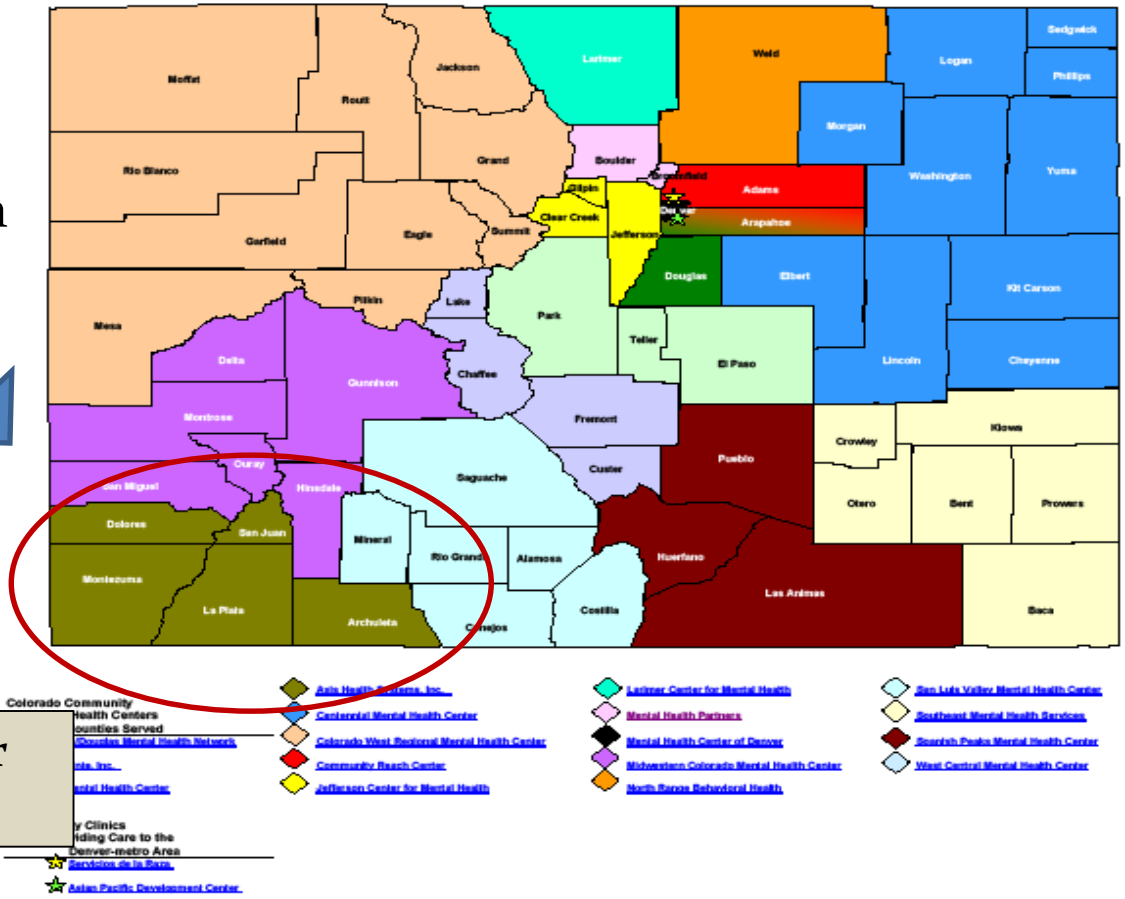
Designing a Structured Approach to Collaborative Care

Lori Raney, MD
Collaborative Care Consulting

October 9, 2014

Colorado CMHCs

Axis Health System



Denominator 125,000

Wall Street Journal Sept 2013

THE WALL STREET JOURNAL.

A4 | Wednesday, September 25, 2013

U.S. NEWS

Mental-Health Care at the Doctor's Office

Providers Take Integrated Approach, With Patient Numbers Set to Jump Under New Law and Psychiatrists in Short Supply

By Melinda Beck

Seattle psychiatrist Anna Ratzliff oversees mental-health care for nearly 500 patients—most of whom she will never meet.

As the consulting psychiatrist for four primary-care practices, Dr. Ratzliff confers weekly with 10 care managers who follow the patients closely, provide counseling and chart their progress in electronic registries. She helps devise treatment plans and suggests changes for those who aren't improving.

"I get to touch so many more lives than I would if I were seeing these patients in person," she said.

Dr. Ratzliff's practice is part of a burgeoning effort to integrate psychiatric care into pri-

The New State Of Health Care

Body and Mind

Who needs, gets, gives care

25% of U.S. adults experience a mental-health issue in a given year

60% of them receive no treatment

68% of adults with a mental-health disorder have at least one medical condition

29% of those with a medical condition have a mental-health issue

50% of care for mental-health disorders is delivered by primary-care providers

66% of visits to family physicians involve stress-related symptoms

Sources: National Alliance on Mental Illness; National Comorbidity Survey

Dr. Thomas Golforth with patient Magali King, who

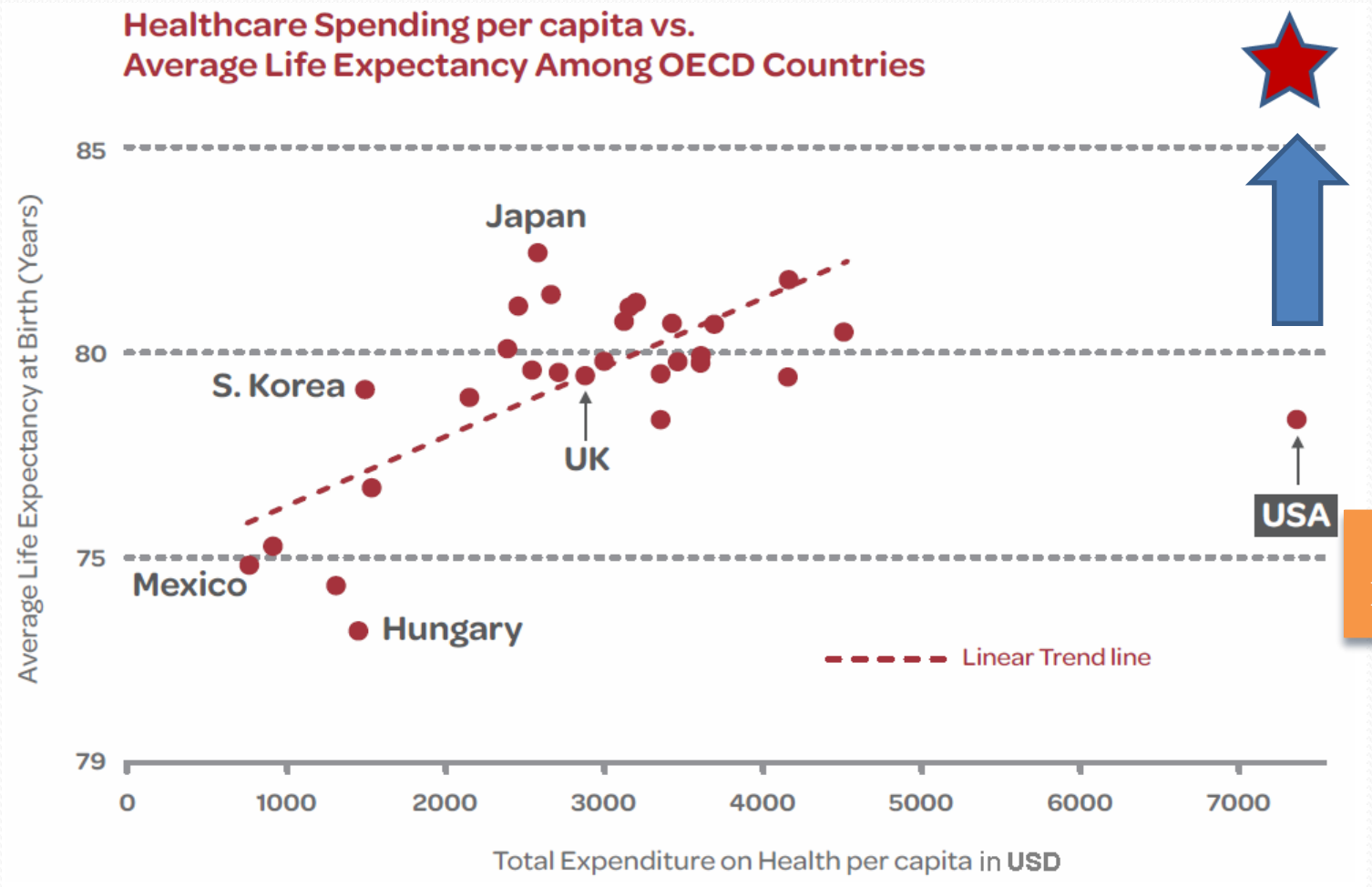
IMPACT study published 2002

"Gold Standard"

"Integrated health care is the ***new gold standard*** for individuals with general medical and mental disorders, whether their "medical home" is a primary care clinic or a community mental health center."

T. Smith, M Erlich, L. Sederer: Integrating General Medical and Behavioral Health Care: The New York State Perspective. Psychiatric Services Sept 2013.

Healthcare Spending



OECD 2009. www.oecd.org. Accessed July 19, 2014.

Annual Cost of Care

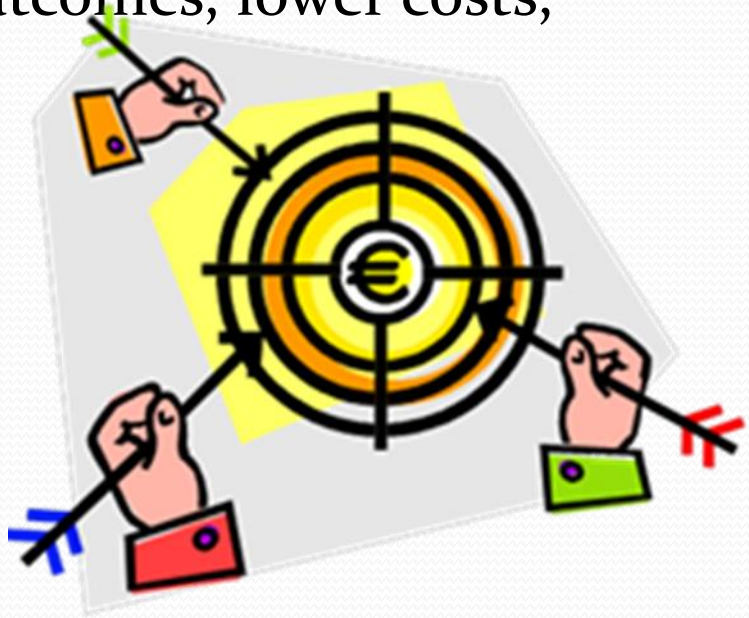
Patient Groups	Annual Cost of Care ($)	Illness Prevalence (%)	Percent with Comorbid Medical Condition*	Annual Cost with Mental Condition ($)	Percent Increase with Mental Condition
All insured	2920		10-15		
Arthritis	5220	6.6	36	10,710	94
Asthma	3730	5.9	35	10,030	169
Cancer	11,650	4.3	37	18,870	62
Diabetes	5480	8.9	30	12,280	124
CHF	9770	1.3	40	17,200	76
Migraine	4340	8.2	43	10,810	149
COPD	3840	8.2	38	10,980	186

Total Population
Common Chronic Medical Illnesses with Comorbid Mental Condition "Value Opportunities"
***Approximately 10% receive evidence-based mental condition treatment.**
Cartesian Solutions, Inc.™--consolidated health plan claims data.
CHF = congestive heart failure; COPD = chronic obstructive pulmonary disease.

Increase cost 2-3 times for "facility based " care

21st Century CMHC

- **Insurance expansion – 60 million more covered**
- **Triple Aim Initiatives:** better outcomes, lower costs, patient satisfacation
  - Innovation grants
    - Collaborative care
    - Payment structures
  - Behavioral Health Homes: SPAs
  - Expand CHCs
  - Expand PBHCI grantee sites



SPAs = State Plan Amendments; CHC = community health center; PBHCI = Primary and Behavioral Health Care Integration.

US Department of Health and Human Services. www.hhs.gov/healthcare/rights/. Accessed July 19, 2014.

NCQA PCMH Standards 2014 – Behavioral

NCQA 2011

PCMH Standard 1: Enhance Access and Continuity

- Comprehensive assessment includes depression screening for adolescents and adults

PCMH Standard 3: Plan and Manage Care

- One of three clinically important conditions identified by the practice must be a condition related to unhealthy behaviors (e.g., obesity) or a mental health or substance abuse condition.

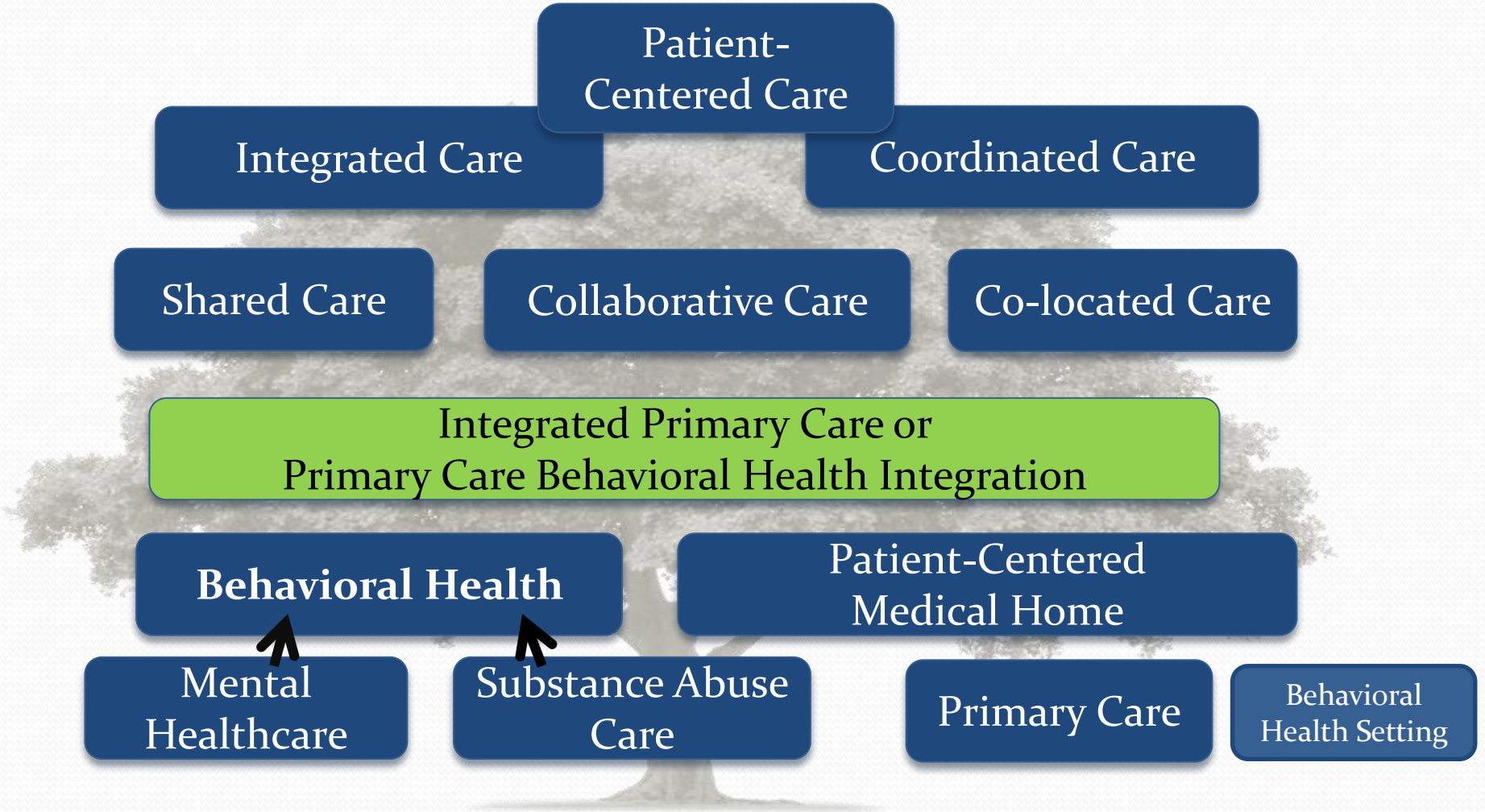
PCMH Standard 5: Track and Coordinate Care

- Track referrals and coordinate care with mental health and substance abuse services

NCQA 2014

- **Program Structure (QI 1)**
  - Does the QI program specifically address behavioral health?
  - Is there a physician and behavioral health practitioner involved in the QI program?
- **Accessibility of Services (QI 5)**
  - Can members get behavioral health care when they need it?
- **7. Complex Case Management (QI 7)**
  - Does the organization assess the characteristics and needs of its member population (including children/adolescents, individuals with disabilities and individuals with SPMI)?
  - Are the organization's case management systems based on sound evidence?
- **9. Practice Guidelines (QI 9)**
  - Does the organization adopt evidence-based practice guidelines for at least two medical conditions and at least two behavioral conditions with at least one behavioral guideline addressing children/adolescents?
- **11. Continuity and Coordination Between Medical and Behavioral Health Care (QI 11)**
  - Does the organization annually collect data about opportunities for coordination between general medical care and behavioral health care?
  - Does the organization collaborate with behavioral health specialists to collect and analyze data and implement improvement of coordination of behavioral health and general medical care?
- **1. UM Structure (UM 1)**
  - Is a behavioral health practitioner involved in the behavioral health aspects of the program?

Lexicon for Integrated Care



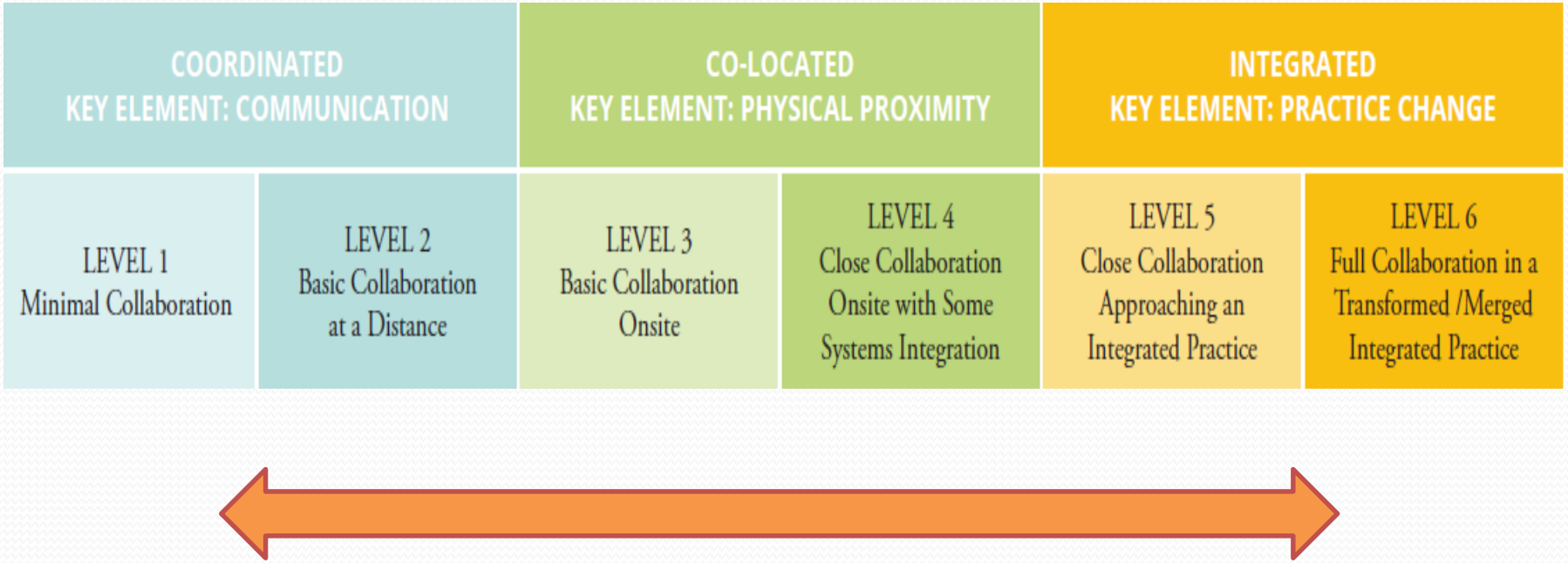
Adapted from: Peek CJ. A family tree of related terms used in behavioral health and primary care integration. http://integrationacademy.ahrq.gov/lexicon. Accessed July 19, 2014.

Definition: AHRQ 2013

- The care that results from a practice team of primary care and behavioral health clinicians, working with patients and families,
- using a **systematic and cost-effective** approach,
- to provide patient-centered care
- for a **defined population**

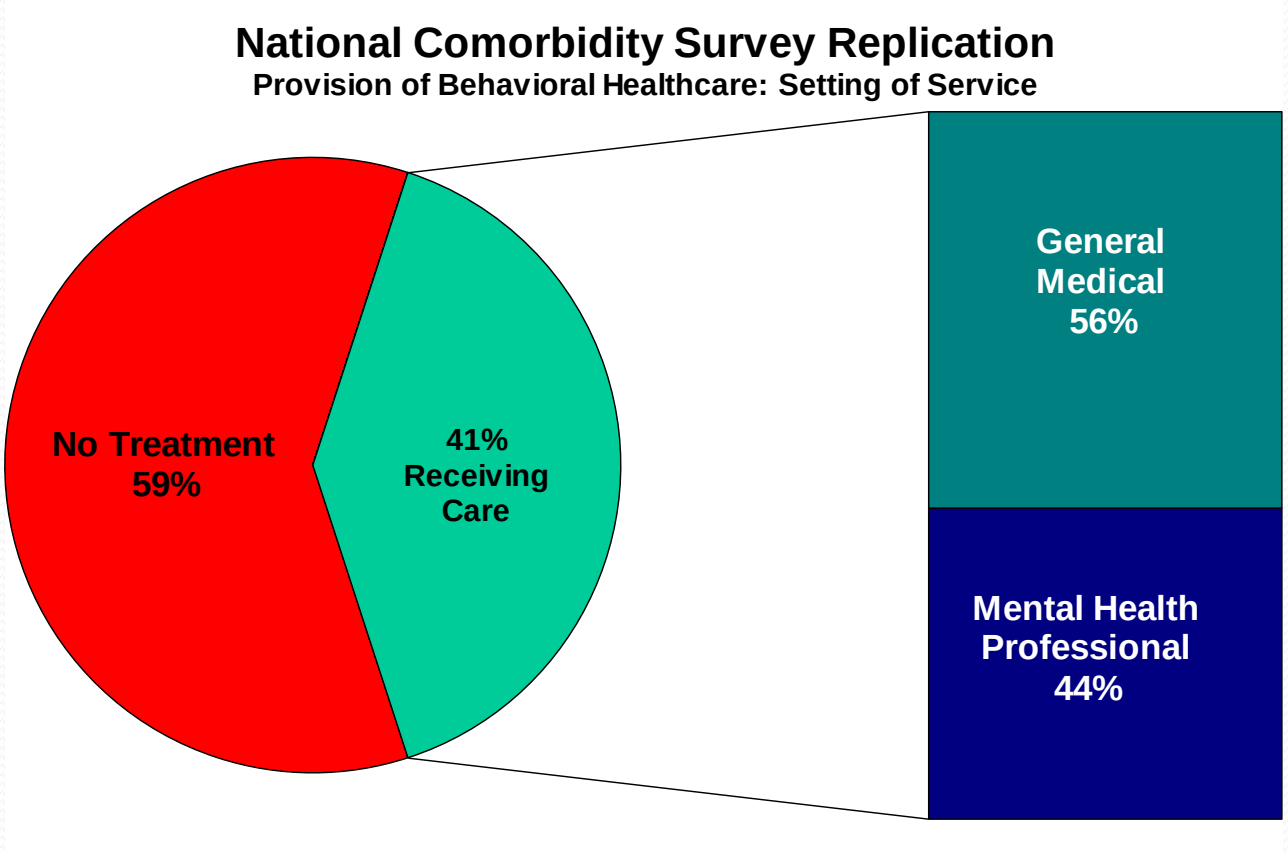
AHRQ = Agency for Healthcare Research and Quality.
Lexicon Project. http://integrationacademy.ahrq.gov/lexicon. Accessed July 19, 2014.

Levels of Integration



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

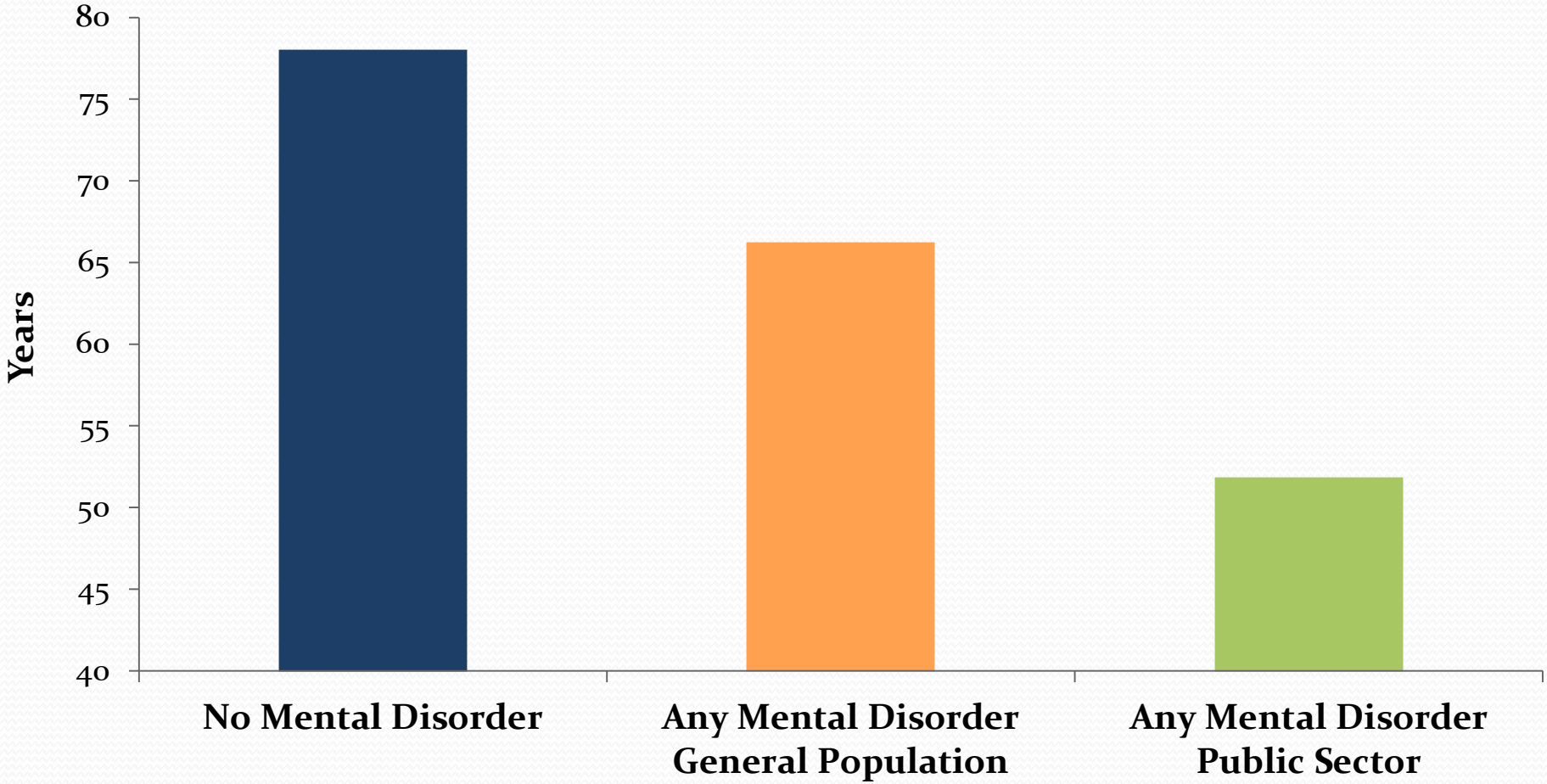
Primary Care is the "De Facto" Mental Health System



~20%
"minimally"
effective

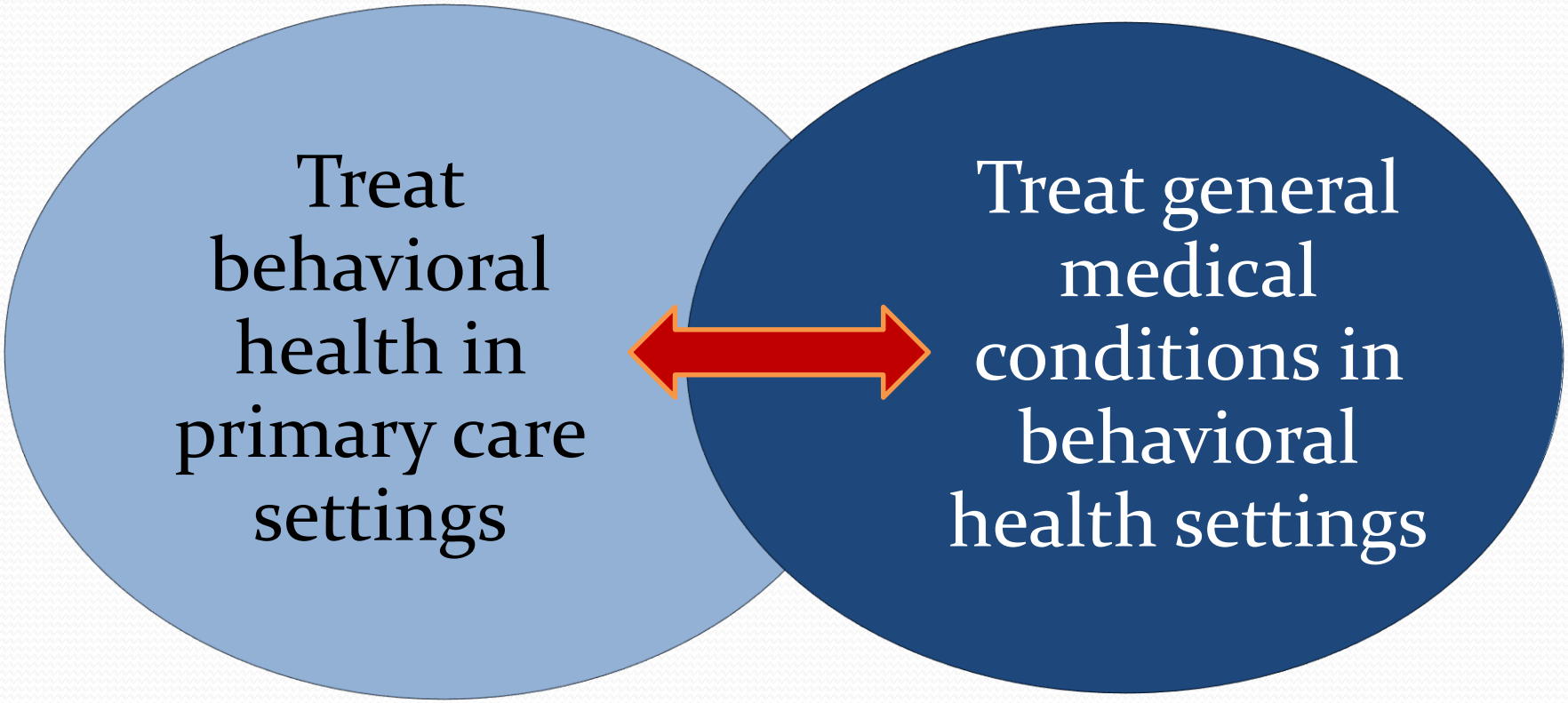
Wang P, et al. *Arch Gen Psychiatry*. 2005;62(6):629-640.

Life Span with and Without Mental Disorders



Druss BG, Zhao L, Von Esenwein S, Morrato EH, Marcus SC. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 June;49(6):599-604

Range of Opportunities for CMHCs



Principles Of Effective Collaborative Care

Patient-Centered Care Teams

- Team-based care: effective collaboration between PCPs and BHPs

Population-Based Care

- Behavioral health patients tracked in a registry: no one "falls through the cracks;" population-based screening

Measurement-Based Treatment to Target

- Measurable treatment goals clearly defined and tracked for each patient
- Treatments are actively changed until the clinical goals are achieved

Evidence-Based Care

- Treatments used are "evidence-based," having credible research evidence

Accountable for Care

Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.

AIMS Center 2011

Collaborative Care Model

Informed, Activated Patient

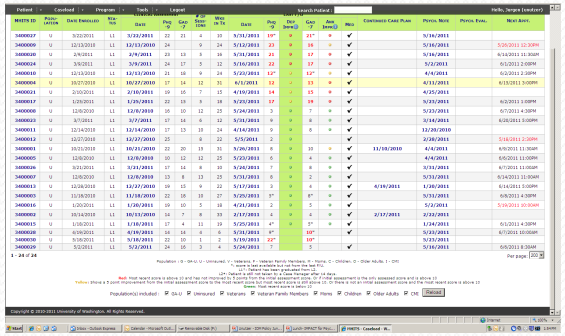
Effective Collaboration

PCP supported by Behavioral Health Care Manager

Practice Support

Measurement-Based Stepped Care

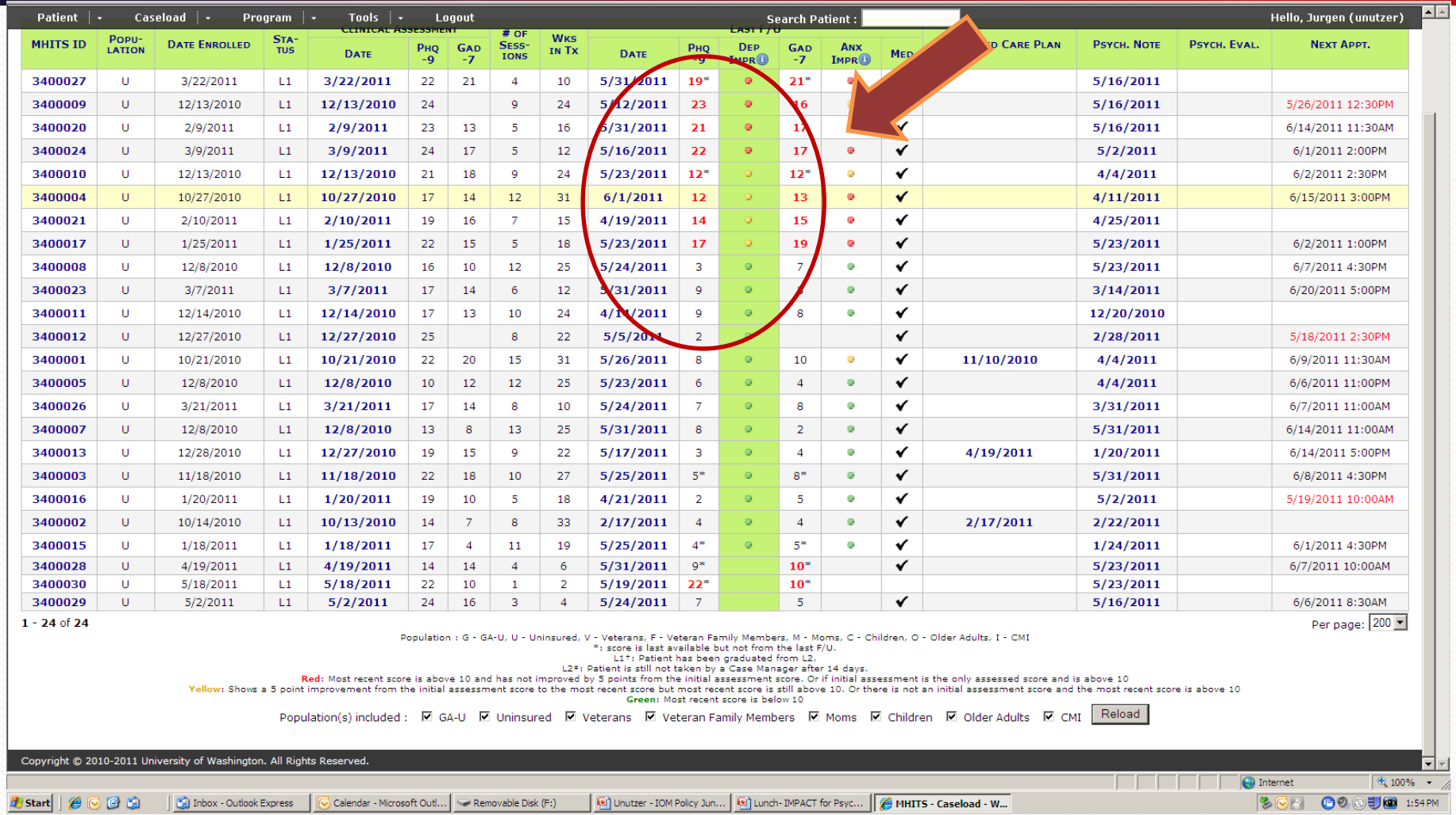
Informal and formal Psychiatric consultation



Caseload-Focused Registry Review

IMPACT. https://impact-uw.org/about/key.html. Accessed July 19, 2014.

Registries to Track Progress and Intensify Treatment



Patient | Caseload | Program | Tools | Logout — Search Patient : — Hello, Jurgen (unutzer)

MHITS ID	Popu-lation	Date Enrolled	Sta-tus	Clinical Assessment Date	PHQ -9	GAD -7	# of Sess-ions	Wks in Tx	Last F/U Date	PHQ -9	Dep Impr	GAD -7	Anx Impr	Med	D Care Plan	Psych. Note	Psych. Eval.	Next Appt.
3400027	U	3/22/2011	L1	3/22/2011	22	21	4	10	5/31/2011	19*		21*		✓		5/16/2011		
3400009	U	12/13/2010	L1	12/13/2010	24		9	24	5/12/2011	23		16		✓		5/16/2011		5/26/2011 12:30PM
3400020	U	2/9/2011	L1	2/9/2011	23	13	5	16	5/31/2011	21		1[illegible]		✓		5/16/2011		6/14/2011 11:30AM
3400024	U	3/9/2011	L1	3/9/2011	24	17	5	12	5/16/2011	22		17		✓		5/2/2011		6/1/2011 2:00PM
3400010	U	12/13/2010	L1	12/13/2010	21	18	9	24	5/23/2011	12*		12*		✓		4/4/2011		6/2/2011 2:30PM
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3400021	U	2/10/2011	L1	2/10/2011	19	16	7	15	4/19/2011	14		15		✓		4/25/2011		
3400017	U	1/25/2011	L1	1/25/2011	22	15	5	18	5/23/2011	17		19		✓		5/23/2011		6/2/2011 1:00PM
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3400023	U	3/7/2011	L1	3/7/2011	17	14	6	12	5/31/2011	9		8		✓		3/14/2011		6/20/2011 5:00PM
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3400007	U	12/8/2010	L1	12/8/2010	13	8	13	25	5/31/2011	8		2		✓		5/31/2011		6/14/2011 11:00AM
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3400016	U	1/20/2011	L1	1/20/2011	19	10	5	18	4/21/2011	2		5		✓		5/2/2011		5/19/2011 10:00AM
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1 - 24 of 24 — Per page: 200

Population : G - GA-U, U - Uninsured, V - Veterans, F - Veteran Family Members, M - Moms, C - Children, O - Older Adults, I - CMI
*: score is last available but not from the last F/U.
L1†: Patient has been graduated from L2.
L2‡: Patient is still not taken by a Case Manager after 14 days.
Red: Most recent score is above 10 and has not improved by 5 points from the initial assessment score. Or if initial assessment is the only assessed score and is above 10
Yellow: Shows a 5 point improvement from the initial assessment score to the most recent score but most recent score is still above 10. Or there is not an initial assessment score and the most recent score is above 10
Green: Most recent score is below 10

Population(s) included : ☑ GA-U ☑ Uninsured ☑ Veterans ☑ Veteran Family Members ☑ Moms ☑ Children ☑ Older Adults ☑ CMI Reload

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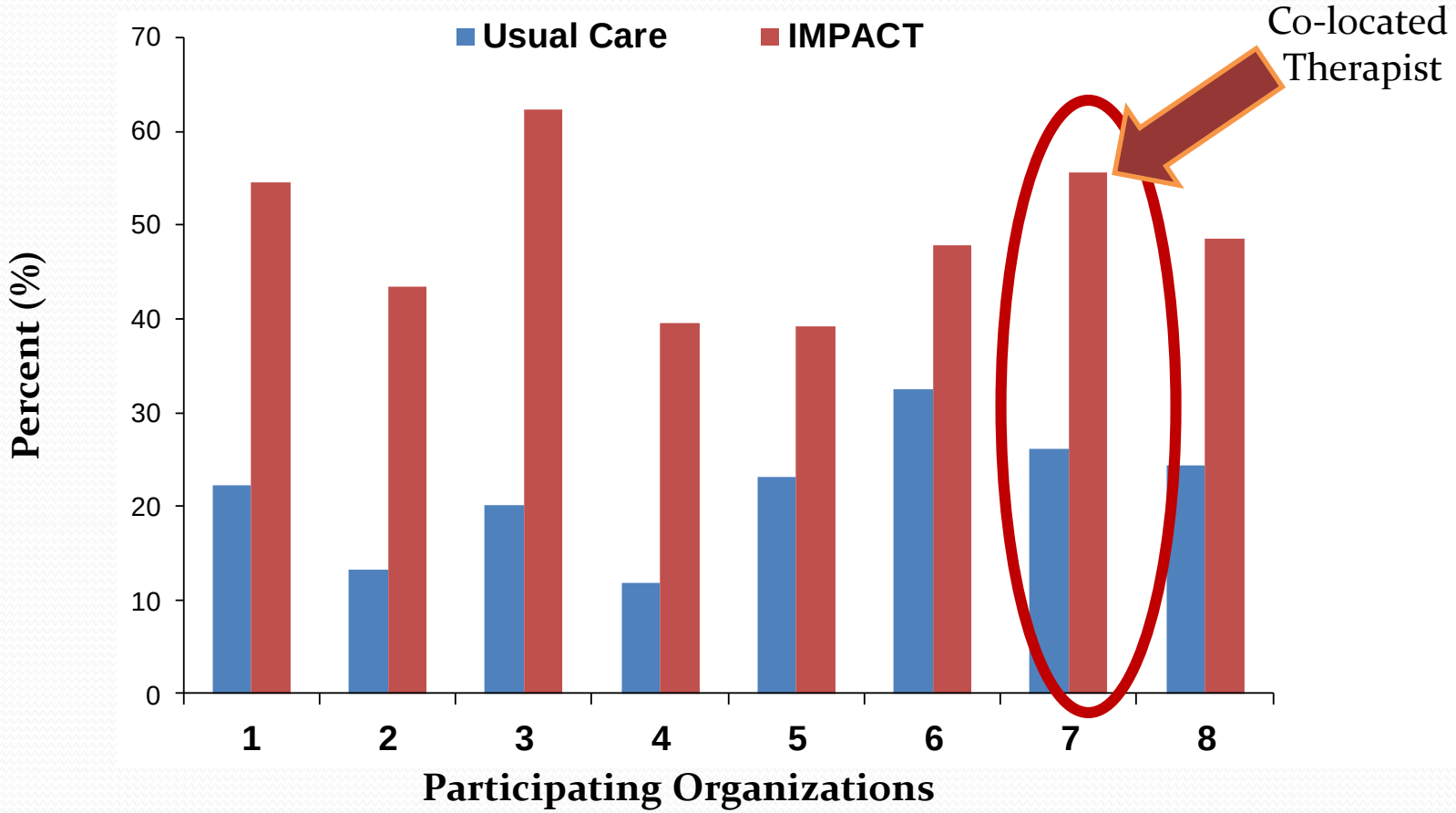
Start | Inbox - Outlook Express | Calendar - Microsoft Outl... | Removable Disk (F:) | Unutzer - IOM Policy Jun... | Lunch- IMPACT for Psyc... | MHITS - Caseload - W... | 1:54 PM

AIMS Center: http://aims.uw.edu/. Accessed July 19, 2014.

Doubles Effectiveness of Care for Depression

50% or greater improvement in depression at 12 months



Unützer J, et al: Collaborative-care management of late-life depression in the primary care setting. JAMA 288(22):2836–2845, 2002

Long-Term Cost Savings

Cost Category	4-Year Costs ($)	Intervention Group Costs ($)	Usual Care Group Costs ($)	Difference ($)
IMPACT program cost		522	0	522
Outpatient mental health costs	661	558	767	-210
Pharmacy costs	7284	6942	7636	-694
Other outpatient costs	14,306	14,160	14,456	-296
Inpatient medical costs	8452	7179	9757	-2578
Inpatient mental health/ substance abuse costs	114	61	169	-108
Total healthcare cost	31,082	29,422	32,785	-$3363

Savings

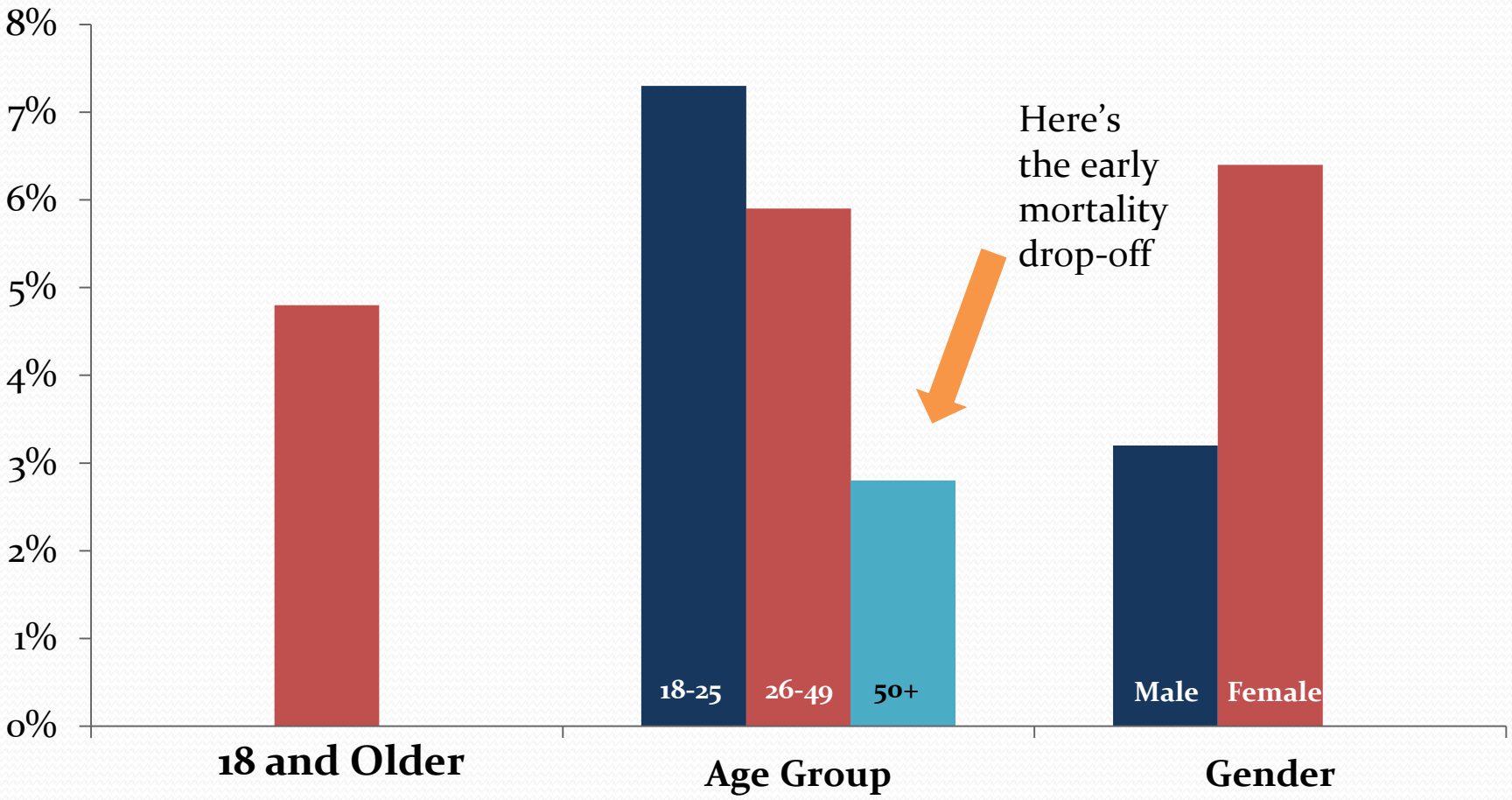
ROI
$6.50 : $1.00

Unützer J, et al. *Am J Manag Care*. 2008;14(2):95-100.

Primary Care for SMI

- High rates of physical illness in mentally ill
- Premature mortality
- Low quality of medical care to patients with mental illness
- *Costly physically ill with mental illness – "High Utilizers"*
- Access problems

Serious Mental Illness in the Past Year

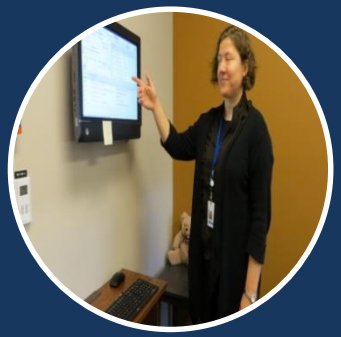


Data courtesy of SAMHSA.

Programs Generally Contain 3 Components

Primary Care Service

Care Management and Tracking



Health Behavior Change

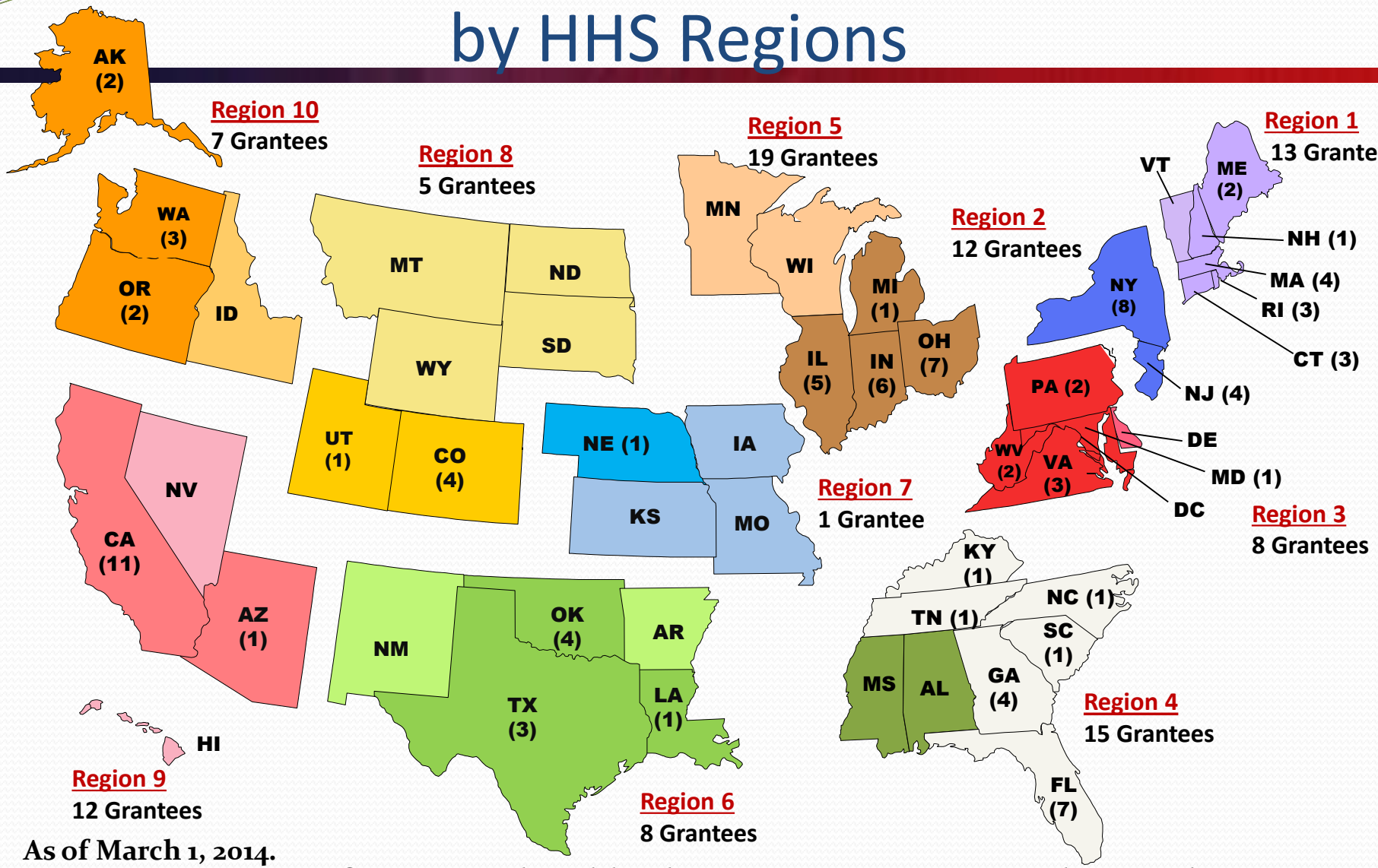
Kern J in Integrated Care: Working at the Interface of Primary Care and Behavioral Health, L Raney editor, September 2014

PCARE

- PCARE study: *Nurse Care Managers* provided communication and advocacy to overcome barriers to primary medical care
- Intervention group received more
  - Recommended preventive services
  - Higher proportion of evidence-based services for cardiometabolic conditions
  - More likely to have a PCP (71.2% vs 51.9%)
- *Reduction in Framingham Cardiovascular Risk Index score in intervention group: 6.9% compared with usual care 9.8%*

PCARE = Primary Care Access, Referral, and Evaluation.
Druss BG, et al. *Am J Psychiatry*. 2010;167(2):151-159.

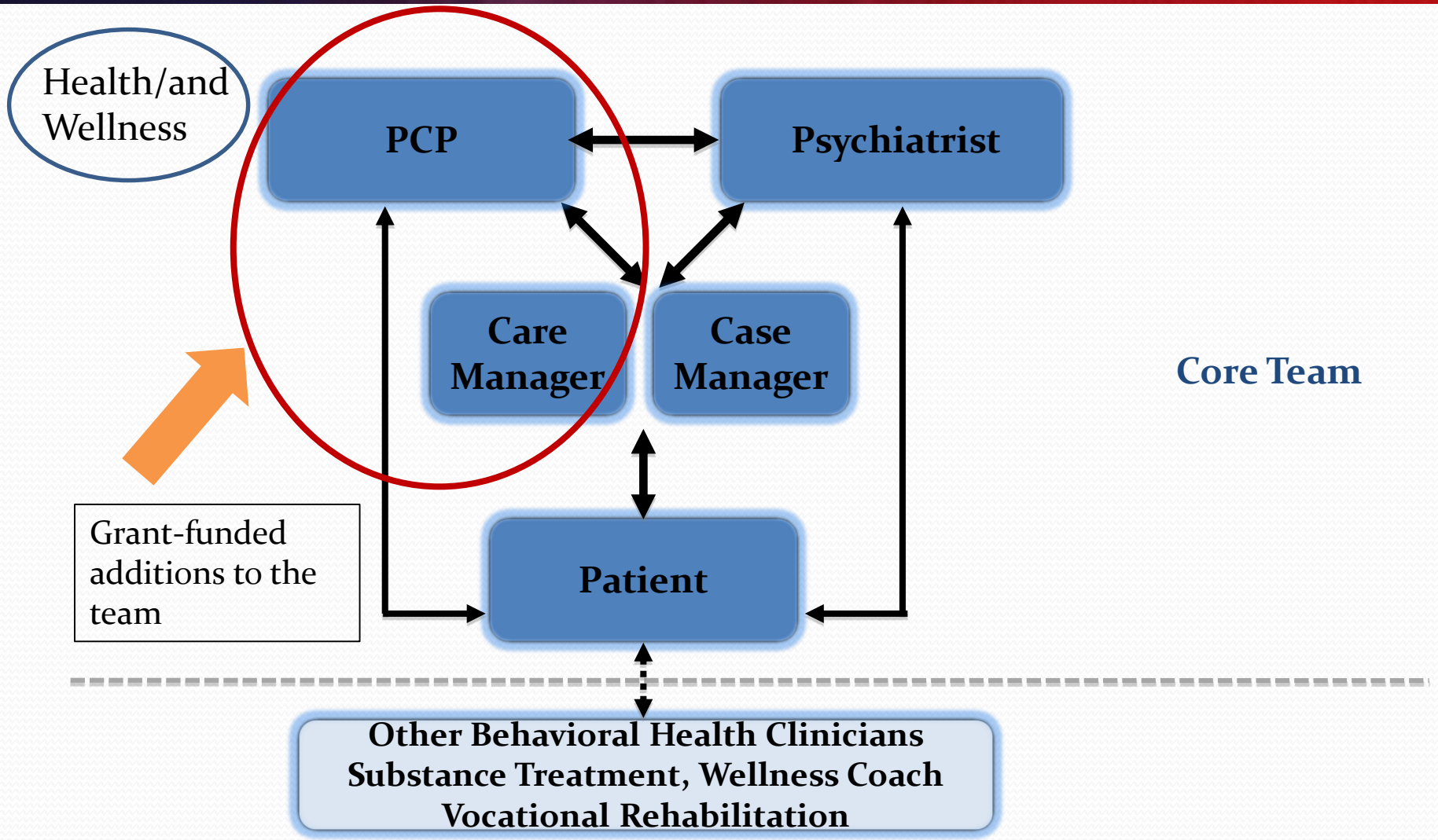
Primary Behavioral Health Care (PBHCI) Grantees by HHS Regions



As of March 1, 2014.

SAMHSA-HRSA. Center for Integrated Health Solutions. www.integration.samhsa.gov/about-us/PBHCI_Grantees_-Cohort_I-VI-.pdf. Accessed July 19, 2014.

PBHCI Approach



PBHCI RAND Evaluation #1

- Registries not simple to construct; data gathering difficult
- Recruiting and retaining qualified staff; PCP turnover
- Patient recruitment; lack of perceived need for care
- Space and licenses to do primary care

Sharf DM, et al. *Psychiatric Services.* 2013;64(7):660-665.

PCPs Qualities

- Flexible
- Adapts well to behavioral health environment
- Likes working with patients with mental illnesses – compassion and passion
- Enjoys being part of a team: no lone rangers
- Want to make a difference in a health disparity group

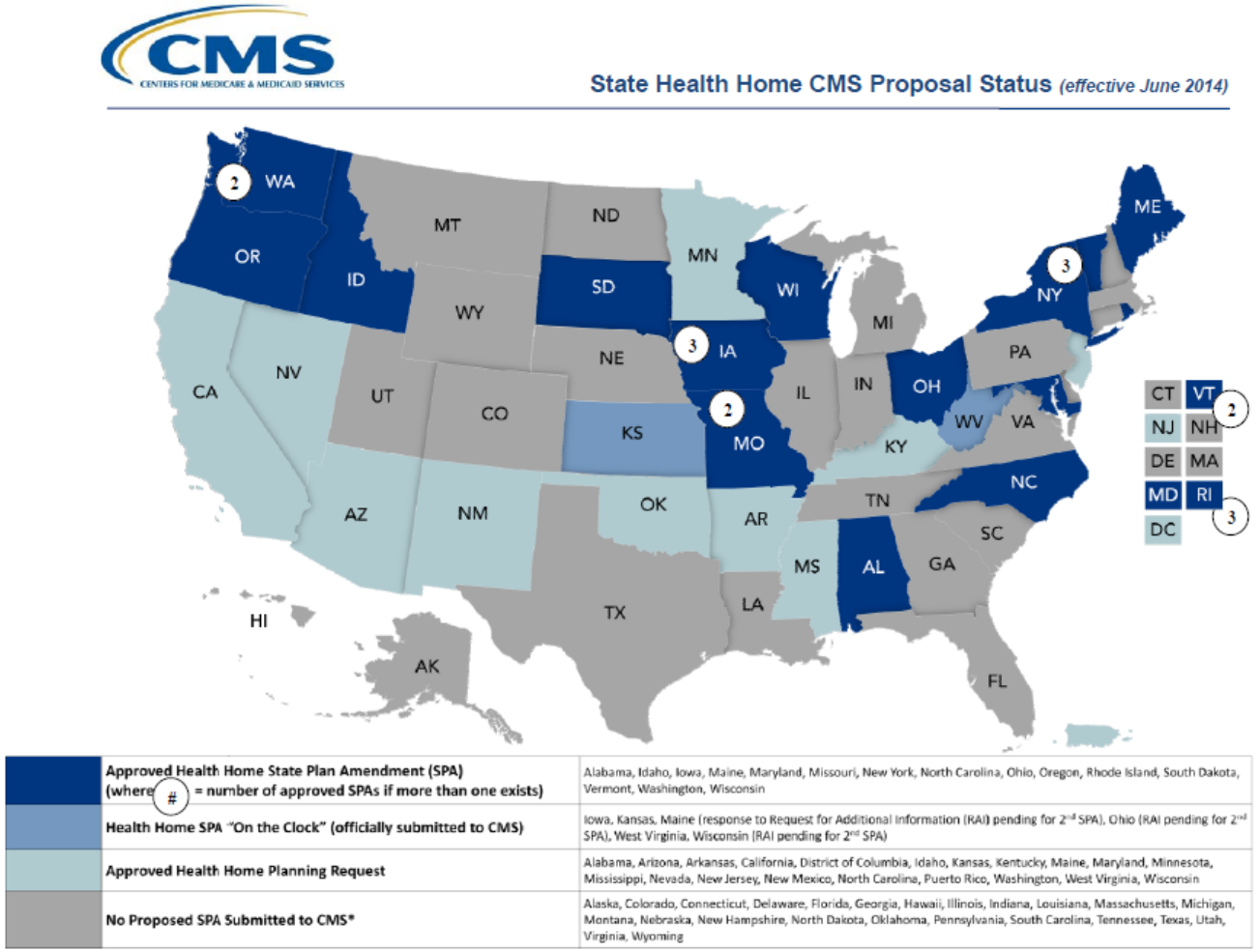
- ***PCP curriculum now available***
  http://www.integration.samhsa.gov

PBHCI RAND Evaluation

- Integrated systems of various kinds created
- Limited use of Evidence Based Practices for smoking, obesity
- Not able to identify centers which functioned best
- Small clinical evaluation did not show significant effect on physical health

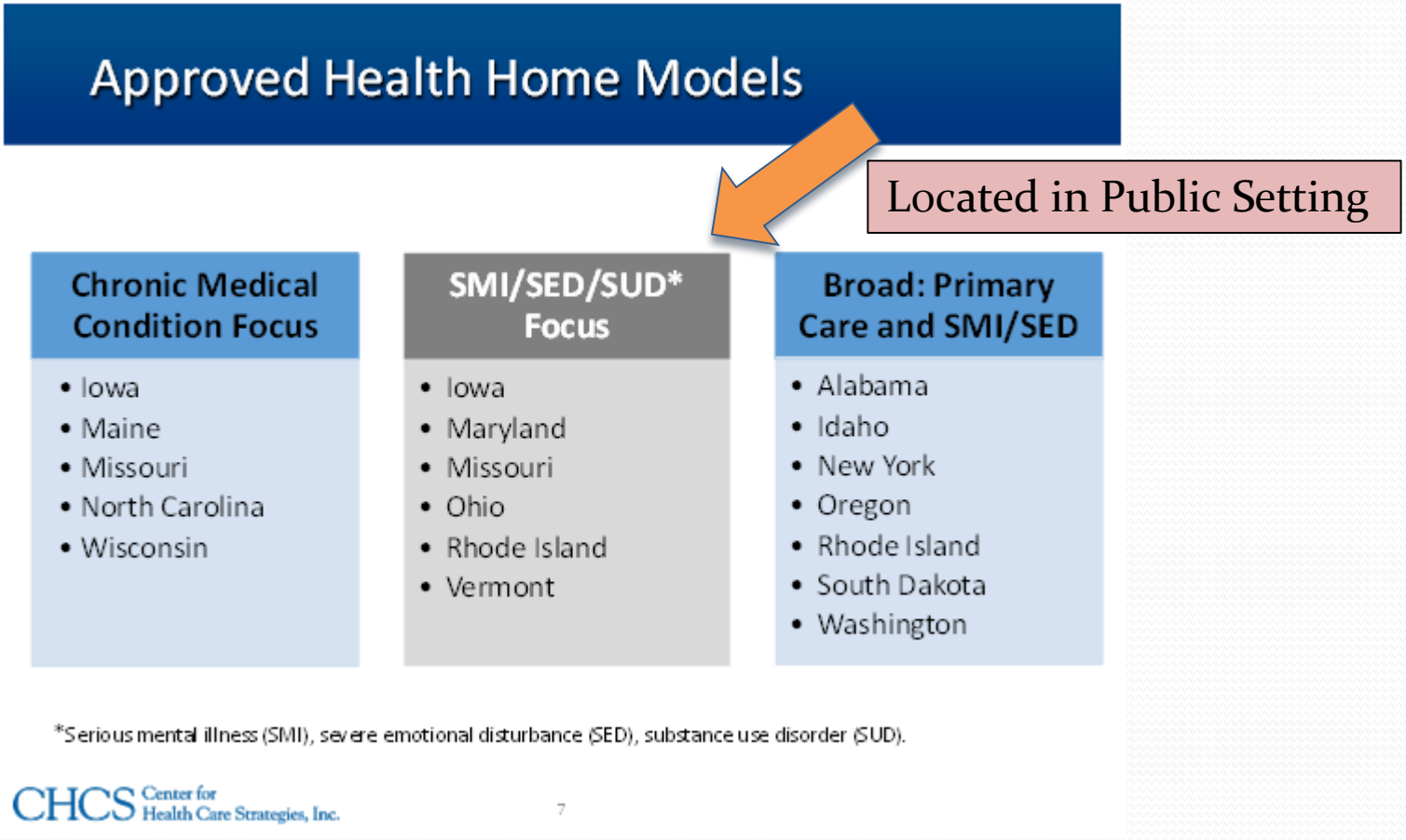
Scharf, et al. 2013 Report to HHS. http://aspe.hhs.gov/daltcp/reports/2013/PBHCIfr.shtml
EBP = Evidence based practice

2703 Medicaid State Plan Amendments



www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-MAP_v34.pdf. Accessed July 19, 2014.

Health Home Focus



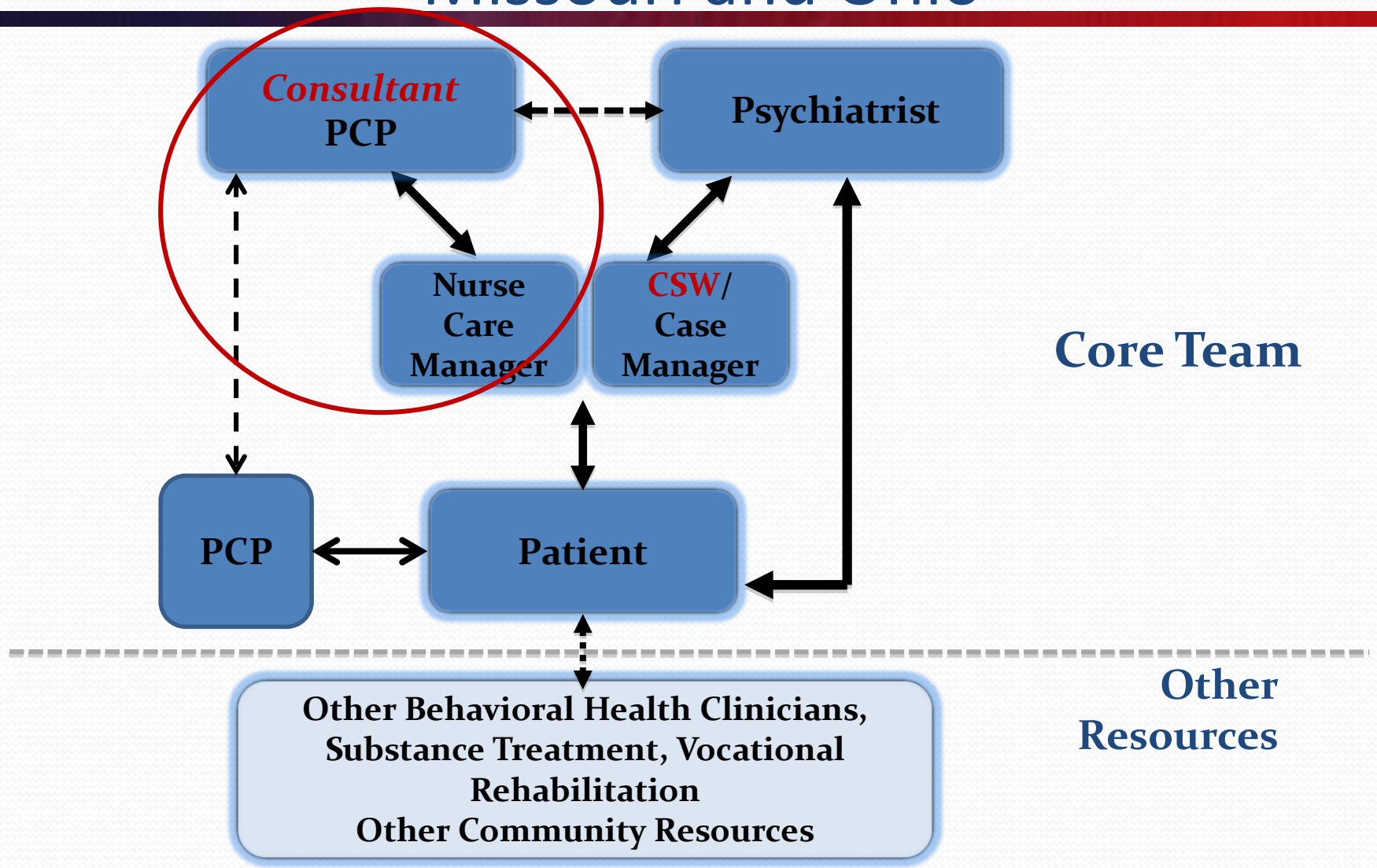
www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-MAP_v34.pdf. Accessed July 19, 2014.

6 Required Services (No Direct Primary Care)

- Individual and Family Support
- Comprehensive Care Management
- Care Coordination
- Referral to Community and Social Support Services
- Health Promotion
- Comprehensive Transitional Care

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html

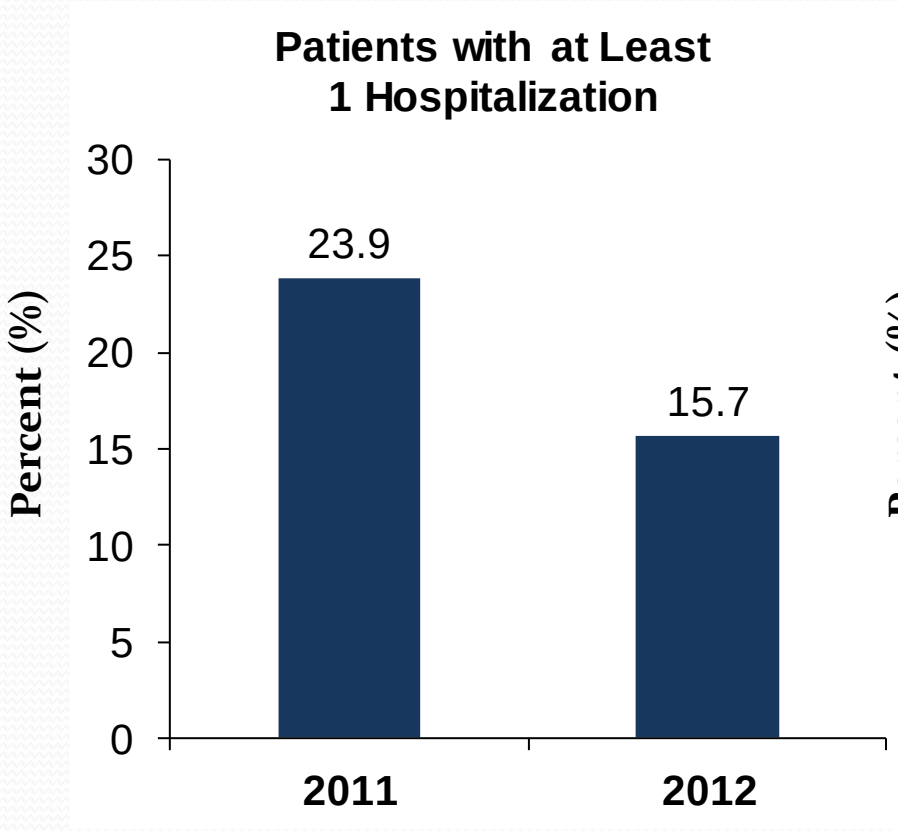
Health Home Approach: Missouri and Ohio



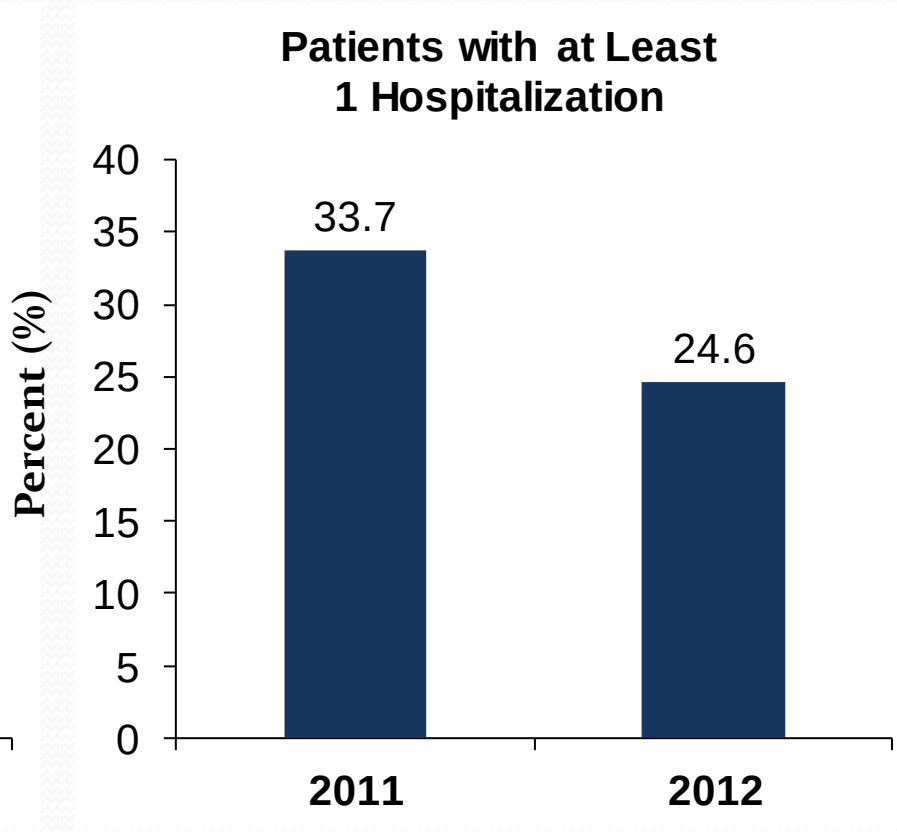
CSW = clinical support worker.

Outcomes Reducing Hospitalization

Primary Care Health Homes



CMHC Healthcare Homes



dmh.mo.gov/docs/mentalillness/18MonthReport.pdf 2014

Certified Community Behavioral Health Clinics (CBHC)

Excellence in Mental Health Act – passed March 31, 2014

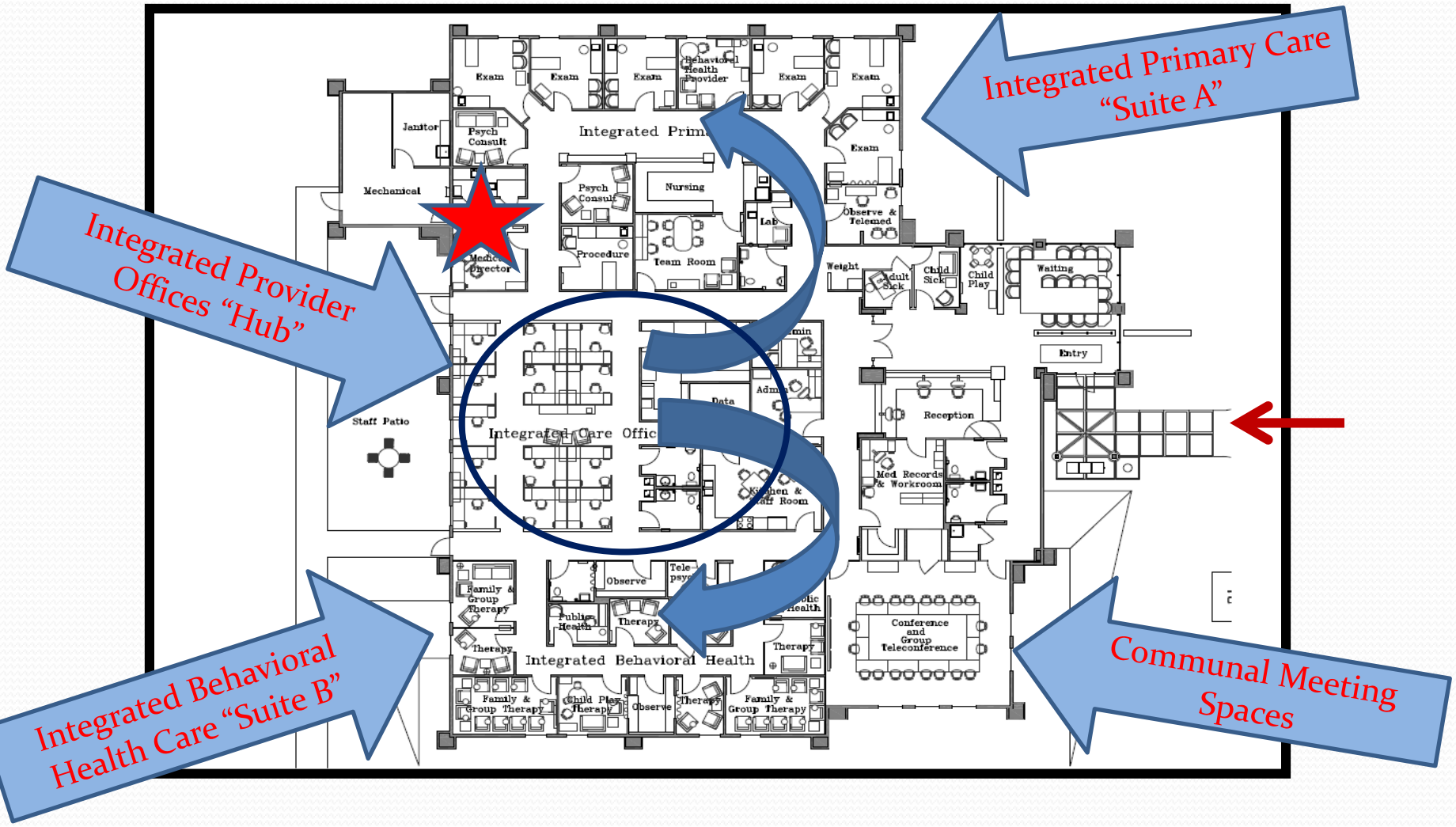
Scope:

- Primary Care Screenings and Monitoring of Key Health Indicators and Risk
- Care Management
- Partnerships with FQHCs for physical health
- Evidence-Based Practices
- Robust evaluation of 8 pilots – Indiana??

BREAK
(back in 15 minutes)

Cortez Integrated Healthcare

Merged Clinic



Population-Based Screening

Adult

- PHQ-9 (depression)
- GAD-7 (anxiety)
- AUDIT (alcohol)
- DAST (drugs)
- PTSD-PC (PTSD)
- HRQL
- Health Goals
- Readiness to Change
- BMI
- BP

Child

- PHQ-A (depression)
- CRIES (PTSD)
- CRAFFT (alcohol)
- SDQ (5 – 11)
- ASQ (2 – 5)
- Health Goals
- HRQL
- Readiness to Change
- BMI

In SBHC use the PHQ-A, CRAFFT

“The Box” – Patient Tools ©

Tracking – Back Office Screens

- PHQ-9 (and adolescent)
- GAD-7
- Change smoking status, health goals
- SDQ

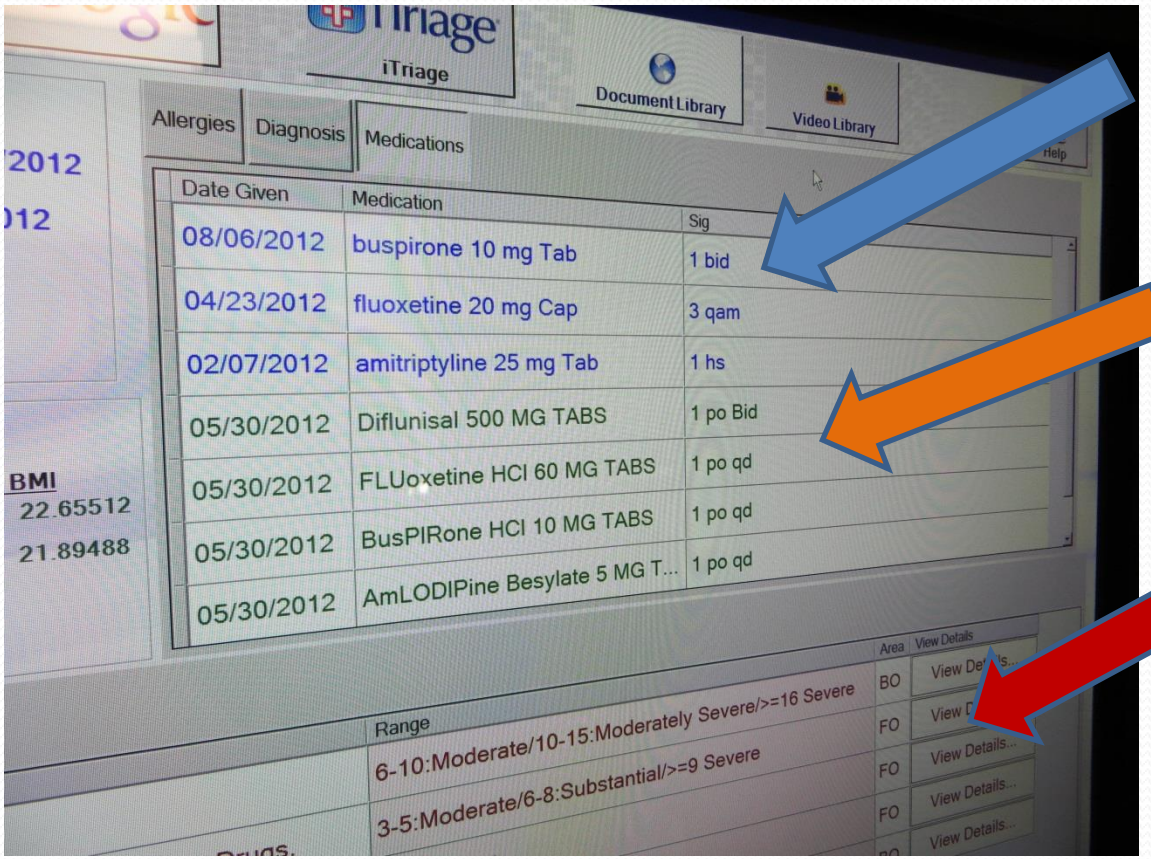
- Additional/Advanced
  - Vanderbilt
  - Edinburgh Post Partum Depression Scale
  - Mood Disorder Questionnaire
  - Autism

KEY Element: Daily Huddles

- Plan for changes in the workflow, manage crises before they arise
- Share details of care being provided by individual members so you have a more comprehensive picture of the patient
- **Who needs to be screened/rescreened?**
- **Who is not improving?**
- Huddle leader, huddle location
- Decide if labs, reports, etc are available and who needs extra intervention
- Check for openings - might be able to get someone in?

Health Tracker

Blending 3 Data Streams: Dashboard

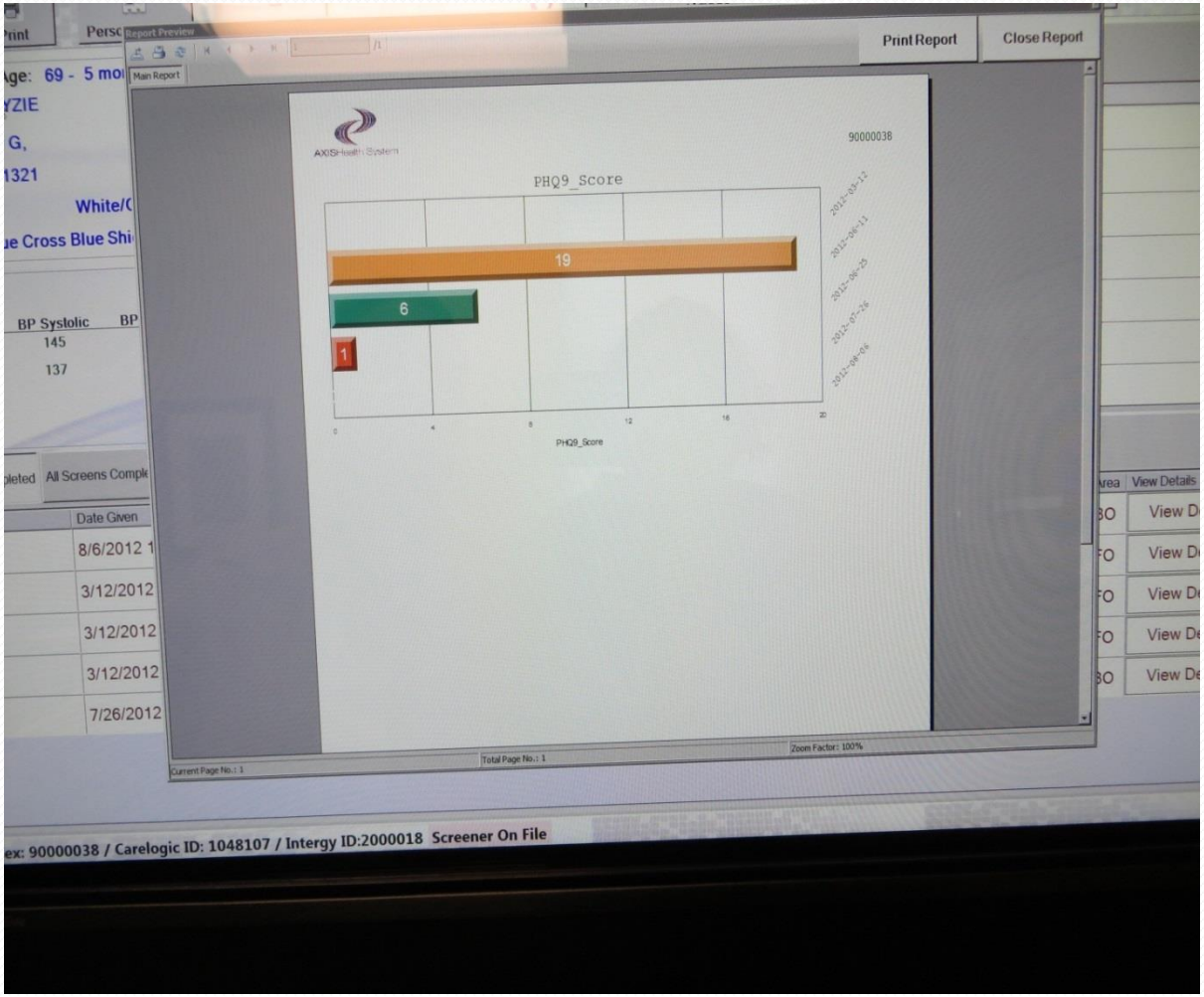


Carelogic

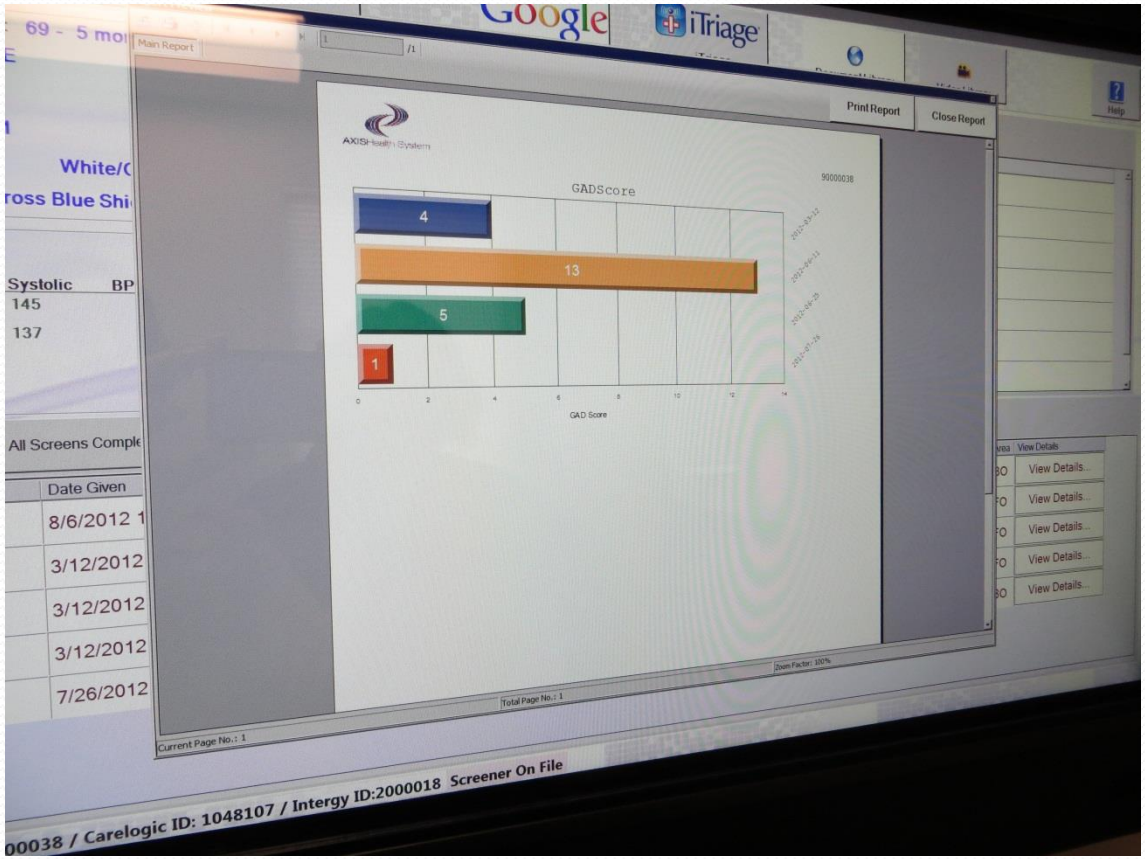
Intergy "Sage"

Patient Tools

PHQ-9


Print Report
Close Report
Main Report
90000038
PHQ9_Score
19
6
1
PHQ9_Score
Current Page No.: 1
Total Page No.: 1
Zoom Factor: 100%
BP Systolic
145
137
Date Given
8/6/2012
3/12/2012
3/12/2012
3/12/2012
7/26/2012
View Details
ex: 90000038 / Carelogic ID: 1048107 / Intergy ID:2000018 Screener On File

GAD-7


Google
iTriage
Print Report
Close Report
GADScore
4
13
5
1
GAD Score
Systolic BP
145
137
Date Given
8/6/2012
3/12/2012
3/12/2012
3/12/2012
7/26/2012
View Details
Screener On File

Staff Use Data to Discuss Both General Medical and BH Conditions

Beneficial Effects of Interventions to Reduce Risks of CVD – "Small Steps, Big Rewards"

- Blood cholesterol
  - 10% ↓ = 30% ↓ in CHD (200-180)
- High blood pressure (> 140 SBP or 90 DBP)
  - ~ 6 mm Hg ↓ = 16% ↓ in CHD; 42% ↓ in stroke
- Diabetes (HbA1c > 7)
  - 1% point ↓ HbA1c = 21% dec in DM related deaths, 14% decrease in MI, 37% dec in microvascular complications
- Cigarette smoking cessation
  - ~ 50% ↓ in CHD
- Maintenance of ideal body weight (BMI = 18.5-25)
  - 5-10 % loss is clinically significant,
  - 35%-55% ↓ in CHD
- Maintenance of active lifestyle
- ~30-min walk daily -30%-50% ↓ in CHD

Stratton, et al, BMJ 2000
Hennekens CH. *Circulation* 1998;97:1095-1102.
Rich-Edwards JW, et al. *N Engl J Med* 1995;332:1758-1766.
Bassuk SS, Manson JE. *J Appl Physiol* 2005;99:1193-1204

.

Case Manager

PCP

LCSW

Psychiatric Providers

Psychologist

Addictions Counselor

ADMIN

Nurse

Peers

Service Dog

Licensed therapist

Basic Medical Knowledge for Non- Medical Staff: A Shared Base of Health Literacy

- What are the illnesses and why should I care? And what should I be doing about it? What does it have to do with mental illness anyway?
  - Hypertension – Systolic? Diastolic? Millimeters of Mercury? Stroke?
  - Diabetes – what is Hemoglobin A one C and what do I do with this number? foot exams?
  - Dyslipidemias – Ok – I've heard of "good" and "bad" cholesterol but what's the ratio business?
  - Asthma – inhaled corticosteroids? How do you use that thing?
  - Smoking – OK – I know this is bad for you but what does NRT stand for?
  - Obesity – Got it – this is bad and diet and exercise treat but what is BMI ?

Encourage Health Behavior Change

Medical Treatments Targets

- Glucose control
- Blood pressure
- Cardiac risk reduction

Health Behavior Change Targets

- Inactivity
- Smoking cessation
- Improving dietary habits

Comprehensive Vital Signs

56 year old male…….

- T 98.6, P 75, R 12, BP 140/95, BMI 27
- PHQ 16, GAD 5, AUDIT 10, PTSD-PC 0

Comprehensive Vital Signs
PCP "sees"

- T 98.6, P 75, R 12, BP 140/95, BMI 27
- PHQ 16, GAD 5, AUDIT 10, PTSD-PC 0

Comprehensive Vital Signs
Behavioral Health "sees"

- T 98.6, P 75, R 12, BP 140/95, BMI 27
- PHQ 16, GAD 5, AUDIT 10, PTSD-PC 0

Comprehensive Vital Signs
All Clinical Staff!

- T 98.6, P 75, R 12, BP 140/95, BMI 27
- PHQ 16, GAD 5, AUDIT 10, PTSD-PC 0

Staff Health Screening Data

• BMI	24.8	18 – 41	23 > 24.9
• SBP	122	88 - 170	7 > 139
• DBP	78	42 – 107	6 > 89
• PHQ9	3	0 - 14	2 > 9
• Audit	2	0 - 14	2 > 8

HRQL – Health Related Quality of Life

• Health	1	0-4
• Physical	2	0-20
• Mental	4	0-30
• Overall	1	0-10

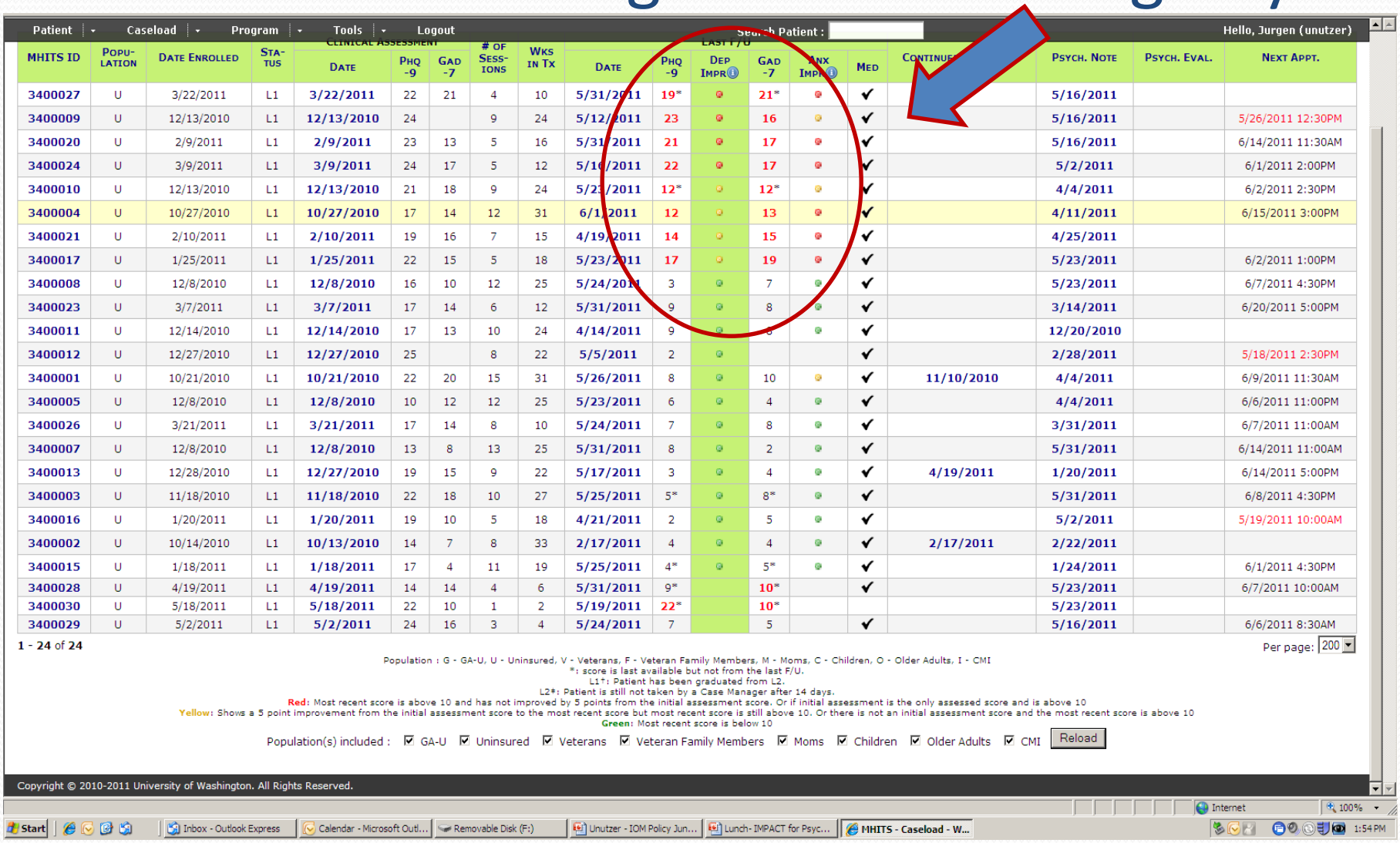
Set a Goal: 5% Reduction in BMI
Over the next year

Population Based Care

Population-based Care: Analyzing Aggregate Data

- Identify high risk individuals in need of immediate attention
- Select chronic disease, cohort of consumers and interventions most likely to have the greatest effect on improving the management of chronic disease
- Choose the initiative most likely to have significant impact and use to focus educational efforts

Systematic Caseload Review: Prioritizing Cases in the Registry



Patient | Caseload | Program | Tools | Logout — Search Patient : — Hello, Jurgen (unutzer)

MHITS ID	Popu-lation	Date Enrolled	Sta-tus	Clinical Assessment			# of Sess-ions	Wks in Tx	Last F/U						Continue	Psych. Note	Psych. Eval.	Next Appt.
				Date	PHQ -9	GAD -7			Date	PHQ -9	Dep Impr	GAD -7	Anx Impr	Med				
3400027	U	3/22/2011	L1	3/22/2011	22	21	4	10	5/31/2011	19*		21*		✓		5/16/2011		
3400009	U	12/13/2010	L1	12/13/2010	24		9	24	5/12/2011	23		16		✓		5/16/2011		5/26/2011 12:30PM
3400020	U	2/9/2011	L1	2/9/2011	23	13	5	16	5/31/2011	21		17		✓		5/16/2011		6/14/2011 11:30AM
3400024	U	3/9/2011	L1	3/9/2011	24	17	5	12	5/16/2011	22		17		✓		5/2/2011		6/1/2011 2:00PM
3400010	U	12/13/2010	L1	12/13/2010	21	18	9	24	5/23/2011	12*		12*		✓		4/4/2011		6/2/2011 2:30PM
3400004	U	10/27/2010	L1	10/27/2010	17	14	12	31	6/1/2011	12		13		✓		4/11/2011		6/15/2011 3:00PM
3400021	U	2/10/2011	L1	2/10/2011	19	16	7	15	4/19/2011	14		15		✓		4/25/2011		
3400017	U	1/25/2011	L1	1/25/2011	22	15	5	18	5/23/2011	17		19		✓		5/23/2011		6/2/2011 1:00PM
3400008	U	12/8/2010	L1	12/8/2010	16	10	12	25	5/24/2011	3		7		✓		5/23/2011		6/7/2011 4:30PM
3400023	U	3/7/2011	L1	3/7/2011	17	14	6	12	5/31/2011	9		8		✓		3/14/2011		6/20/2011 5:00PM
3400011	U	12/14/2010	L1	12/14/2010	17	13	10	24	4/14/2011	9		8		✓		12/20/2010		
3400012	U	12/27/2010	L1	12/27/2010	25		8	22	5/5/2011	2				✓		2/28/2011		5/18/2011 2:30PM
3400001	U	10/21/2010	L1	10/21/2010	22	20	15	31	5/26/2011	8		10		✓	11/10/2010	4/4/2011		6/9/2011 11:30AM
3400005	U	12/8/2010	L1	12/8/2010	10	12	12	25	5/23/2011	6		4		✓		4/4/2011		6/6/2011 11:00PM
3400026	U	3/21/2011	L1	3/21/2011	17	14	8	10	5/24/2011	7		8		✓		3/31/2011		6/7/2011 11:00AM
3400007	U	12/8/2010	L1	12/8/2010	13	8	13	25	5/31/2011	8		2		✓		5/31/2011		6/14/2011 11:00AM
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3400016	U	1/20/2011	L1	1/20/2011	19	10	5	18	4/21/2011	2		5		✓		5/2/2011		5/19/2011 10:00AM
3400002	U	10/14/2010	L1	10/13/2010	14	7	8	33	2/17/2011	4		4		✓	2/17/2011	2/22/2011		
3400015	U	1/18/2011	L1	1/18/2011	17	4	11	19	5/25/2011	4*		5*		✓		1/24/2011		6/1/2011 4:30PM
3400028	U	4/19/2011	L1	4/19/2011	14	14	4	6	5/31/2011	9*		10*		✓		5/23/2011		6/7/2011 10:00AM
3400030	U	5/18/2011	L1	5/18/2011	22	10	1	2	5/19/2011	22*		10*				5/23/2011		
3400029	U	5/2/2011	L1	5/2/2011	24	16	3	4	5/24/2011	7		5		✓		5/16/2011		6/6/2011 8:30AM

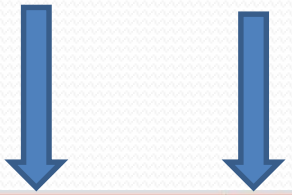
1 - 24 of 24 — Per page: 200

Population : G - GA-U, U - Uninsured, V - Veterans, F - Veteran Family Members, M - Moms, C - Children, O - Older Adults, I - CMI
*: score is last available but not from the last F/U.
L1†: Patient has been graduated from L2.
L2#: Patient is still not taken by a Case Manager after 14 days.
Red: Most recent score is above 10 and has not improved by 5 points from the initial assessment score. Or if initial assessment is the only assessed score and is above 10
Yellow: Shows a 5 point improvement from the initial assessment score to the most recent score but most recent score is still above 10. Or there is not an initial assessment score and the most recent score is above 10
Green: Most recent score is below 10

Population(s) included : ☑ GA-U ☑ Uninsured ☑ Veterans ☑ Veteran Family Members ☑ Moms ☑ Children ☑ Older Adults ☑ CMI Reload

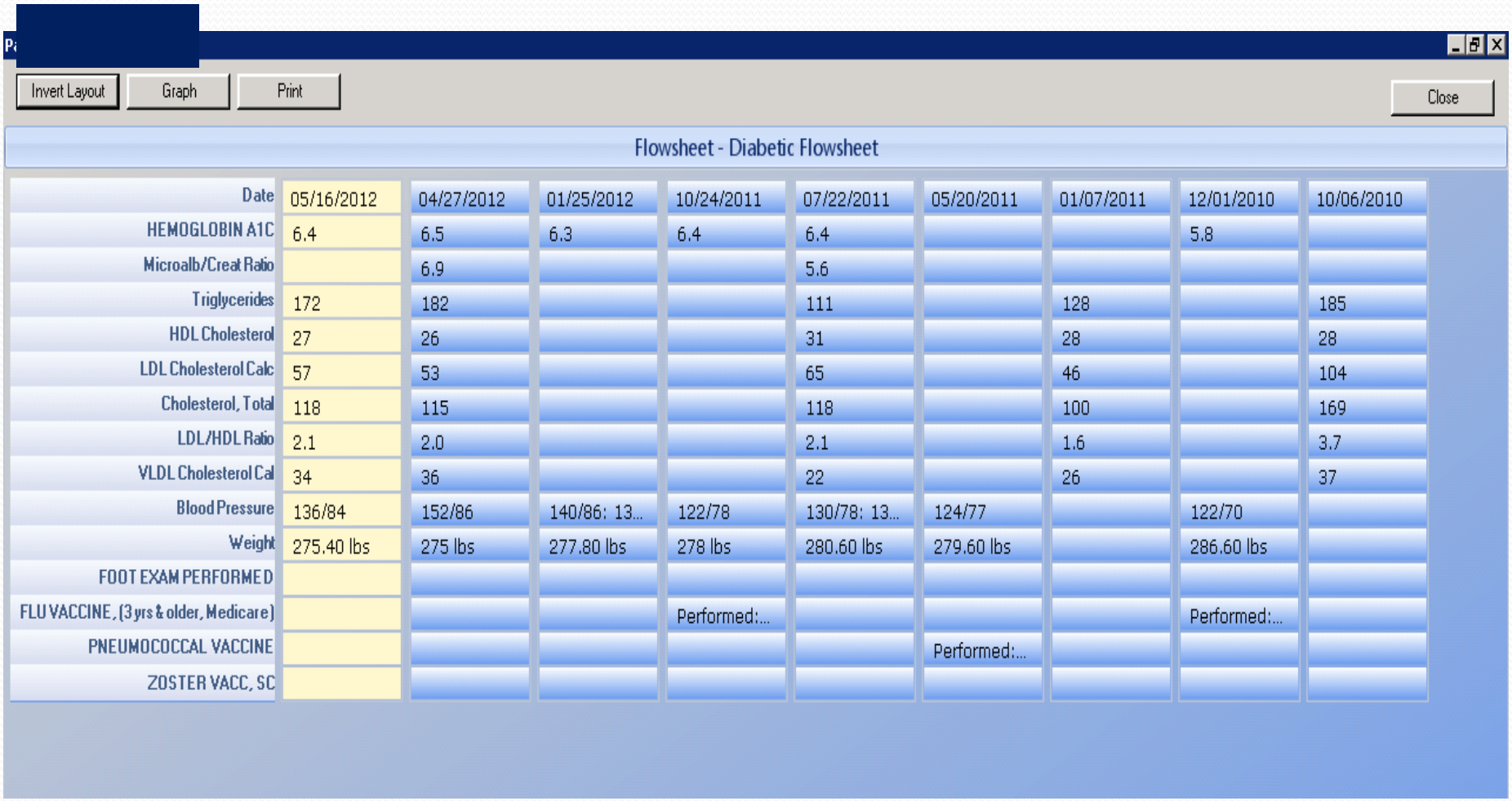
Start | Inbox - Outlook Express | Calendar - Microsoft Outl... | Removable Disk (F:) | Unutzer - IOM Policy Jun... | Lunch- IMPACT for Psyc... | MHITS - Caseload - W... | Internet | 100% | 1:54 PM

Metrics – HEDIS



CL ID	Description	Flagged	OK	% Flagged	% OK		Goal	Var
DM01	Use of inhaled corticosteroid medications by persons with a history of COPD (chronic obstructive pulmonary disease) or Asthma.	54	48	52.94	47.06	52.94 47.06	70	-22.94
DM02	Use of ARB (angiotensin II receptor blockers) or ACEI (angiotensin converting enzyme inhibitors) medications by persons with a history of CHF (congestive heart failure).	6	8	42.86	57.14	42.86 57.14	70	-12.86
DM03	Use of beta-blocker medications by persons with a history of CHF (congestive heart failure).	8	6	57.14	42.86	57.14 42.86	70	-27.14
DM04	Use of statin medications by persons with a history of CAD (coronary artery disease).	12	5	70.59	29.41	70.59 29.41	70	-40.59
DM05	Use of H2A (histamine 2-receptor antagonists) or PPI (proton pump inhibitors) medications for no more than 8 weeks by persons with a history of GERD (gastro-esophageal reflux disease).	73	81	47.40	52.60	47.4 52.6	50	2.60
DM06	Presence of a fasting lipid profile within the past 12 months for patients with CAD (coronary artery disease).	12	5	70.59	29.41	70.59 29.41	70	-40.59
DM07	Presence of a DRE (dilated retinal exam) within the past 12 months for patients with diabetes mellitus.	75	51	59.52	40.48	59.52 40.48	70	-29.52
DM08	Presence of a urinary microalbumin test within the past 12 months for patients with diabetes mellitus.	103	23	81.75	18.25	81.75 18.25	70	-51.75
DM09	Presence of at least 2 hemoglobin A1C tests within the past 12 months for patients with diabetes mellitus.	81	45	64.29	35.71	64.29 35.71	70	-34.29
DM10	Presence of a fasting lipid profile within past 12 months for patients with diabetes mellitus.	80	46	63.49	36.51	63.49 36.51	70	-33.49

Registry Example: Diabetes



Invert Layout | Graph | Print | Close

Flowsheet - Diabetic Flowsheet

Date	05/16/2012	04/27/2012	01/25/2012	10/24/2011	07/22/2011	05/20/2011	01/07/2011	12/01/2010	10/06/2010
HEMOGLOBIN A1C	6.4	6.5	6.3	6.4	6.4			5.8	
Microalb/Creat Ratio		6.9			5.6				
Triglycerides	172	182			111		128		185
HDL Cholesterol	27	26			31		28		28
LDL Cholesterol Calc	57	53			65		46		104
Cholesterol, Total	118	115			118		100		169
LDL/HDL Ratio	2.1	2.0			2.1		1.6		3.7
VLDL Cholesterol Cal	34	36			22		26		37
Blood Pressure	136/84	152/86	140/86: 13...	122/78	130/78: 13...	124/77		122/70	
Weight	275.40 lbs	275 lbs	277.80 lbs	278 lbs	280.60 lbs	279.60 lbs		286.60 lbs	
FOOT EXAM PERFORMED									
FLU VACCINE, (3 yrs & older, Medicare)				Performed:...				Performed:...	
PNEUMOCOCCAL VACCINE						Performed:...			
ZOSTER VACC, SC									

DIABETES PATIENTS

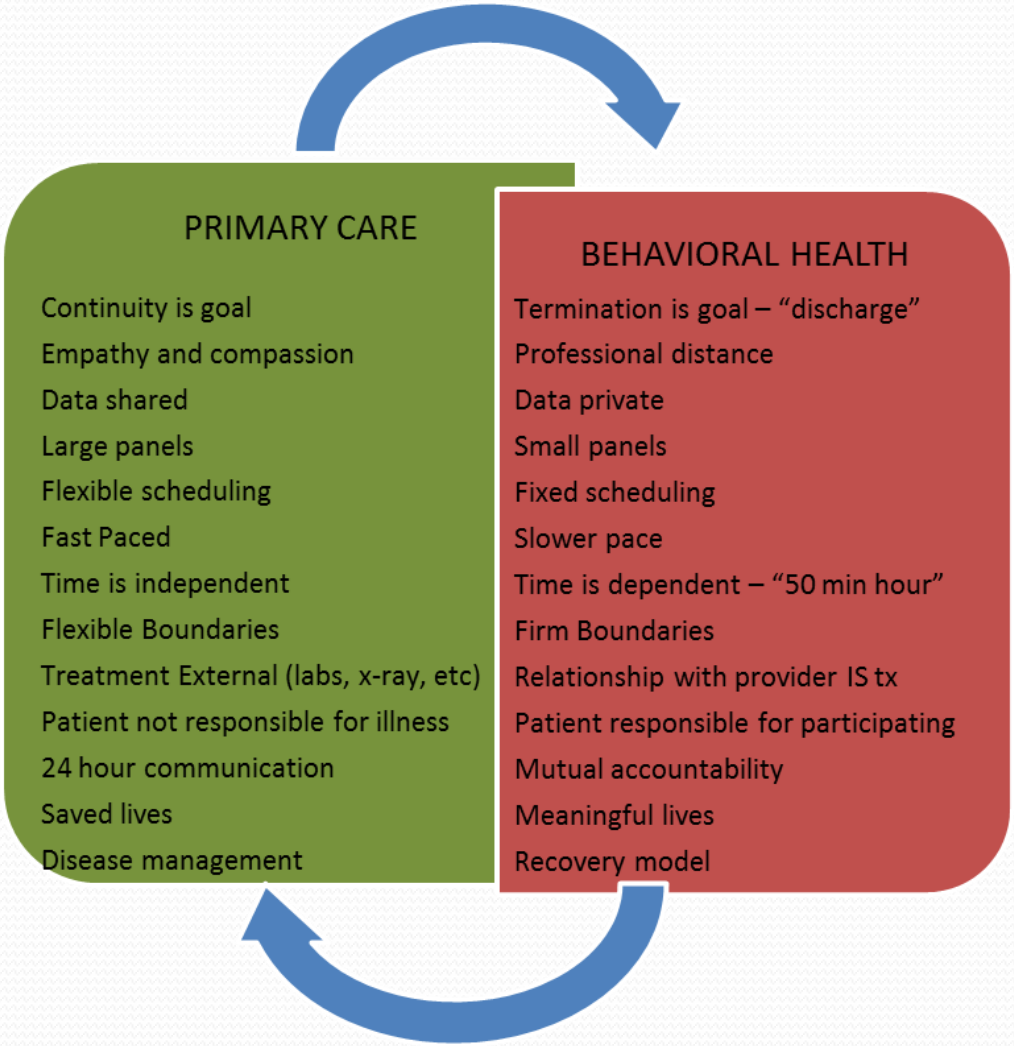
	ALL PROVIDERS	Provider A	Provider B	Provider C	Provider D	Provider E	All Providers Aug-08
HbA1c <7.0 **GOAL 40%**	48%	51%	41%	43%	61%	0%	47%
HbA1c <9.0 **GOAL 68%**	75%	80%	72%	78%	70%	100%	
BP <130/80 mm Hg **GOAL 25%**	35%	41%	32%	47%	21%	0%	
LDL <100 mg/dL **GOAL 36%**	42%	42%	44%	35%	42%	100%	27%
Annual Dilated Eye Exam **GOAL 40%**	7%	9%	3%	4%	9%	100%	0%
Annual Foot Exam **GOAL 80%**	96%	93%	95%	100%	91%	100%	24%
Annual Nephropathy Exam **GOAL 80%**	95%	93%	92%	100%	94%	100%	24%
Smoking Status Documented and/or Advised Treatment **GOAL 80%**	93%	96%	92%	96%	94%	100%	55%

Make it Fun and Rewarding

- Use data to show staff the impact they are having – can be real morale booster
- Build excitement and enthusiasm
- A little healthy competition is OK
- Share the wins with the team
- Tell a compelling story to funders

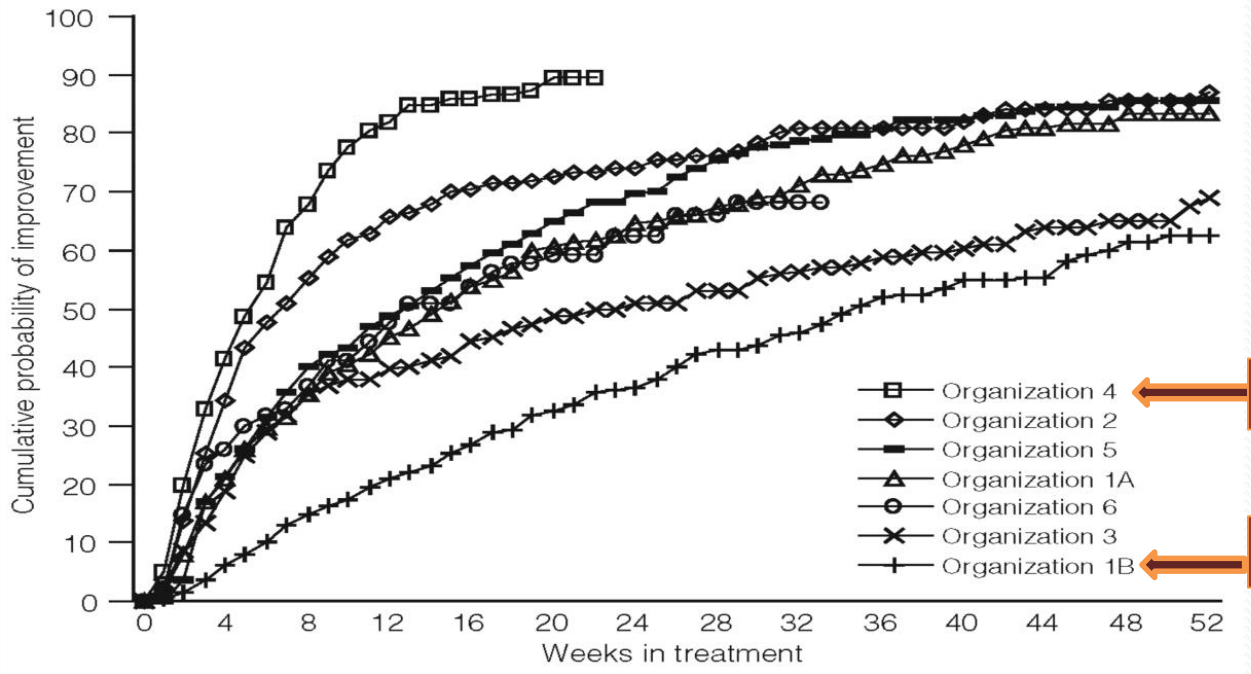
Caution: Merging Cultures

2 Cultures, 1 Patient



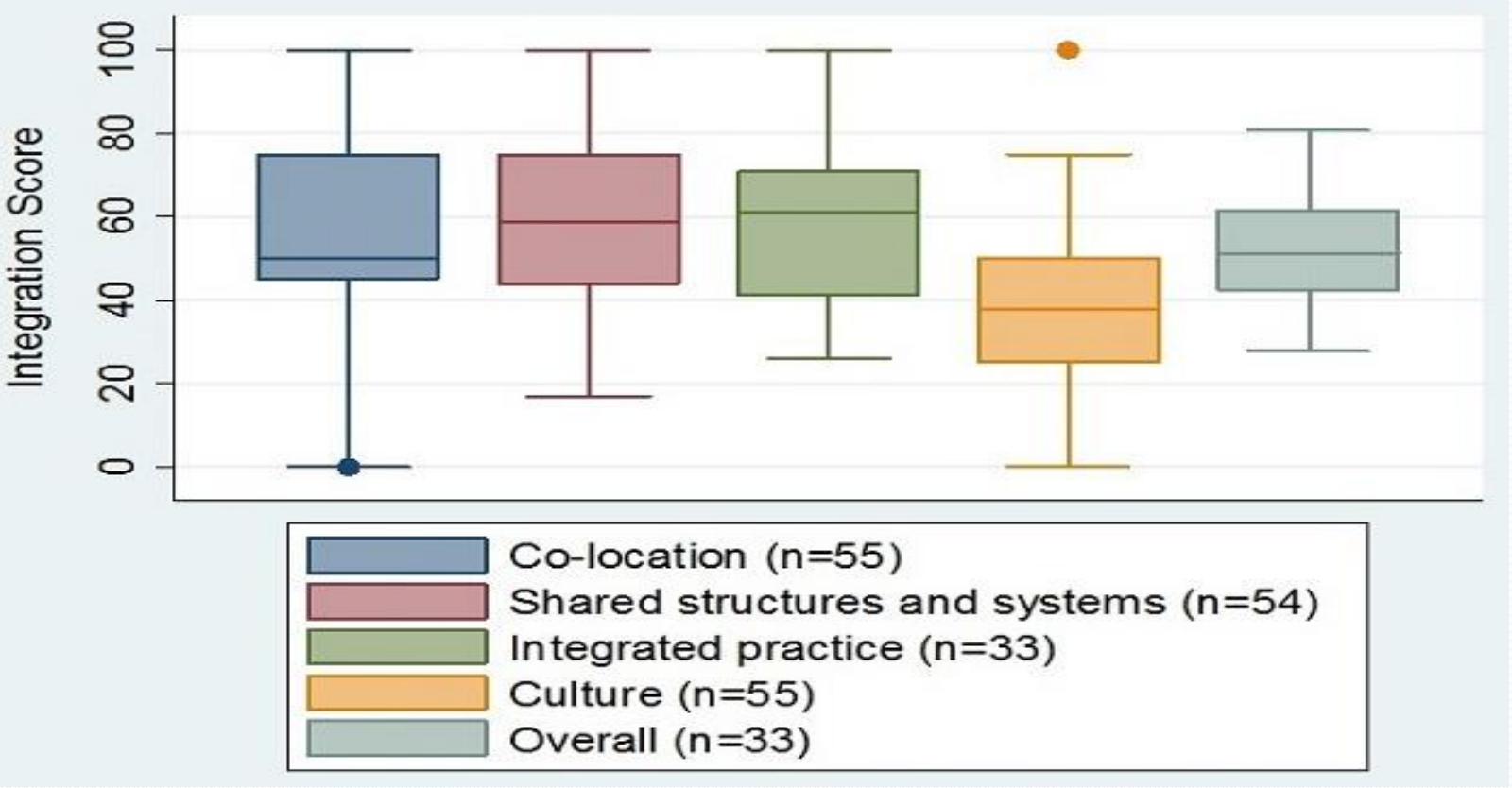
Culture Counts

Estimated Time Elapsed between Initial Assessment and Improvement of Depression During First Year of Treatment: 6 Organizations



Bauer AM, et al. *Psychiatric Services.* 2011;62(9):1047-1053.

Integration Scores for PBHCI Grantees



Collaboration on Tx Plans-Low
Collaboration on Pt Goals – Med
Overall Leadership Collab – Med
Overall Provider Collab – Med-Low

Principles of Team-Based Heath Care

Principles

- Shared goals
- Clear roles
- Mutual trust
- Effective communication
- Measurable processes and outcomes

Personality Traits

- Honesty
- Discipline
- Creativity
- Humility
- Curiosity

Mitchell, et al 2012, Institute of Medicine, Washington, DC. www.iom.edu/tbc,

Elements of High Functioning Integrated Care Teams

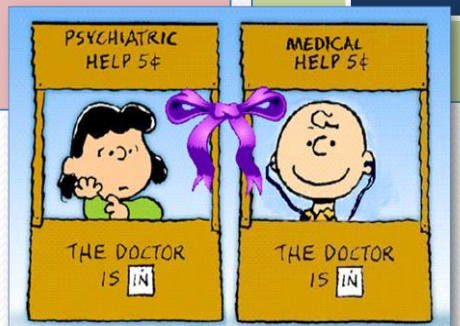
- Leadership and organizational commitment
- Time and energy for team development
- Team processes worked out to foster integration - humility and willingness to let go of hierarchy
- Committing to outcomes

Lasky, Raney, HRSA 2014

Making the Most of Your Medical Staff

- Education
- Champion medical cause
- Get off the hamster wheel
- Support vitals and metabolic monitoring with staff

PCP ROLES	PSYCHIATRIST ROLES
Establish Priorities	Medical Leadership
Education	Shared Medical Oversight
Develop Collaborative Relationships	Collaboration with other Team Members in Comprehensive Care Management
Case Consultation	



Take the Leap!

Resources

- AIMS Center website http://aims.uw.edu/
- CIHS website http://www.integration.samhsa.gov/
- APA website www.psych.org
- American Psychiatric Publishing