

HEALTH MANAGEMENT ASSOCIATES



Integrated Primary and Behavioral Health Care Management

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AGENDA

- ☐ The CoCM: Embedded in a PCMH Practice Context
- ☐ CoCM and Care Management:
 Critical New Team Roles
- ☐ Care Manager Core Competencies: Who Can Do It?
- ☐ From Concept to Reality: How Do You Adjust Your Practice Team?

PCMH PRIME Elements to be discussed:

- B1 or B2: Coordinating or Integrating with BH Providers
- C1: Practice has a Care Manager qualified to address BH needs
- F1: Practice has a process for identifying patients for care management that includes BH

■ KEY COMPONENTS OF THE COLLABORATIVE CARE MODEL



Informed,
Activated Patient



Measurement-based Treat to Target

Effective Collaboration





PCP supported by Behavioral Health Care Manager



Psychiatric Consultation



Caseload-focused Registry review



Training

PCMH PRIME CRITERIA, COLLABORATIVE CARE AND CARE MANAGEMENT IMPLICATIONS

PCMH PRIME Element A: NCQA PCMH Prerequisite Transformation to team-based care and population management are pre-requisites

CoCM: Transformation to team-based care and population management are foundational



Criteria: Coordinate with Internal or External BH Providers, Track Referrals

CoCM: Clearly define the roles of all team members, including stepped model for integrated care. Use registry to track all outcomes including referrals.



PCMH PRIME Element C: The Practice Team

Criteria: BH Care Manager in practice;
Provider for MAT

CoCM: Care Manager role includes brief intervention and registry tracking. Stepped Model helps define roles.

PCMH PRIME Element
D: Comprehensive
Health Assessment

Criteria: Practice regularly screens patients for diverse BH history and

CoCM: Practice regularly screens patients for range of BH conditions, sets goals based on results and does repeated screenings to measure progress toward target

PCMH PRIME Element E: Evidence Based Decision Support Criteria: Implements evidence-based clinical decision support for MH

CoCM: Model is evidence based, interventions tied to outcomes



Criteria: Practice's process for identifying patients who may benefit from care management includes considering BH needs

CoCM: Registry used to track values from screenings and identify patients for follow-up and intervention over time



CORE CoCM TASKS BUILD ON A PCMH FOUNDATION



■ COMMON TOOLS AND APPROACHES: PCMH PRIME AND CoCM

- ♣ Population health management
- **★** Registries
- ★ Care alerts and tracking systems
- ♣ Care plans used by integrated care team
- ♣ Protocols and treatment guidelines
- ♣ Self-management skills and tools
- ♣ PCMH team-based processes of care (e.g., huddles, systematic case reviews, etc.)
- ★ Measurement-based care with standardized tools, consistent methods
- + Care manager role



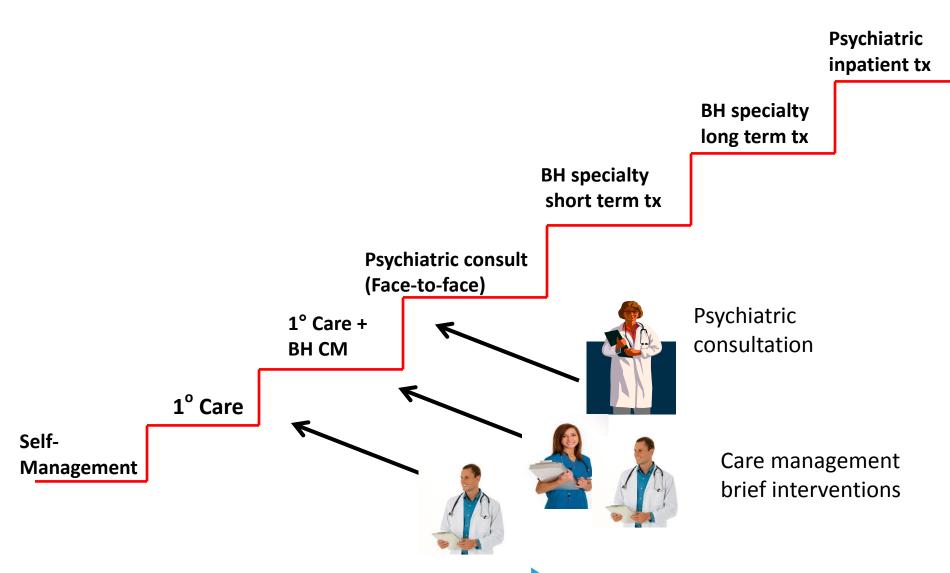
ADDED DIMENSIONS: THE CoCM MODEL FOR BH INTEGRATION

- **★** Measurement/monitoring
 - → BH screening/ data elements/use of registry
- **+** Stepped care approach
 - ♣ Intensify/modify based on BH supports/treatment needs
- **+** Self-management skills
 - ♣ Focus on recovery and relapse prevention
- + Care manager
- **★**BH care planning, care coordination, brief interventions
- Consulting psychiatrist
 - + Caseload review and primary care team support

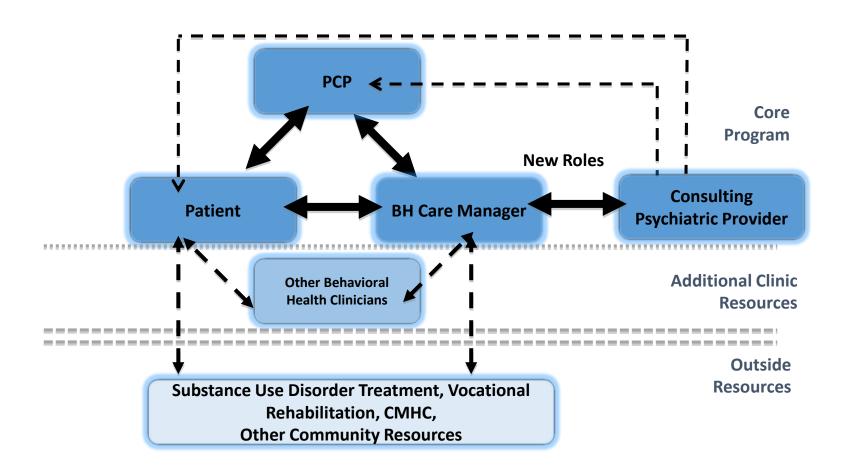
^{*}Based on the Collaborative Care Model for depression by Wayne Katon, MD and the IMPACT study by Jurgen Unutzer, MD as well as numerous other controlled trials.



■ OPERATIONALIZING THE CoCM – A "STEPPED CARE" APPROACH



■ CoCM DISTINCTIONS – THE TEAM ROLES AND RELATIONSHIPS





■ SHIFTS IN THE PRACTICE TEAM, ENVIRONMENT, PATIENT/CLIENT EXPERIENCE

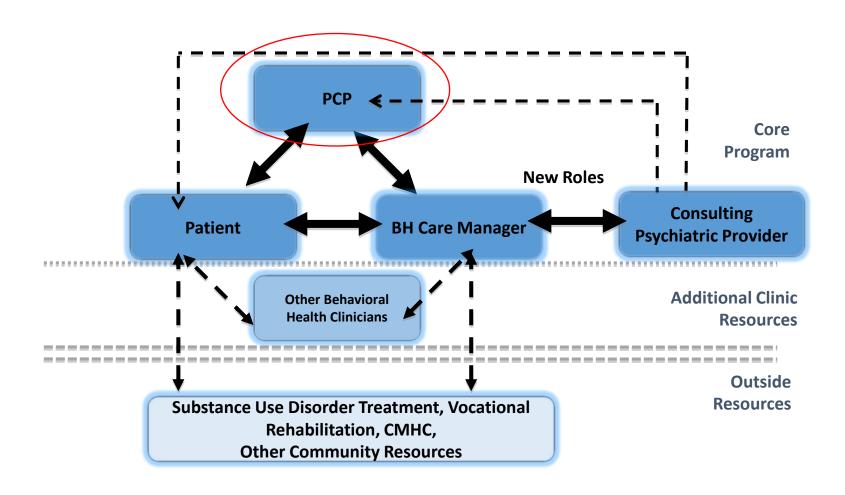
- +Scope of care management
- ♣ Nature of care coordination e.g., internal, external
- + Consultation roles and processes
- ♣ Incorporating brief BH interventions in primary care/care management workflow
- ♣ Patient/client expectations and engagement



■ STEPPED CARE: REQUIRES THE RIGHT PEOPLE IN THE RIGHT ROLES

- **★** With fidelity to the CoCM, key care management functions and roles must be part of a practice-specific blueprint involving:
 - ♣ BH care manager
 - **→** BH provider
 - ♣ Primary care provider
 - **★** Consulting psychiatrist
 - ★ Telemedicine (as appropriate)
- **★** Consider what it takes to achieve true BH integration into primary care
 - ♣ A significant number of your practice panel has co-occurring physical and mental health/substance use needs that are not identified or adequately addressed. Integration will help to better identify and address their existing BH needs
 - ★ The size and nature of your practice will determine your blueprint, e.g., Who serves in the BH care manager role? Can one care manager provide complex care management including for BH? Is your consulting psychiatrist accessible via telemedicine?

■ CoCM DISTINCTIONS – THE TEAM ROLES AND RELATIONSHIPS





■ ENHANCED ROLE OF THE PRIMARY CARE CLINICIAN

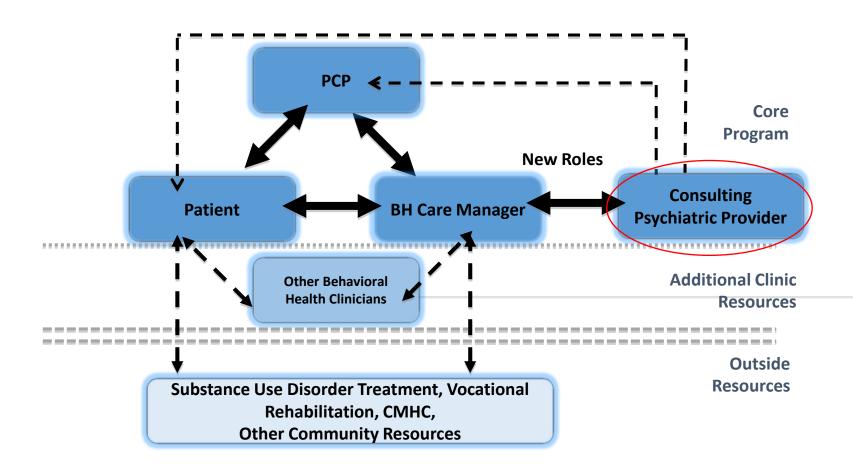
 Provide usual medical care with sufficient psychopharmacology knowledge



- Identify individuals who need BH support and engage them in the treatment model
- ◆ Collaborate and consult with psychiatric clinicians (behavioral health provider and/or psychiatric consultant) to enhance BH care
- Utilize screening tools to track progress related to BH (e.g., PHQ-9)
- Involve BHP and tiered workforce for chronic disease selfmanagement techniques



■ CoCM DISTINCTIONS – THE TEAM ROLES AND RELATIONSHIPS





INEW ROLE OF THE PRACTICE CONSULTING PSYCHIATRIST

Timely Consultation (for Patients/Panel/Team)

- Diagnostic dilemmas
- Education about diagnosis or medications
- Complex patients, such as pregnant or medically complicated
- Pattern recognition
- Education
- Build confidence and competence

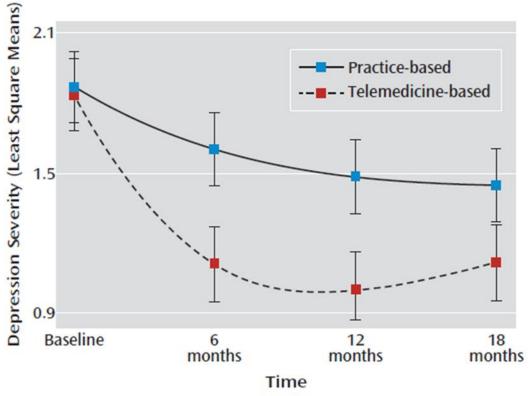
Caseload Reviews

- Scheduled (ideally weekly)
- Prioritize patients that are not improving – extends psychiatric expertise to more people in need
- Make recommendations –
 PCP may or may not implement



EXPERIMENTING WITH TELEMEDICINE FOR CoCM WHERE RESOURCES ARE LIMITED

FIGURE 1. Adjusted Depression Severity Scores for Patients Receiving Practice-Based or Telemedicine-Based Collaborative Care^a



^{*} In this study, practice based means depression care delivered by onsite PCP and nurse care manager, no mental health providers present. Telemedicine based means depression care delivered by onsite PCP and tele-medicine based team.

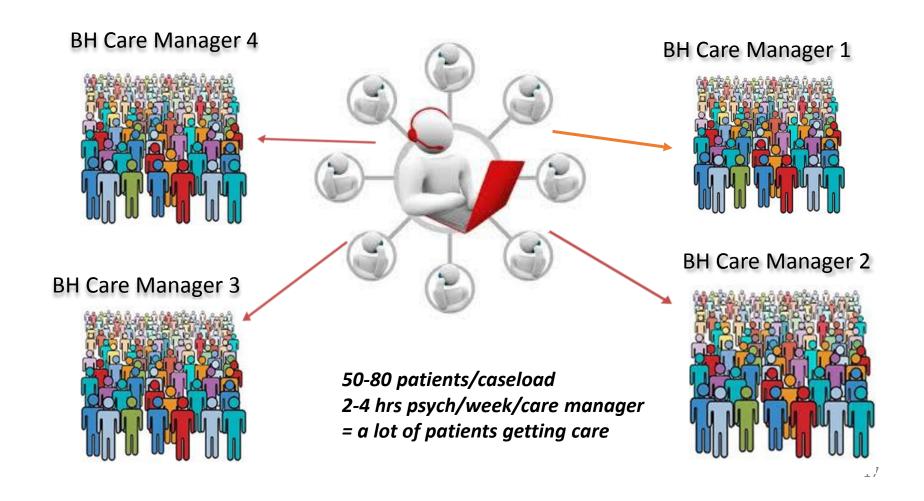


+ Telemedicine-based team:

- ♣ Nurse care manager phone
- Pharmacist phone
- ♣ Psychologist CBT televideo
- Psychiatrist televideo if did not respond to 2 antidepressants
- Weekly whole team met to make recommendations

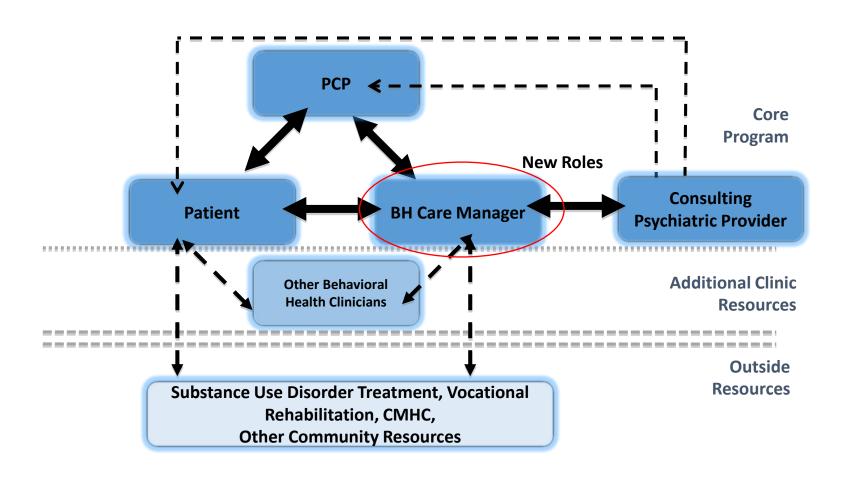
Fortney, Pyne et al Am J Psychiatry 2013; 170:414–425

■ PSYCHIATRIC PROVIDERS SUPPORTING TEAMS





■ CoCM DISTINCTIONS – THE TEAM ROLES AND RELATIONSHIPS





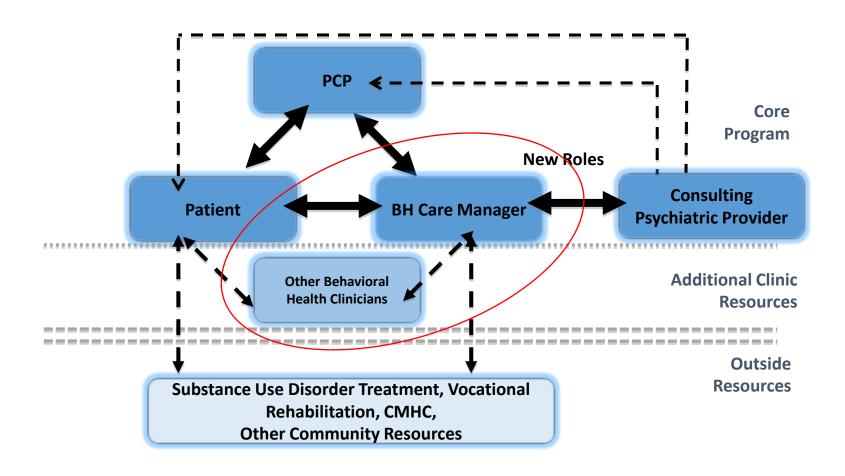
A NEW OR ENHANCED ROLE: THE BH CARE MANAGER

- Conduct screening and assessment
- ♣ Provide education and support
- ♣ Monitor patient progress through standardized reassessment (PHQ-9 and other instruments) and using registry
- ♣ Problem solve with patient, monitor treatment adherence & side effects concerns
- ➡ Help patient set behavioral activation goals and promote self-management for recovery / preventing relapse
- ♣ Provide brief therapeutic interventions
- ♣ Coordinate referrals, other needed resources and/or coordinate (warm) handoffs to next care giver on the team
- ♣ Communicate appropriately with PCP, BH Specialty Provider, and Psychiatry consultant, about concerns and progress of patients in your case load

PCMH PRIME Criterion C-1: Practice has a care manager qualified to identify and coordinate behavioral health needs.



■ CoCM DISTINCTIONS – THE TEAM ROLES AND RELATIONSHIPS





A NEW ROLE AND/OR RELATIONSHIP: THE BEHAVIORAL HEALTH PROVIDER

- ♣ Help patient set behavioral activation goals and promote selfmanagement for recovery, to foster recovery and prevent relapse
- ♣ Provide brief therapeutic interventions
- ♣ Provides short term therapy
- ★ May provide longer term therapy per practice capacity and patient needs (i.e. BH Department)
- ♣ May be an external provider engaged as needed based on the BH needs of the practice panel
- ♣ A BH Provider may serve a dual role as a BH Care Manager role
- ♣ A BH Provider for PCMH PRIME is distinct from non-licensed staff roles such as Community Health Workers that provide peer support

PCMH PRIME Criterion B-1 and/or B2: Practice coordinates, co-locates or is fully integrated with BH Providers



BH PROVIDERS IN A PRIMARY CARE SETTING – THE "RIGHT" PROVIDER

Who are the BH Providers?

- Role can change based on the skills, licensure of staff and needs of patients
- Typically LICSW, LCSW (with supervision), PhD, PsyD
- Brief intervention skills, short-term or long-term treatment, patient engagement

What makes a good BH Provider?

- Organization
- Persistence- tenacity
- Creativity and flexibility
- Strong communication skills
- Enthusiasm for learning
- Strong patient advocate
- Willingness to be interrupted
- Ability to work in a team



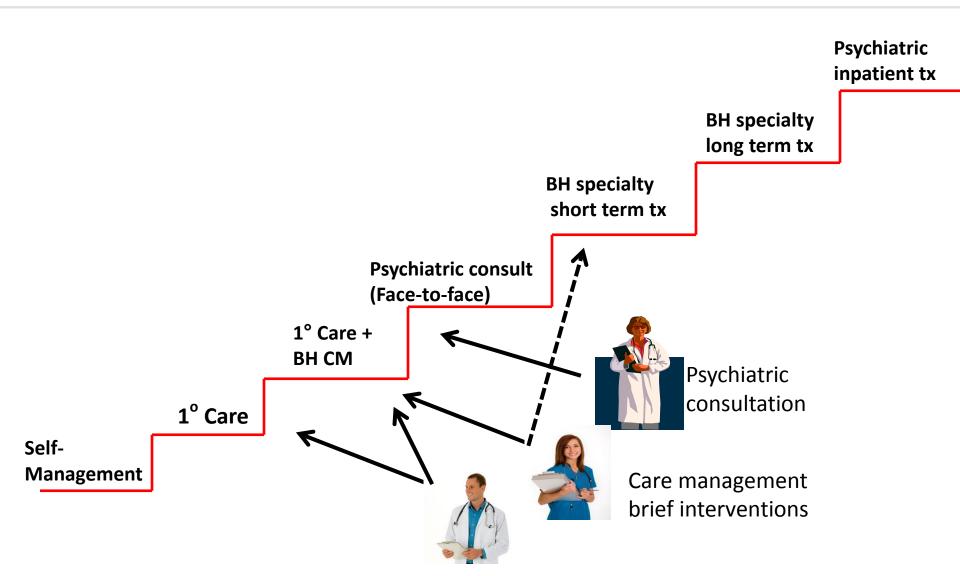
IMPLEMENTING NEW RELATIONSHIPS: FORMAL AGREEMENTS WITH BH PROVIDERS OUTSIDE THE PRACTICE

- ♣ Seek a BH provider with a shared vision for true BH integration into primary care
- ♣ Fidelity to the CoC model is key, but can be achieved with various team configurations
- ♣ Work to create an MOU (memorandum of understanding) or formal agreement with a BH provider, listing out expectations, roles, and metrics of success for each organization
- ♣ Be open to working with licensed behavioral health practitioners of varying backgrounds, based on local resources, or a telemedicine team.
- ♣ Agreement will vary based on whether BH practitioners are independent or part of a clinic or other organization.
- ★ Terms of an agreement need to consider use of EHR and registry.

PCMH PRIME Criterion B-1 and/or B2: Practice coordinates, co-locates or is fully integrated with BHPs

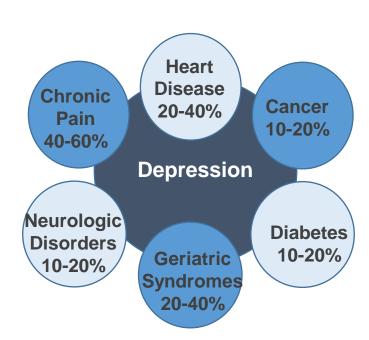


■ OPERATIONALIZING THE CoCM – A "STEPPED CARE" APPROACH





CoCM CARE MANAGEMENT: WHO CAN PLAY THE CARE MANAGER ROLE?



Willingness, knowledge, skills, and experience working with PH-BH conditions and practice cultures





Expertise in behavior change

Ability to work with data/registries

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THE BEHAVIORAL HEALTH CARE MANAGER — THE "RIGHT" PERSON

Who are the BH CMs?

- Typically MSW, LCSW, LICSW, MA, RN, LPN, CHW
- Variable clinical experience need brief intervention skills
- Registry management skills

What makes a good BH CM?

- Organization
- Persistence- tenacity
- Creativity and flexibility
- Strong communication skills
- Enthusiasm for learning
- Strong patient advocate
- Willingness to be interrupted
- Ability to work in a <u>team</u>





■ THINKING ABOUT YOUR PRIMARY CARE PRACTICE

- ♣ Develop a thoughtful blueprint for your CoCM implementation
- **♣** Balance fidelity to the model with practical reality
- ★ Take a resourceful approach
- **★** Consider key factors
 - ♣ Size and characteristics of your practice panel
 - ★ Maturity of your current PCMH model i.e., population health management, use of registry, screening tools, etc.
- ♣ Assess your current BH and care management assets
 - ★ Current workforce qualifications and interest
 - Recruitment and hiring strategy
 - ♣ Community partners (for psychiatry and BHP resources)



PRACTICE CHANGES TO SUPPORT THE COCM: ROUTINE WORKFLOW

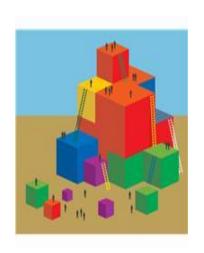
Every contact – 3 absolutes

- ♣ Review (administer if not already done) latest results from BH screening tools and how they compare to the historical scores
- ♣ Discuss care plan/treatment plan, review meds and how patient is taking them, side effects, and coping mechanisms in order to follow care plan
- ♣ Facilitate behavioral activation and setting of self-management (SM) goals; or review progress and stories around SM goals set previously and set next goals/actions accordingly – and document in EMR



BUILDING BLOCKS FOR CoCM CARE MANAGER SUCCESS

- Visibility (location)
 - ★ Be available
- + Proactive readiness
 - ★ Be a part of the huddles and review daily schedules
 - ★ Know your team and who you can turn to for a question
- **★** Skill building and personal development
 - Motivational interviewing
 - Medication reviews
 - **★** Self-care & support





■ THE "SECRET SAUCE" FOR EFFECTIVE IMPLEMENTATION: 9 FACTORS

■ Table 1. Factors Considered Important for Implementation of DIAMOND

Ran	king Implement	tation Factor	Definition
1	Operating costs of DIAM(OND not seen as a barrier	The clinic has adequate coverage or other financial resources for most patients to be able to afford the extra operational costs.
2	Engaged psychiatrist		The consulting psychiatrist is responsive to the care manager and to all patients, especially those not improving.
3	Primary care provider (PC	P) "buy-in"	Most clinicians in the clinic support the program and refer patients to it.
4	Strong care manager		The care manager is seen as the right person for this job and works well in the clinic setting.
5	Warm handoff		Referrals from clinicians to the care manager are usually conducted face-to-face rather than through indirect means.
6	Strong top leadership sup	port	Clinic and medical group leaders are committed and support the care model.
7	Strong PCP champion		There is a PCP in the clinic who actively promotes and supports the project.
8	Care manager role well de	efined and implemented	The care manager job description is well defined, with appropriate time, support, and a dedicated space.
9	Care manager on-site and	accessible	The care manager is present and visible in the clinic and is available for referrals and patient care problems.
DIAN	MOND indicates Depression Improven	nent Across Minnesota—Offeri	ng a New Direction.

Whitebird, Jaeckels Kamp et al. Am J Manag Care. 2014;20(9):699-707



EVALUATION

Please complete this evaluation of the webinar:

https://www.surveymonkey.com/r/JGS3SZM

