work at the top of their training, and incorporate the services of non-Registered Nurse and non-Licensed Social Worker staff

Elements of Success: The Process (continued)

12. Interaction with other care facilities/programs which patients may be transitioning to or from:

- Long-term care, Community Health Workers (CHWs), Public Health Nurse (PHN), group homes, Assertive Community Teams (ACT)
- Establish rapport for communications and hand-off of patient's information
- Understand their programs

Elements of Success: The Process (continued)

13. Effective management of chronic conditions in a primary care setting

Jack Meyer, 2014

Introduction to CM/CC Tools and Skills

- CM checklist
- HRA
- Registries
- Care plan
- Relapse prevention/maintenance worksheet
- Protocols
- Communication tools
- Motivational interviewing (MI)
- Behavioral Activation (BA)
- Patient engagement and self-management
- Shared decision-making (SDM)

CM Checklist

- Building rapport with the providers and care team
- Work flows, roles, and hand-offs
- Understanding protocols, guides, and any standing orders
- Care plans and where to document contacts and visits
- Part of Team Huddles
- Contingency plan
- Comfort with patient engagement techniques
- Community resources and connections

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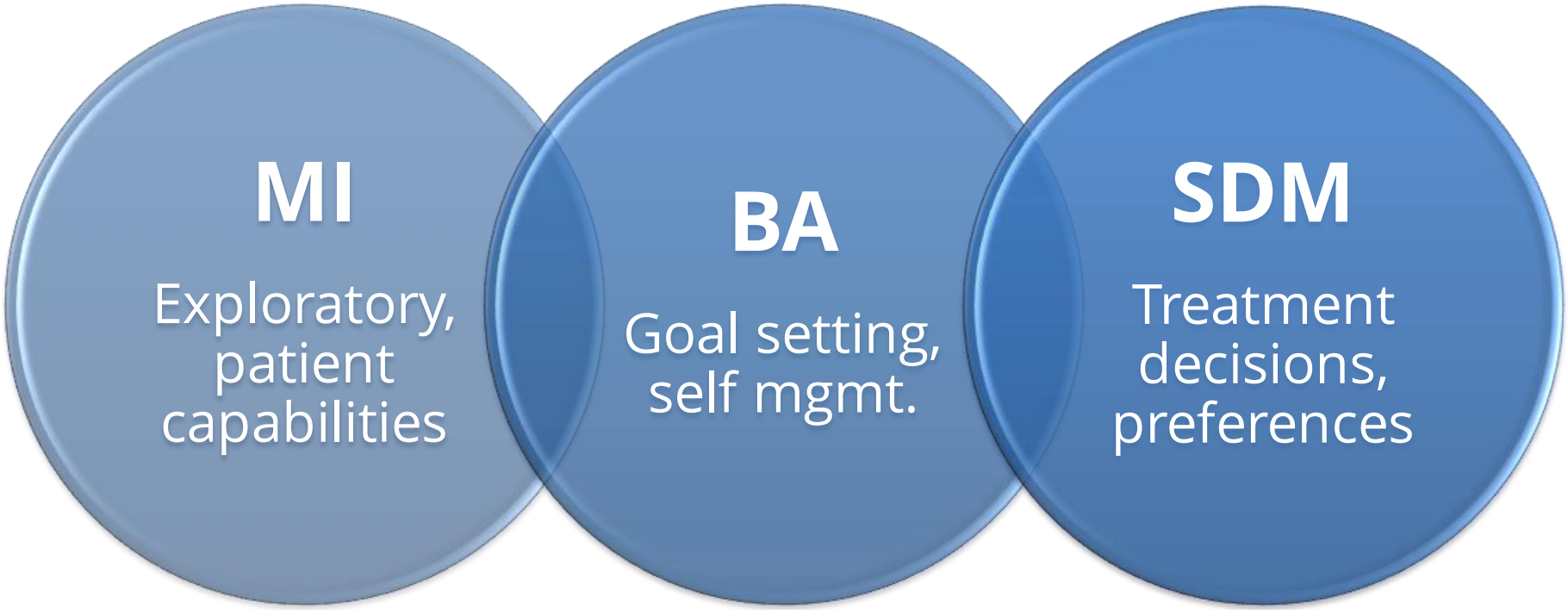
Patient Engagement and Self-Management Support



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PCMH BH Terms

Integrated Care

- Addresses physical and BH conditions concurrently in various settings
  - Primary care
  - Community mental health centers
  - Inpatient
  - EDs

PCMH BH Terms (continued)

Collaborative Care

- Often used interchangeably with the term *integrated care*
- How we interact with other disciplines
- Sometimes used as shorthand for the Collaborative Care Model

Behavioral Health

How many of these people with BH concerns will see a Mental Health Provider or receive needed treatment?

Wang P, et al., Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005

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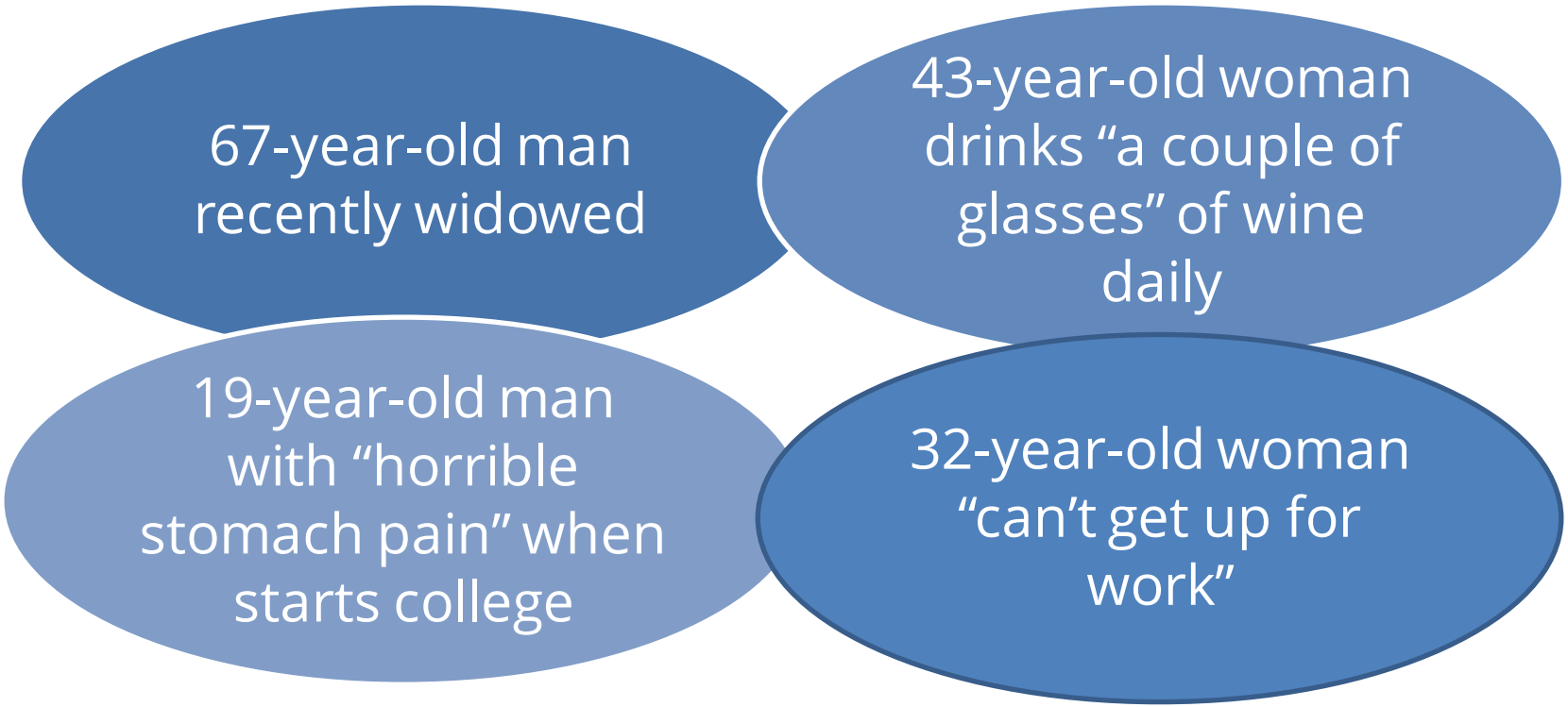
Behavioral Health (continued)

What does a BH patient look like in the primary care setting?



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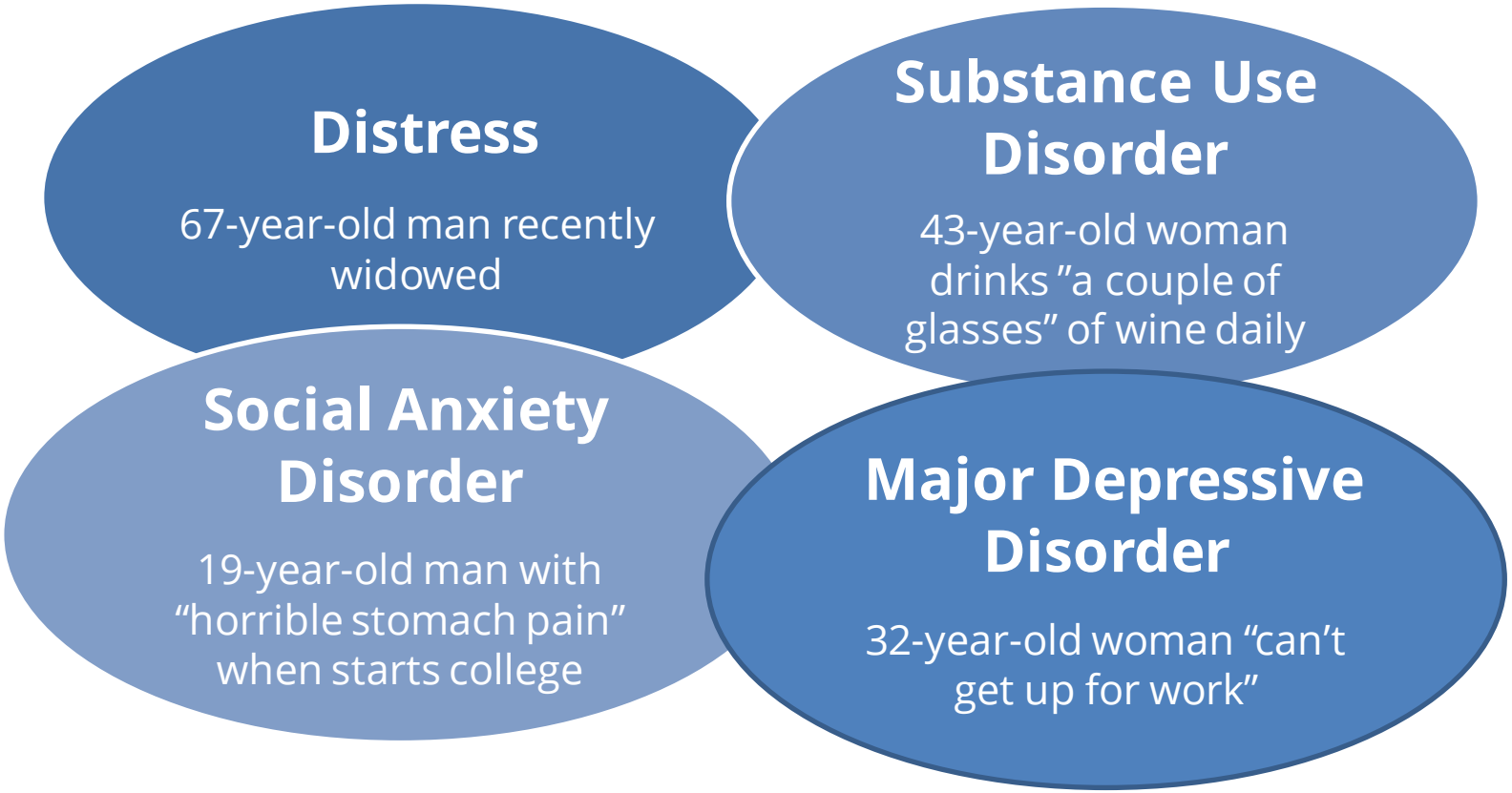
Behavioral Health (continued)

What is the actual issue at the end of the visit?



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Need for Integrated Care

- Depression
  - One of the top 10 conditions driving medical costs
  - Ranks seventh in a national survey of employers
  - Greatest cause of productivity loss among workers
- Type 2 Diabetes
  - Presence in a person nearly doubles an individual's risk of depression
  - Estimated 28.5% of patients meet the criteria for clinical depression

Need for Integrated Care (continued)

- Back/neck and other chronic pain also have a significant depression/social anxiety (SA) component
- Of all patients with a BH disorder, 80% will visit primary care at least one time in a calendar year

Sources:

Chen et al., *American Journal of Geriatric Psychiatry*. 2006; 14:371-379.

Gallo et al., *Annals of Family Medicine*. 2004; 2:305-309

Melek S. et al., *APA 2013* www.psych.org

Unutzer et al., *JAMA*. 2002; 288:2836-2845.

Walker, E.R., McGee, R.E., Druss, B.G. *JAMA Psychiatry*. Epub, doi:10.1001/jamapsychiatry. 2014.2502

Wang P, et al., "Twelve-Month Use of Mental Health Services in the United States," *Arch Gen Psychiatry*, 62,, June 2005

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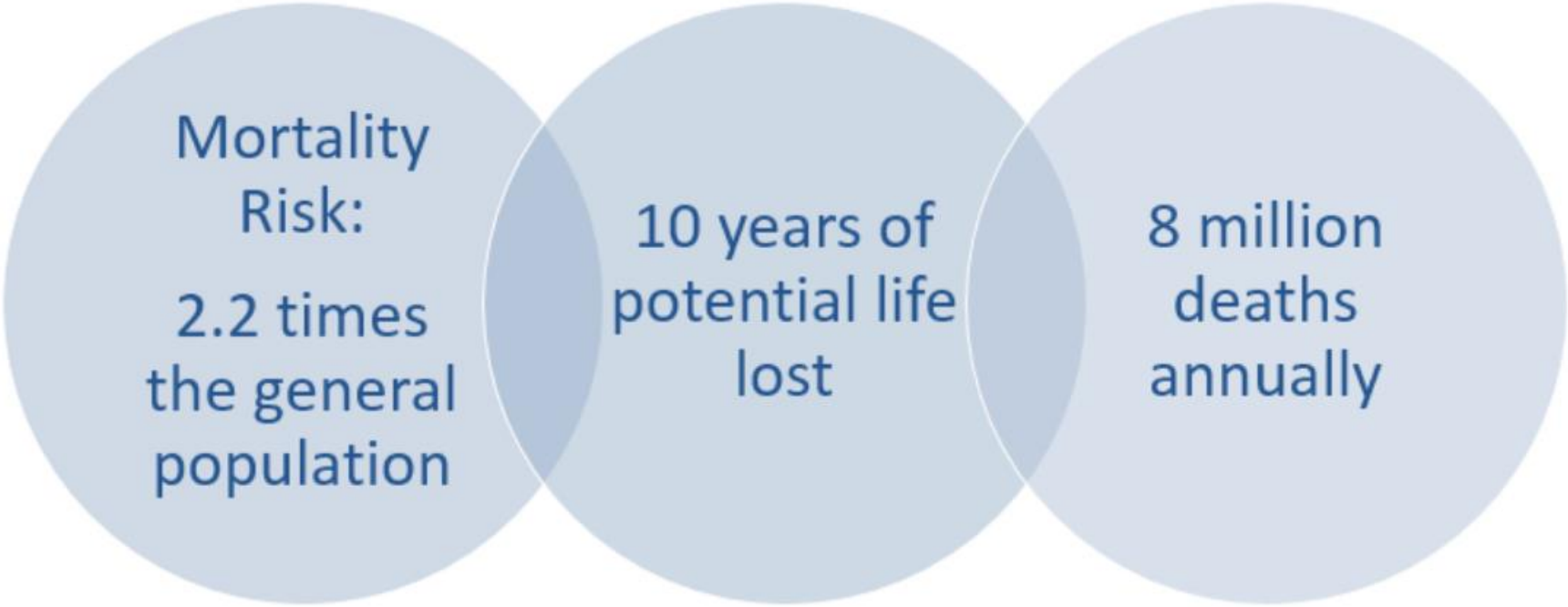
Mental Illness and Mortality



Walker, E.R., McGee, R.E., Druss, B.G. *JAMA Psychiatry*. Epub, doi:10.1001/jamapsychiatry.2014.2502

Annual Per Person Cost of Care

Patient Groups	Annual Cost of Care	Annual Cost with Mental Condition	% Increase with Mental Condition
All Insured	$2,920		
Arthritis	$5,220	$10,710	**94%**
Asthma	$3,730	$10,030	**169%**
Cancer	$11,650	$18,870	**62%**
Diabetes	$5,480	$12,280	**124%**
CHF	$9,770	$17,200	**76%**
Migraine	$4,340	$10,810	**149%**
COPD	$3,840	$10,980	**186%**

Source: Cartesian Solutions, Inc. – Consolidated Health Plan Claims Data
Melek S et al APA 2013 www.psych.org

Idaho's Mental Health Burden

- **22.%** of persons aged 18+ experience mental illness.
- **5.8%** of persons experienced SMI in 2008 and 2009.
- **7.5%** of persons aged 18+ experienced a major depressive episode (MDE).
- **9%** of persons aged 12 to 17 reported past MDE.
- **SUICIDE** is the SECOND leading cause of death for Idahoans aged 15 to 34, particularly males 10 to 14.

Clinical Quality Measure Workgroup (2015)

Levels of Integration

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 Systems Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/Merged Integrated Practice

Center for Integrated Health Solutions. http:integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf. Accessed July 19, 2014.

Models of Integrated Care

1. Coordinated:
    - Screen patients for BH problems
    - Coordinate approaches with PCP and BH specialists in separate facilities
    - Work together through phone or e-mail or provide an online service to provide BH advice to PCP

… limited effect, but a start …

Models of Integrated Care (continued)

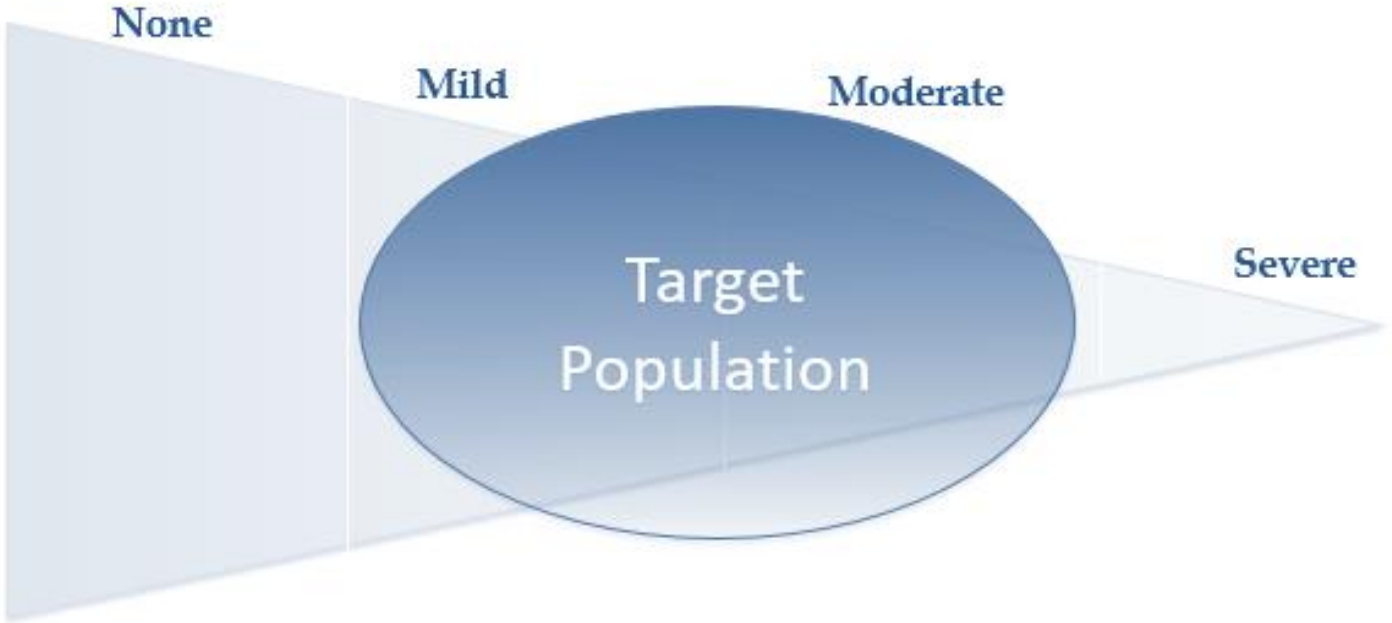
2. Co-located:

- PCP and BH specialist work in same facility and together to varying degrees
- Referrals are provided back and forth
- May have patient huddles and send each other information about shared patient
- Does not naturally promote full sharing and integration of systems

Models of Integrated Care (continued)

3. Integrated:
    - BH specialists within PCP facility and system
    - Team approach to co-management
    - Integrated care plan
    - One Electronic Health Record (EHR)
    - One billing system

Importance of Early Detection



- Issues with depression and substance abuse must be pre-empted, rather than treated once advanced
- Goal is to detect early and apply early interventions to prevent from getting more severe

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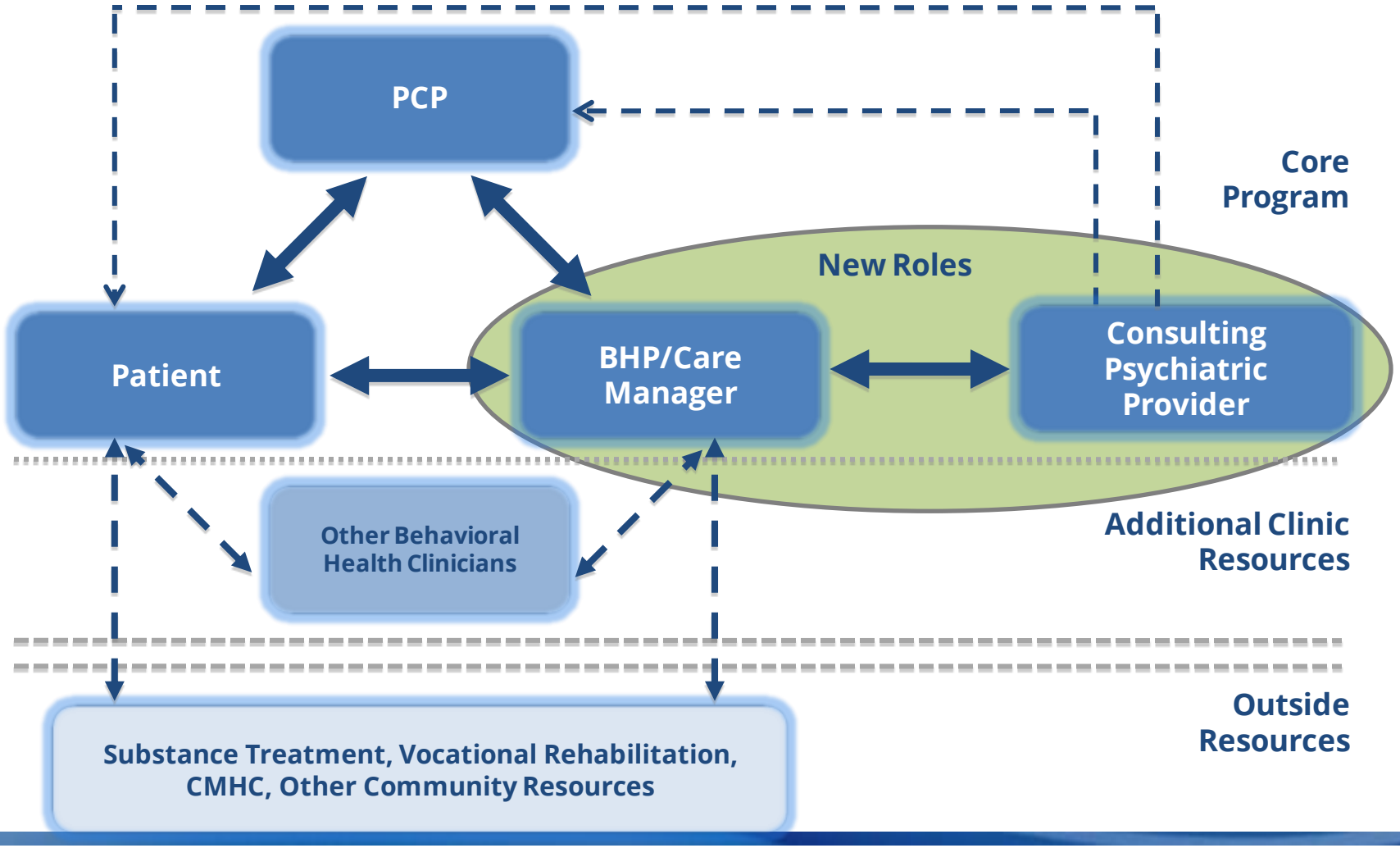
Collaborative Team Approach



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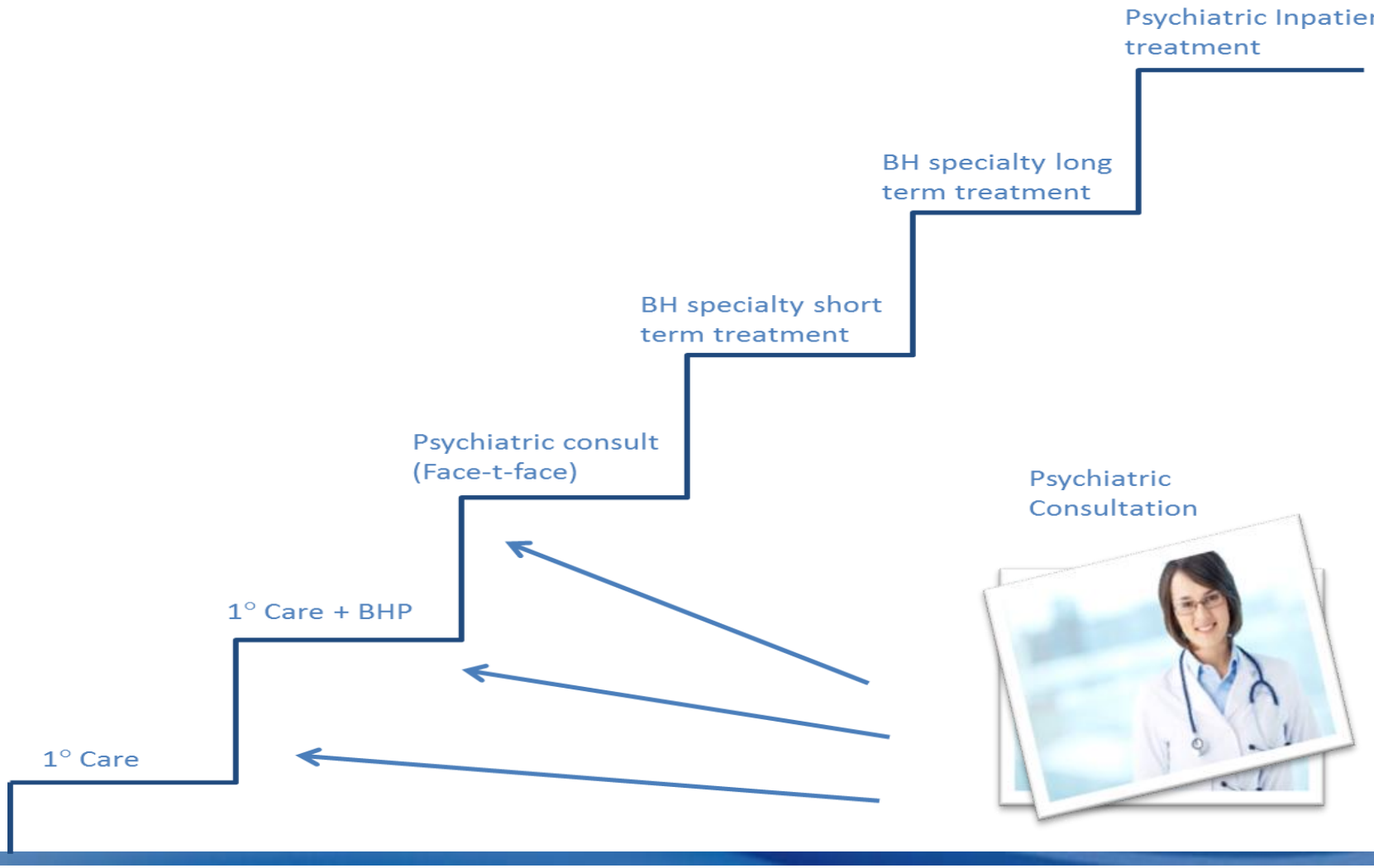
Stepped Care Approach



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Discussion/Gap Analysis

- Where is your clinic currently in meeting the five Core Principles?
  - Team-based
  - Evidence-based
  - Measurement-based
  - Population-based
  - Accountable for the care delivered

"Nothing About Me … Without Me"

- Don Berwick

Question/Answer/Discussion

Do you have any questions or comments that you would like to share?