HEALTH MANAGEMENT ASSOCIATES

MASSACHUSETTS HEALTH POLICY COMMISSION

Integrated Primary and Behavioral Health Care Management

Lynn Dierker, Principal
Nancy Jaeckels Kamp, Managing Principal
Health Management Associates

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

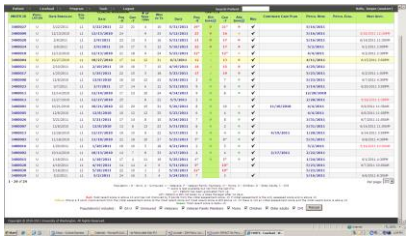
Effective Collaboration

PRACTICE SUPPORT

PCP supported by
Behavioral Health
Care Manager

Measurement-based
Treat to Target

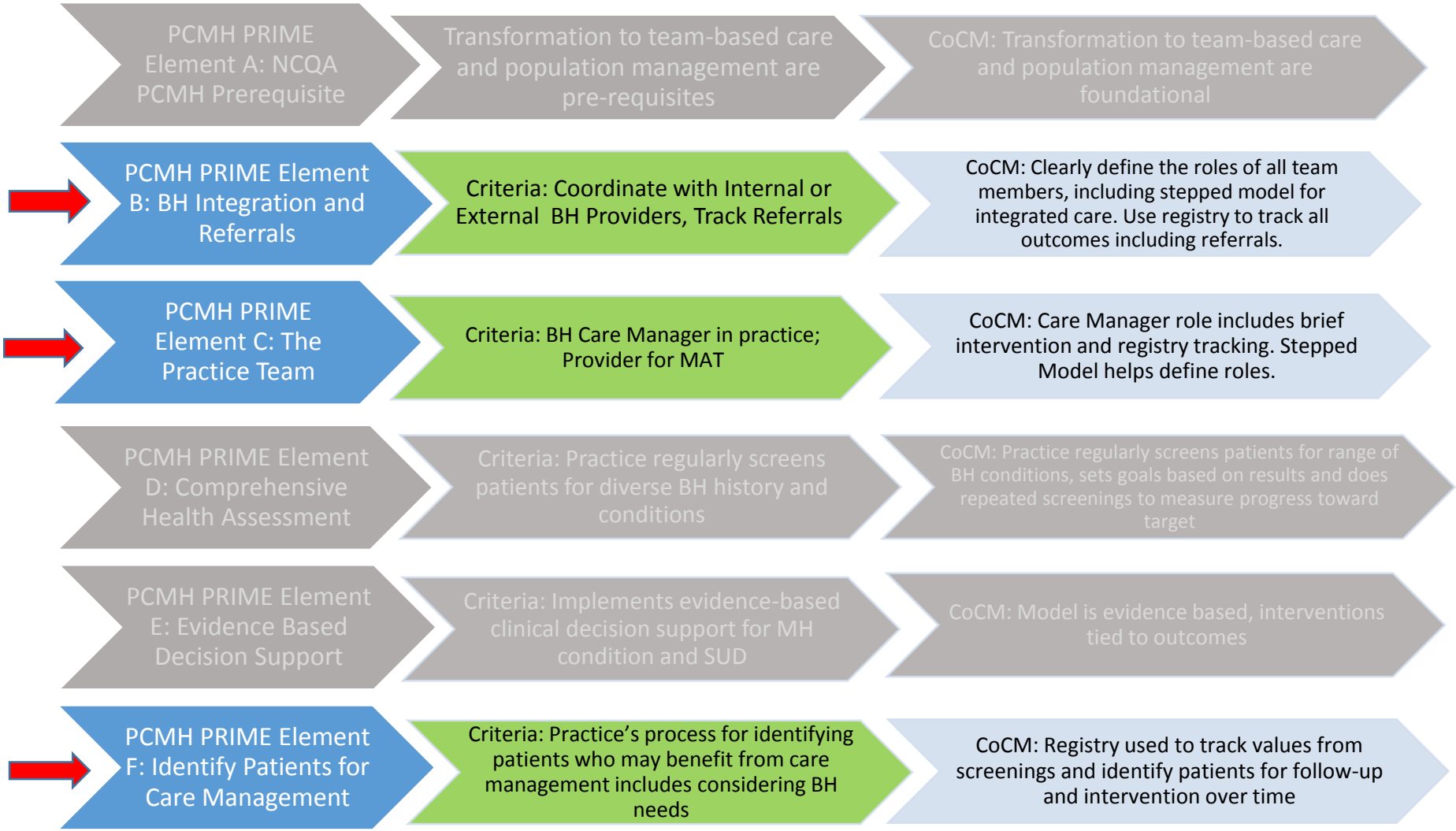
Psychiatric
Consultation



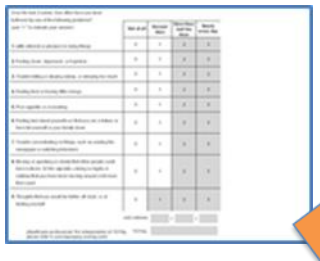
Caseload-focused
Registry review

Training

PCMH PRIME CRITERIA, COLLABORATIVE CARE AND CARE MANAGEMENT IMPLICATIONS



CORE CoCM TASKS BUILD ON A PCMH FOUNDATION



Patient Identification and Diagnosis

Engagement in Integrated Care Program

Evidence-Based Treatment

Systematic Follow-up, Treatment Adjustment, Relapse Prevention

Communication, Care Coordination and Referrals

Systematic Case Review and Psychiatric Consultation

Program Oversight and Quality Improvement

COMMON TOOLS AND APPROACHES: PCMH PRIME AND CoCM

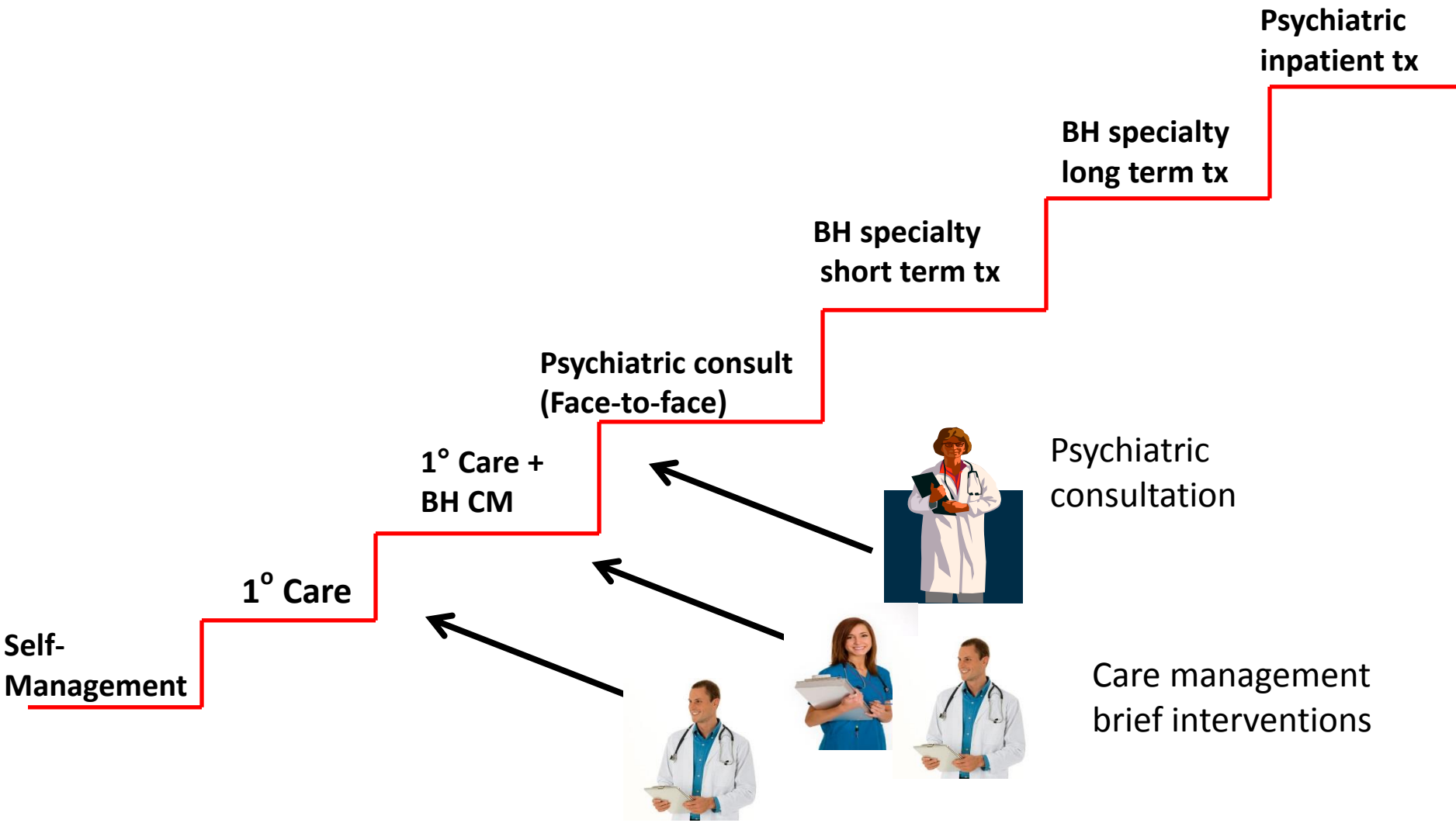
- Population health management
- Registries
- Care alerts and tracking systems
- Care plans used by integrated care team
- Protocols and treatment guidelines
- Self-management skills and tools
- PCMH team-based processes of care (e.g., huddles, systematic case reviews, etc.)
- Measurement-based care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

ADDED DIMENSIONS: THE CoCM MODEL FOR BH INTEGRATION

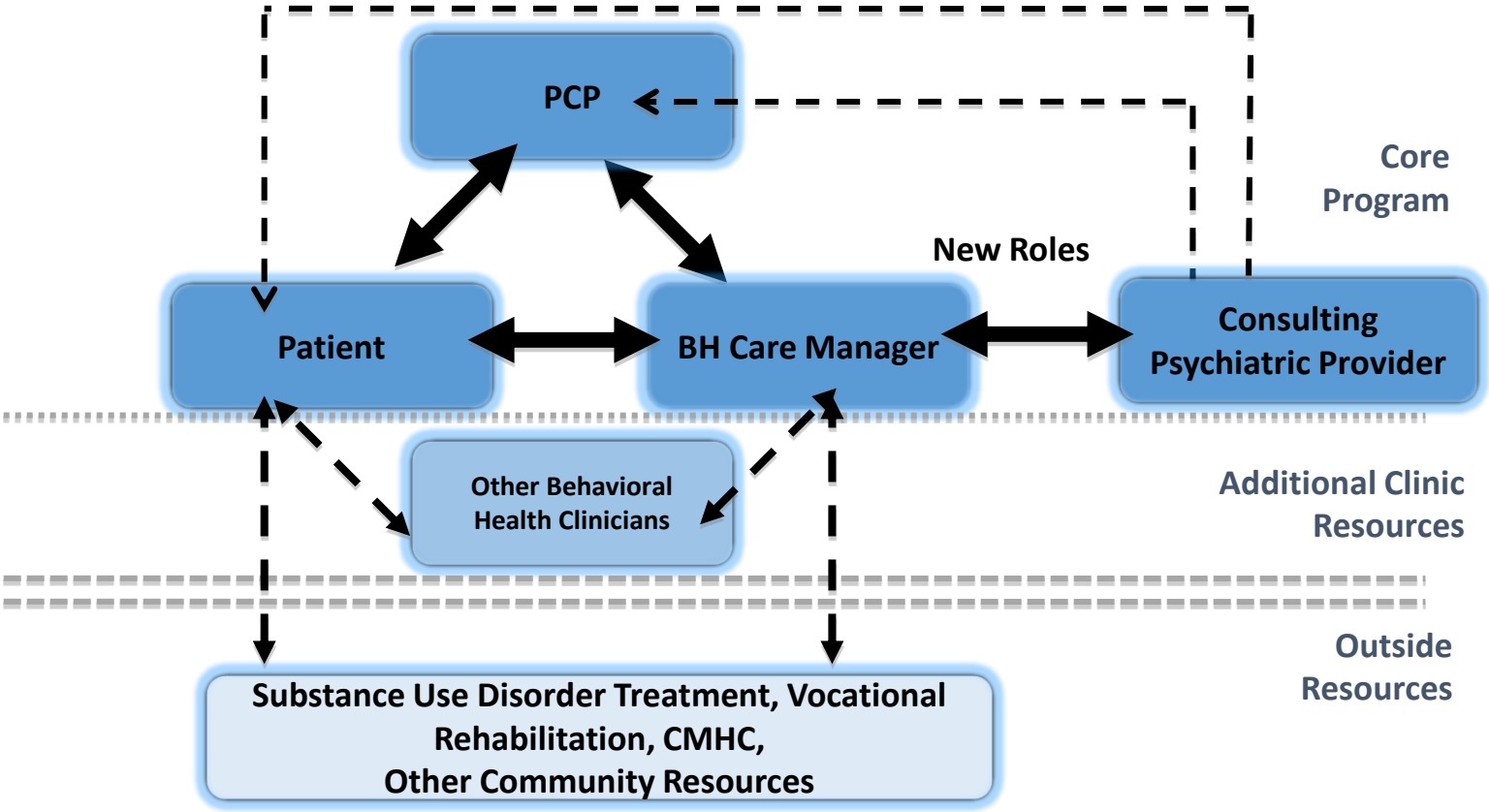
- Measurement/monitoring
  - BH screening/ data elements/use of registry
- Stepped care approach
  - Intensify/modify based on BH supports/treatment needs
- Self-management skills
  - Focus on recovery and relapse prevention
- Care manager
- BH care planning, care coordination, brief interventions
- 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



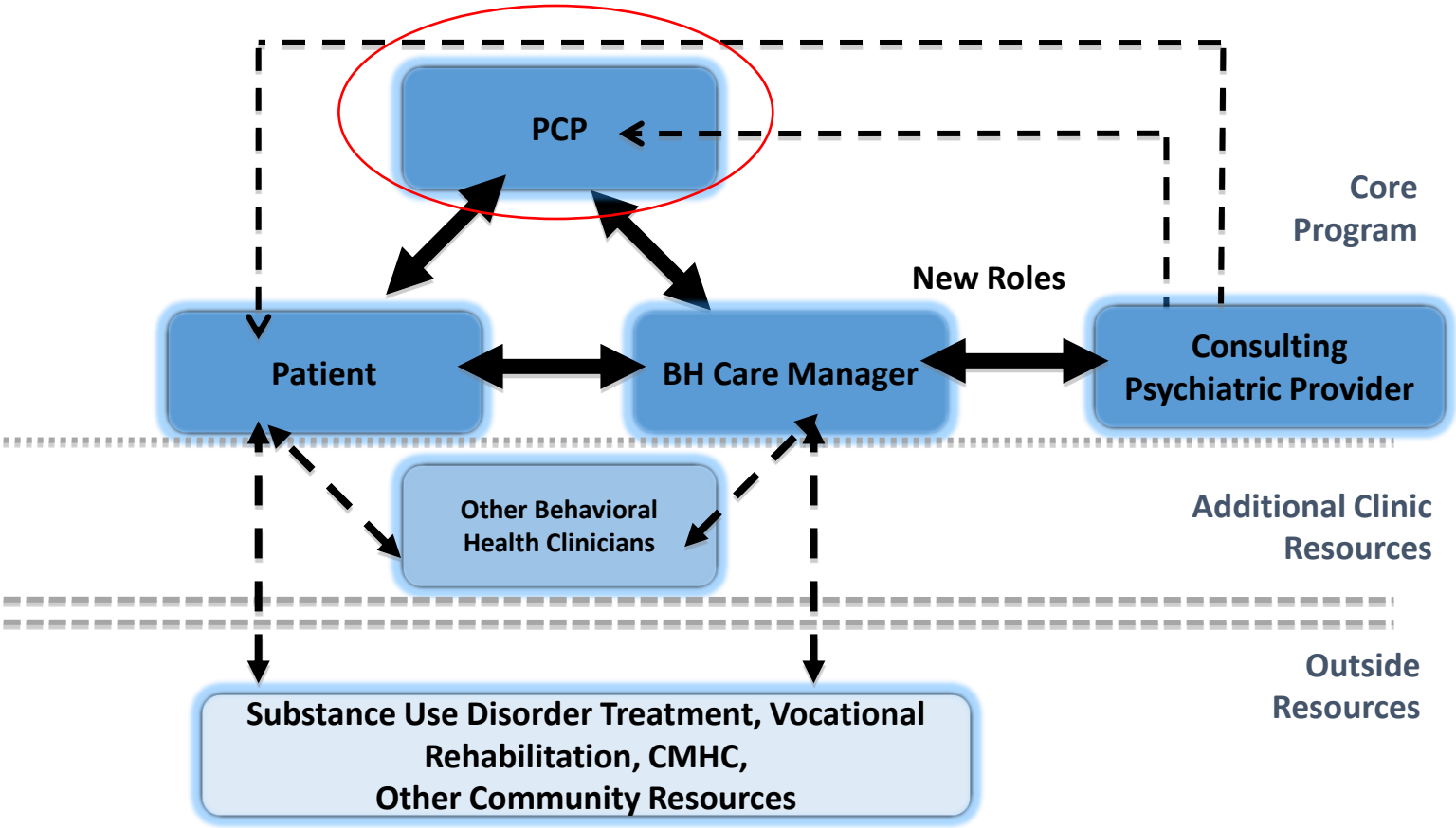
SHIFTS IN THE PRACTICE TEAM, ENVIRONMENT, PATIENT/CLIENT EXPERIENCE

- 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?

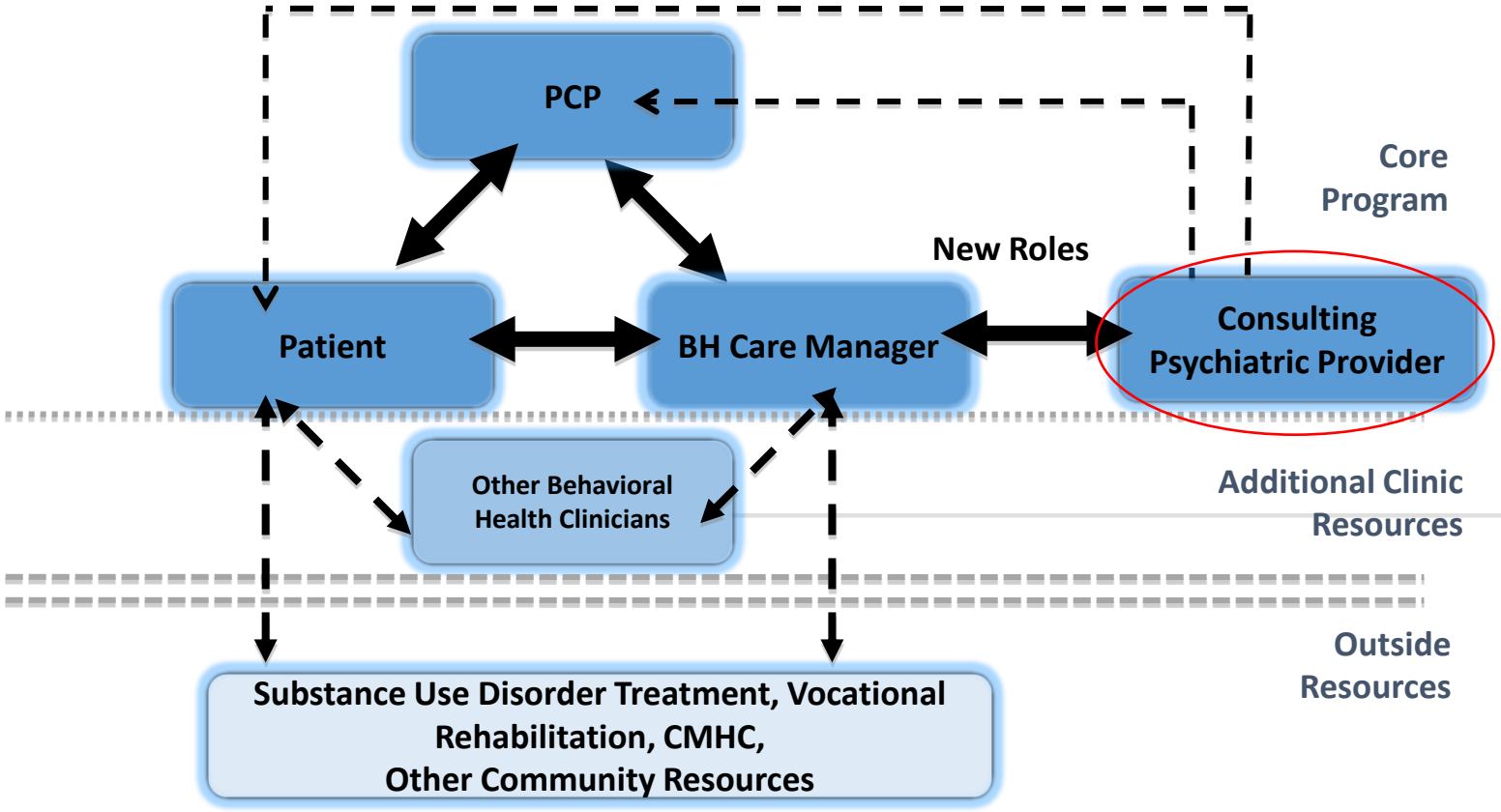
CoCM DISTINCTIONS – THE TEAM ROLES AND RELATIONSHIPS



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 self-management techniques

CoCM DISTINCTIONS – THE TEAM ROLES AND RELATIONSHIPS



NEW ROLE OF THE PRACTICE CONSULTING PSYCHIATRIST

Timely Consultation (for Patients/Panel/Team)

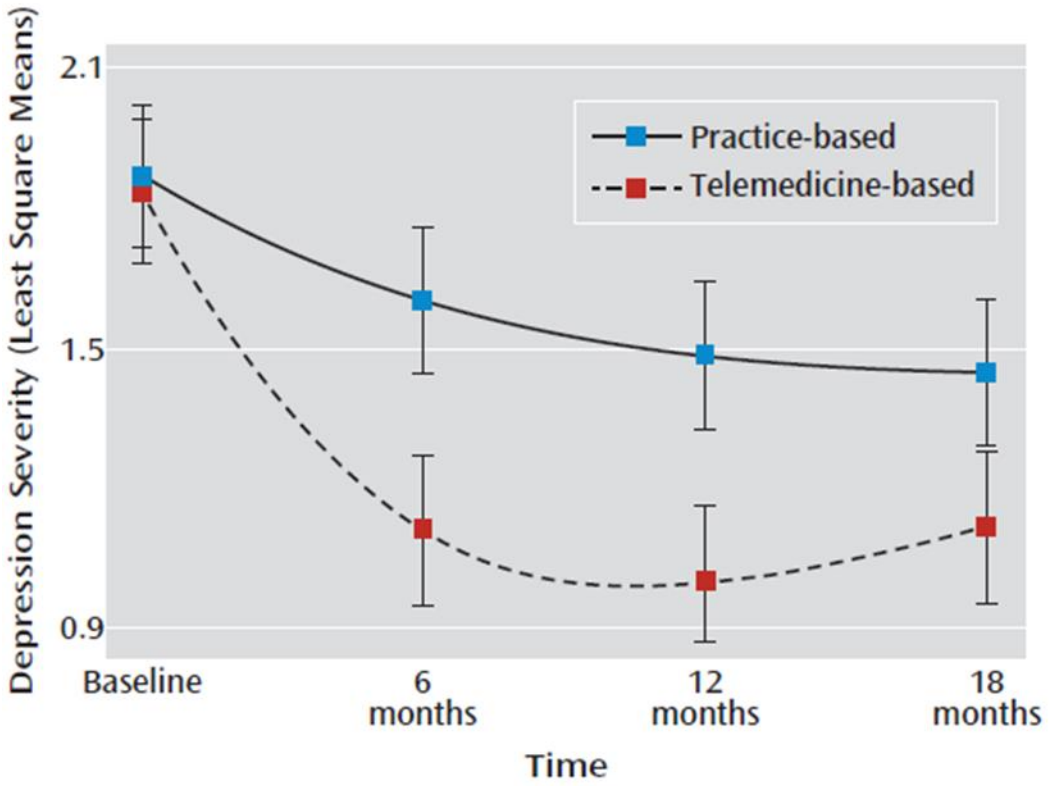
- Diagnostic dilemmas
- Education about diagnosis or medications
- Complex patients, such as pregnant or medically complicated
- Pattern recognition
- Education
- Build confidence and competence

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]

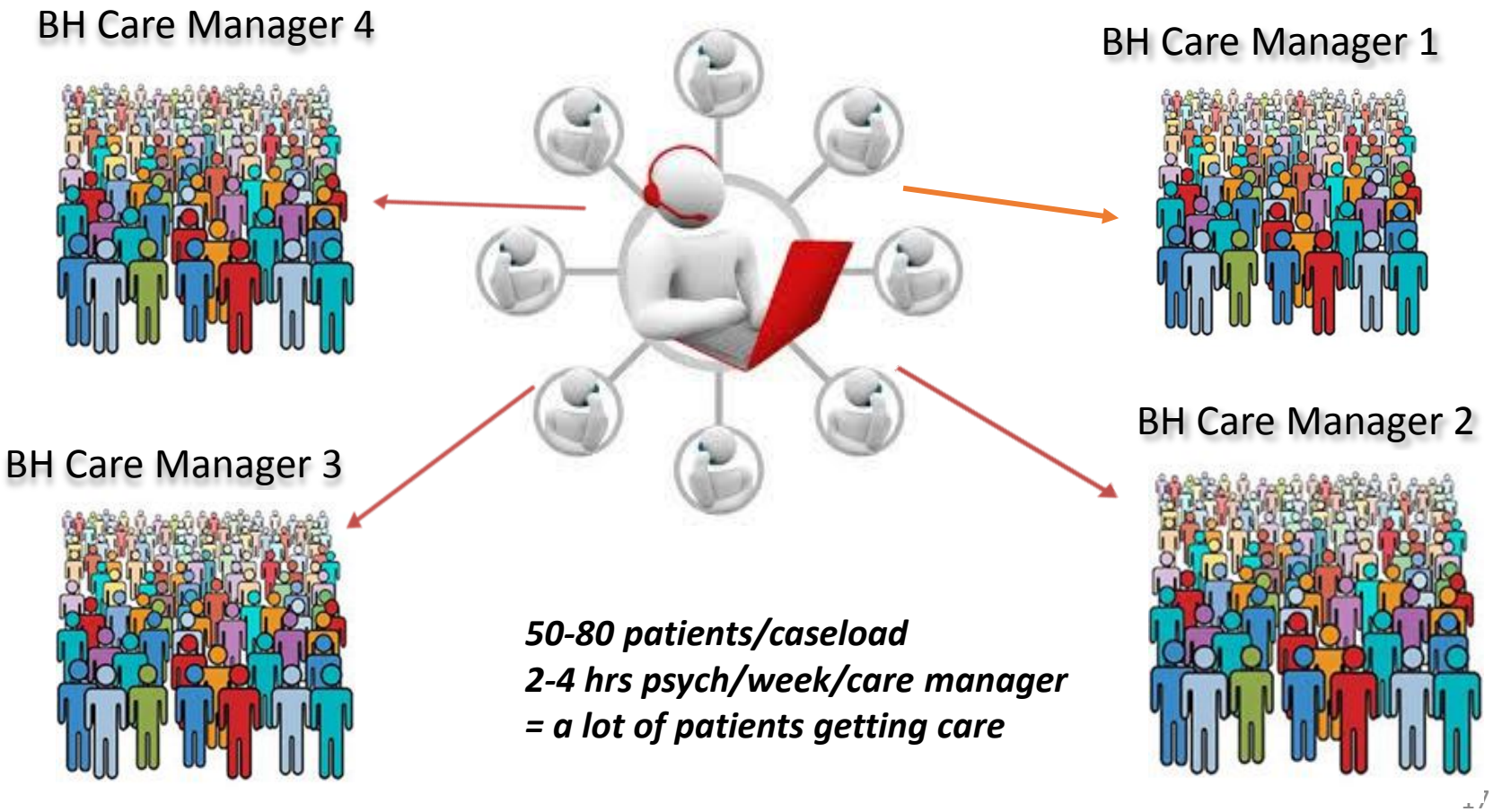


* In this study, practice based means depression care delivered by onsite PCP and nurse care manager, no mental health providers present. Telemedicine based means depression care delivered by onsite PCP and tele-medicine based team.

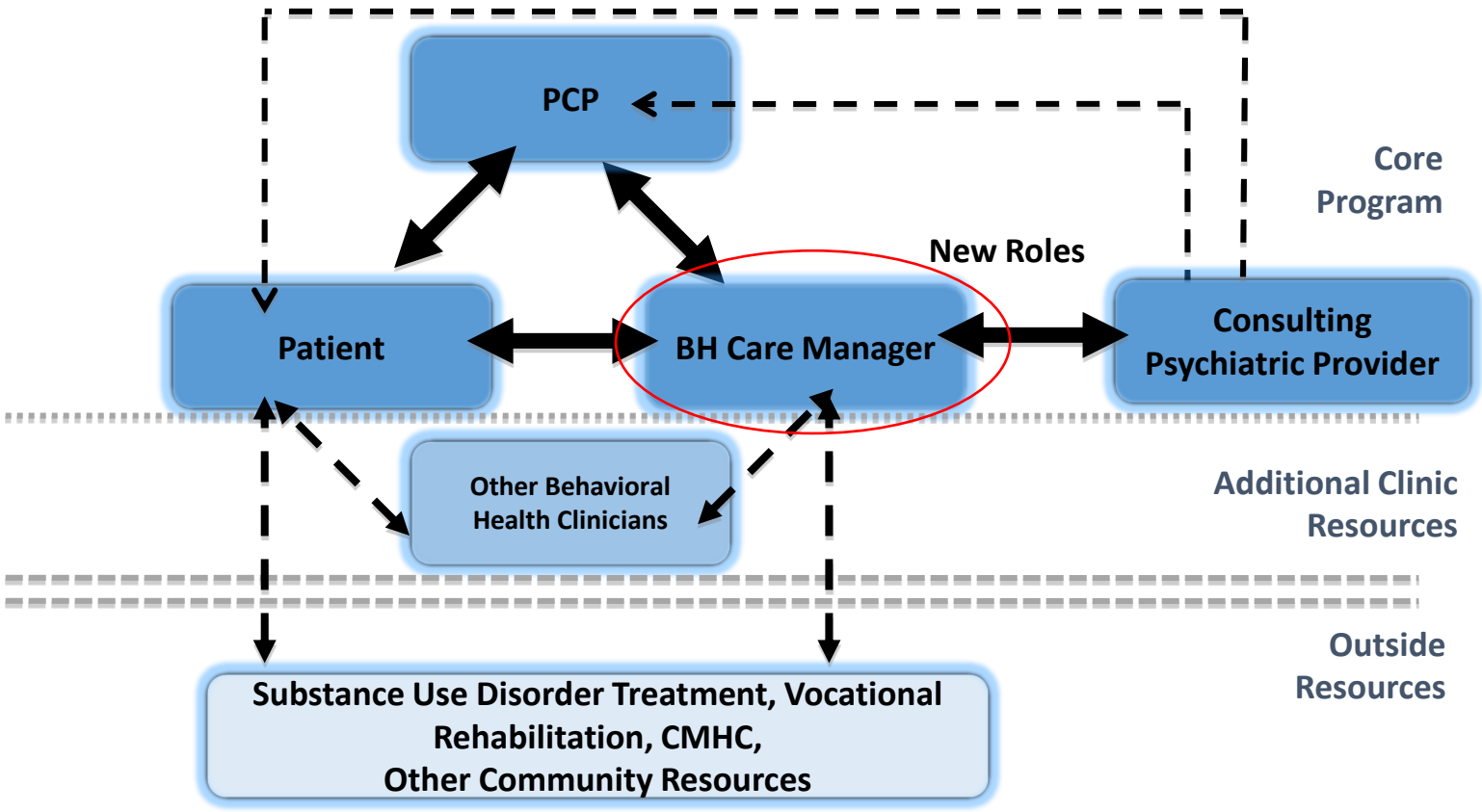
- **Telemedicine-based team:**
  - Nurse care manager - phone
  - Pharmacist – phone
  - Psychologist – CBT - televideo
  - Psychiatrist – televideo if did not respond to 2 antidepressants
  - Weekly – whole team met to make recommendations

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

PSYCHIATRIC PROVIDERS SUPPORTING TEAMS



CoCM DISTINCTIONS – THE TEAM ROLES AND RELATIONSHIPS

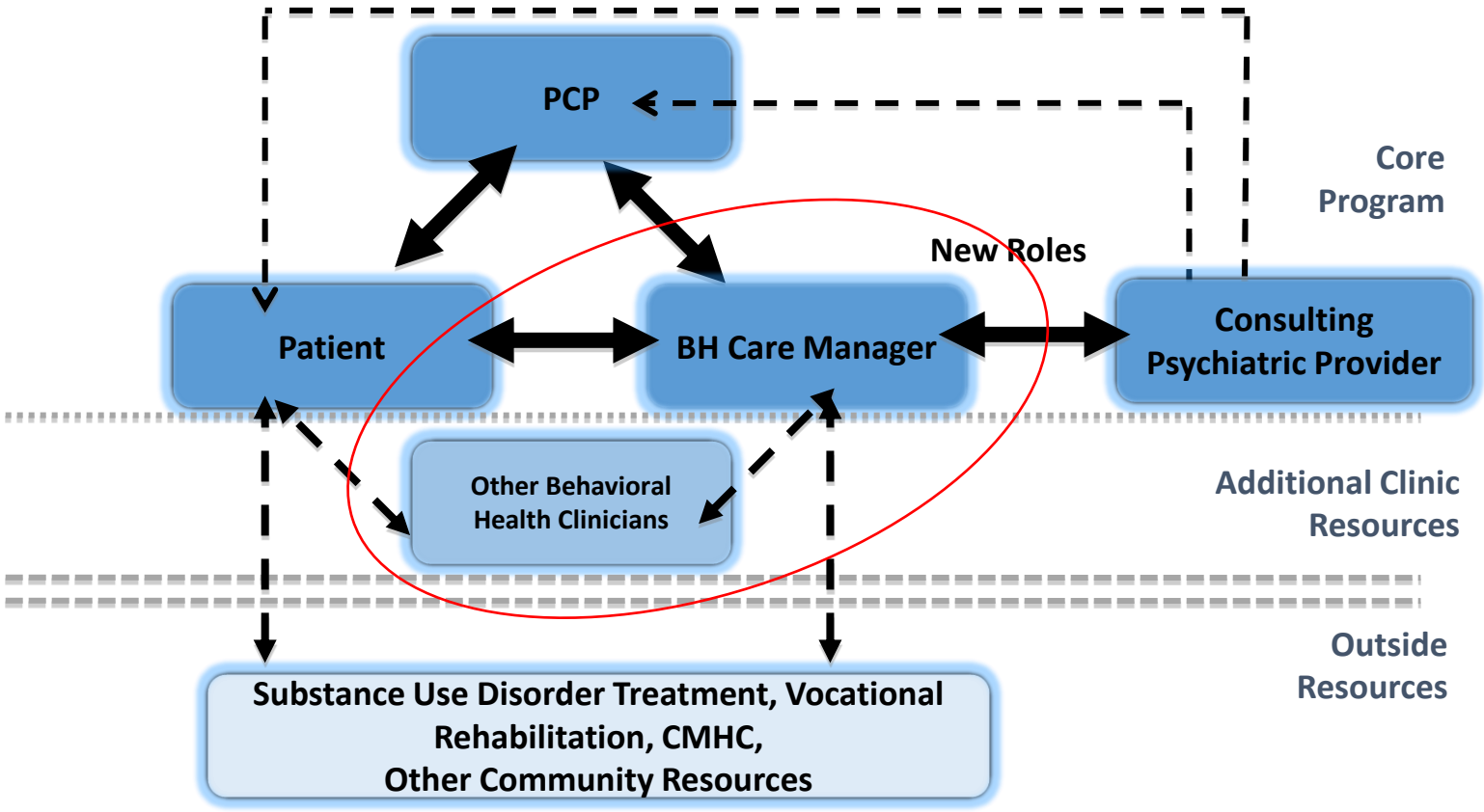


A NEW OR ENHANCED ROLE: THE BH CARE MANAGER

- 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) hand-offs 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 self-management 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 internal member of the primary care practice team
- 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?

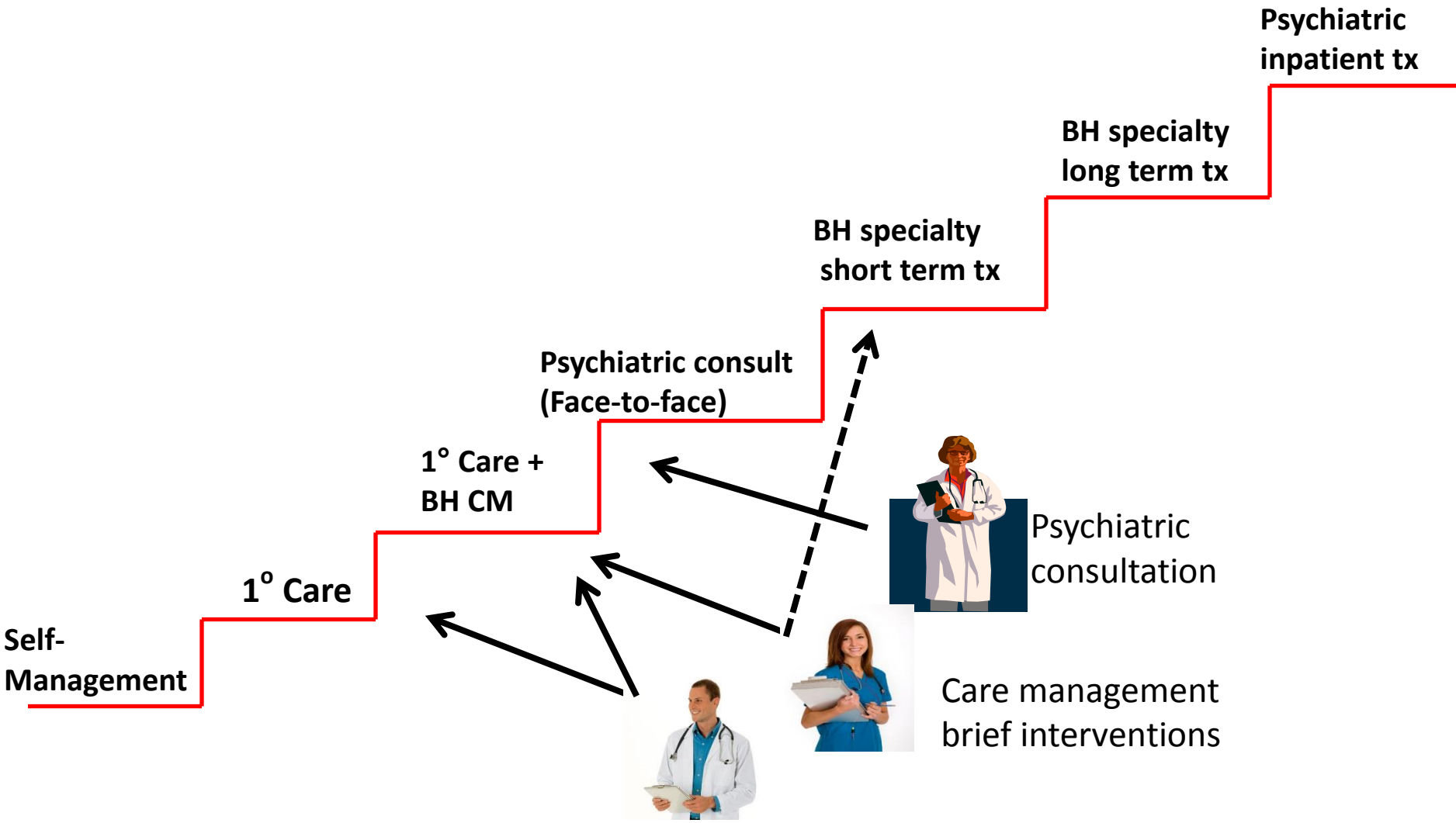
- Organization
- Persistence- tenacity
- Creativity and flexibility
- Strong communication skills
- Enthusiasm for learning
- Strong patient advocate
- Willingness to be interrupted
- Ability to work in a team

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

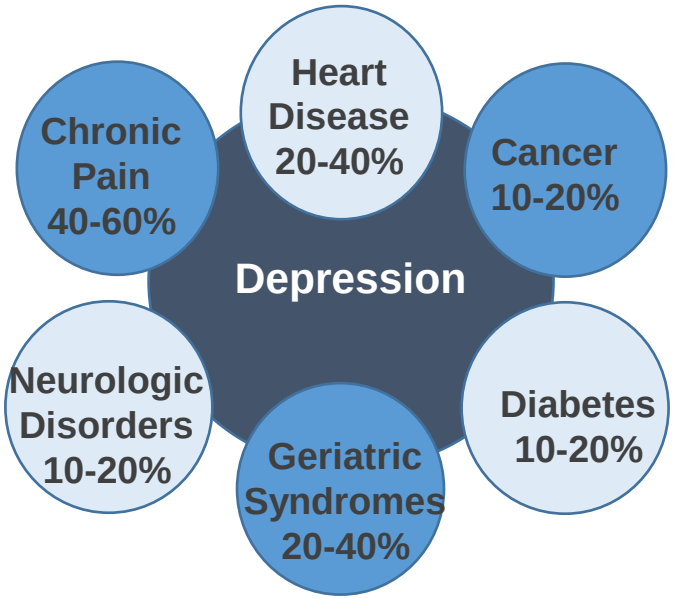
- Seek a BH provider with a shared vision for true BH integration into primary care
- Fidelity to the CoC model is key, but can be achieved with various team configurations
- Work to create an MOU (memorandum of understanding) or formal agreement with a BH provider, listing out expectations, roles, and 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

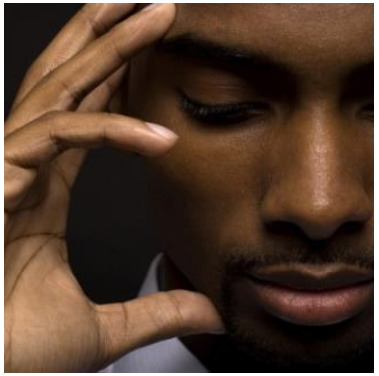
OPERATIONALIZING THE CoCM – A "STEPPED CARE" APPROACH



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

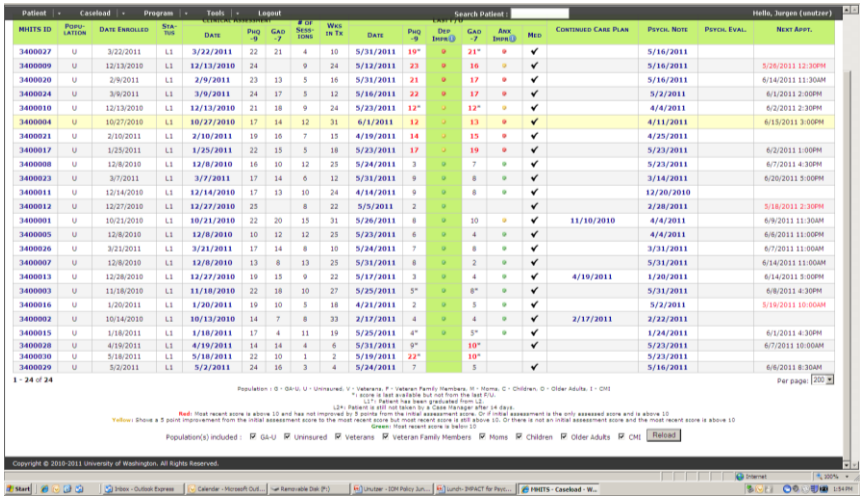


Willingness, knowledge, skills, and experience working with PH-BH conditions and practice cultures



Expertise in behavior change

Ability to work with data/registries



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 team

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
  - Have a few patients in mind at all times to update providers
- 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

Ranking	Implementation Factor	Definition
1	Operating costs of DIAMOND 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 (PCP) "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 support	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 defined 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.

DIAMOND indicates Depression Improvement Across Minnesota—Offering a New Direction.

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

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EVALUATION

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