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

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 Ratcliff 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. Ratcliff confers weekly with 10 care managers who follow the patients closely, providing counseling and charting 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. Ratcliff’s practice is part of a burgeoning effort to integrate psychiatric care into primary care.

Body and Mind
Who needs, gets, gives care
25% of U.S. adults experience a mental-health disorder in a given year
50% 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

Special: National Library of Medicine

Dr. Thomas Gallo with patient Meg Hall, 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.”

Healthcare Spending

Healthcare Spending per capita vs. Average Life Expectancy Among OECD Countries

## Annual Cost of Care

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

**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.
21st Century CMHC

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

SPAs = State Plan Amendments; CHC = community health center; PBHCCI = Primary and Behavioral Health Care Integration.
<table>
<thead>
<tr>
<th>NCQA 2011</th>
<th>NCQA 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PCMH Standard 1: Enhance Access and Continuity</strong></td>
<td><strong>Program Structure (QI 1)</strong></td>
</tr>
<tr>
<td>• Comprehensive assessment includes depression screening for adolescents and adults</td>
<td>• Does the QI program specifically address behavioral health?</td>
</tr>
<tr>
<td><strong>PCMH Standard 3: Plan and Manage Care</strong></td>
<td>• Is there a physician and behavioral health practitioner involved in the QI program?</td>
</tr>
<tr>
<td>• 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.</td>
<td><strong>Accessibility of Services (QI 5)</strong></td>
</tr>
<tr>
<td><strong>PCMH Standard 5: Track and Coordinate Care</strong></td>
<td>• Can members get behavioral health care when they need it?</td>
</tr>
<tr>
<td>• Track referrals and coordinate care with mental health and substance abuse services</td>
<td><strong>7. Complex Case Management (QI 7)</strong></td>
</tr>
<tr>
<td></td>
<td>• Does the organization assess the characteristics and needs of its member population (including children/adolescents, individuals with disabilities and individuals with SPMI)?</td>
</tr>
<tr>
<td></td>
<td>• Are the organization’s case management systems based on sound evidence?</td>
</tr>
<tr>
<td></td>
<td><strong>9. Practice Guidelines (QI 9)</strong></td>
</tr>
<tr>
<td></td>
<td>• 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?</td>
</tr>
<tr>
<td></td>
<td><strong>11. Continuity and Coordination Between Medical and Behavioral Health Care (QI 11)</strong></td>
</tr>
<tr>
<td></td>
<td>• Does the organization annually collect data about opportunities for coordination between general medical care and behavioral health care?</td>
</tr>
<tr>
<td></td>
<td>• 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?</td>
</tr>
<tr>
<td></td>
<td><strong>1. UM Structure (UM 1)</strong></td>
</tr>
<tr>
<td></td>
<td>• Is a behavioral health practitioner involved in the behavioral health aspects of the program?</td>
</tr>
</tbody>
</table>
Lexicon for Integrated Care

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.
Levels of Integration

<table>
<thead>
<tr>
<th>COORDINATED</th>
<th>CO-LOCATED</th>
<th>INTEGRATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>KEY ELEMENT: COMMUNICATION</td>
<td>KEY ELEMENT: PHYSICAL PROXIMITY</td>
<td>KEY ELEMENT: PRACTICE CHANGE</td>
</tr>
<tr>
<td>LEVEL 1 Minimal Collaboration</td>
<td>LEVEL 2 Basic Collaboration at a Distance</td>
<td>LEVEL 5 Close Collaboration Approaching an Integrated Practice</td>
</tr>
<tr>
<td>LEVEL 3 Basic Collaboration Onsite</td>
<td>LEVEL 4 Close Collaboration Onsite with Some Systems Integration</td>
<td>LEVEL 6 Full Collaboration in a Transformed/Merged Integrated Practice</td>
</tr>
</tbody>
</table>

Primary Care is the “De Facto” Mental Health System

National Comorbidity Survey Replication
Provision of Behavioral Healthcare: Setting of Service

- No Treatment: 59%
- General Medical: 56%
- Mental Health Professional: 44%
- Receiving Care: 41%

Range of Opportunities for CMHCs

- Treat behavioral health in primary care settings
- Treat general medical conditions in behavioral health settings
# 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

- **Effective Collaboration**
  - Informed, Activated Patient
  - Practice Support
  - PCP supported by Behavioral Health Care Manager

- Measurement-Based Stepped Care
- Informal and formal Psychiatric consultation
- Caseload-Focused Registry Review

Registries to Track Progress and Intensify Treatment

<table>
<thead>
<tr>
<th>Patient ID</th>
<th>Population</th>
<th>Date Enrolled</th>
<th>Status</th>
<th>Tools</th>
<th>Layout</th>
<th>Search Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>3400009</td>
<td>U</td>
<td>12/13/2010</td>
<td>L1</td>
<td>23</td>
<td>10</td>
<td>5/16/2011</td>
</tr>
<tr>
<td>3400020</td>
<td>U</td>
<td>2/6/2011</td>
<td>L1</td>
<td>21</td>
<td>10</td>
<td>5/16/2011</td>
</tr>
<tr>
<td>3400010</td>
<td>L1</td>
<td>12/13/2010</td>
<td>L1</td>
<td>12</td>
<td>10</td>
<td>5/16/2011</td>
</tr>
<tr>
<td>3400004</td>
<td>L1</td>
<td>10/27/2010</td>
<td>L1</td>
<td>12</td>
<td>10</td>
<td>5/16/2011</td>
</tr>
<tr>
<td>3400221</td>
<td>L1</td>
<td>2/10/2011</td>
<td>L1</td>
<td>15</td>
<td>10</td>
<td>5/16/2011</td>
</tr>
<tr>
<td>3400008</td>
<td>U</td>
<td>12/9/2010</td>
<td>L1</td>
<td>8</td>
<td>10</td>
<td>5/16/2011</td>
</tr>
<tr>
<td>3400011</td>
<td>U</td>
<td>12/14/2010</td>
<td>L1</td>
<td>8</td>
<td>10</td>
<td>5/16/2011</td>
</tr>
<tr>
<td>3400012</td>
<td>L1</td>
<td>12/27/2010</td>
<td>L1</td>
<td>8</td>
<td>10</td>
<td>5/16/2011</td>
</tr>
<tr>
<td>3400001</td>
<td>L1</td>
<td>10/21/2010</td>
<td>L1</td>
<td>10</td>
<td>10</td>
<td>5/16/2011</td>
</tr>
<tr>
<td>3400005</td>
<td>U</td>
<td>12/8/2010</td>
<td>L1</td>
<td>8</td>
<td>10</td>
<td>5/16/2011</td>
</tr>
<tr>
<td>340026</td>
<td>U</td>
<td>3/21/2011</td>
<td>L1</td>
<td>8</td>
<td>10</td>
<td>5/16/2011</td>
</tr>
<tr>
<td>3400007</td>
<td>L1</td>
<td>12/8/2010</td>
<td>L1</td>
<td>7</td>
<td>10</td>
<td>5/16/2011</td>
</tr>
<tr>
<td>340013</td>
<td>L1</td>
<td>12/27/2010</td>
<td>L1</td>
<td>7</td>
<td>10</td>
<td>5/16/2011</td>
</tr>
<tr>
<td>3400003</td>
<td>L1</td>
<td>11/18/2010</td>
<td>L1</td>
<td>7</td>
<td>10</td>
<td>5/16/2011</td>
</tr>
<tr>
<td>340016</td>
<td>L1</td>
<td>1/20/2011</td>
<td>L1</td>
<td>7</td>
<td>10</td>
<td>5/16/2011</td>
</tr>
<tr>
<td>3400002</td>
<td>L1</td>
<td>10/14/2010</td>
<td>L1</td>
<td>7</td>
<td>10</td>
<td>5/16/2011</td>
</tr>
<tr>
<td>340015</td>
<td>L1</td>
<td>1/18/2011</td>
<td>L1</td>
<td>7</td>
<td>10</td>
<td>5/16/2011</td>
</tr>
<tr>
<td>340028</td>
<td>U</td>
<td>4/10/2011</td>
<td>L1</td>
<td>7</td>
<td>10</td>
<td>5/16/2011</td>
</tr>
<tr>
<td>340030</td>
<td>L1</td>
<td>5/18/2011</td>
<td>L1</td>
<td>7</td>
<td>10</td>
<td>5/16/2011</td>
</tr>
<tr>
<td>340029</td>
<td>L1</td>
<td>5/2/2011</td>
<td>L1</td>
<td>7</td>
<td>10</td>
<td>5/16/2011</td>
</tr>
</tbody>
</table>

## Long-Term Cost Savings

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

**Savings**

**ROI**

$6.50 : $1.00
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

Here's the early mortality drop-off

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 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.
As of March 1, 2014.
PBHCI Approach

PCP

Psychiatrist

Care Manager

Case Manager

Patient

Other Behavioral Health Clinicians
Substance Treatment, Wellness Coach
Vocational Rehabilitation

Grant-funded additions to the team

Health/and Wellness

Core Team
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

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

EBP = Evidence based practice
Health Home Focus

Approved Health Home Models

- Chronic Medical Condition Focus
  - Iowa
  - Maine
  - Missouri
  - North Carolina
  - Wisconsin

- SMI/SED/SUD* Focus
  - Iowa
  - Maryland
  - Missouri
  - Ohio
  - Rhode Island
  - Vermont

- Broad: Primary Care and SMI/SED
  - Alabama
  - Idaho
  - New York
  - Oregon
  - Rhode Island
  - South Dakota
  - Washington

*Serious mental illness (SMI), severe emotional disturbance (SED), substance use disorder (SUD).

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

Consultant
PCP

Psychiatrist

Nurse Care Manager

CSW/Case Manager

Patient

Other Behavioral Health Clinicians, Substance Treatment, Vocational Rehabilitation, Other Community Resources

CSW = clinical support worker.
Outcomes Reducing Hospitalization

Primary Care Health Homes

Patients with at Least 1 Hospitalization

- 2011: 23.9%
- 2012: 15.7%

CMHC Healthcare Homes

Patients with at Least 1 Hospitalization

- 2011: 33.7%
- 2012: 24.6%

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)
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 ©

In the PAST 7 DAYS ...
I have been able to laugh and see the funny side of things
1. As much as I always could
2. Not quite so much now
3. Definitely not so much now
4. Not at all
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
GAD-7
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

Hennekens CH. *Circulation* 1998;97:1095-1102.
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?
  - **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

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
<th>Lower Limit</th>
<th>Upper Limit</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BMI</strong></td>
<td>24.8</td>
<td>18 – 41</td>
<td>23</td>
<td>&gt; 24.9</td>
</tr>
<tr>
<td><strong>SBP</strong></td>
<td>122</td>
<td>88 – 170</td>
<td>7</td>
<td>&gt; 139</td>
</tr>
<tr>
<td><strong>DBP</strong></td>
<td>78</td>
<td>42 – 107</td>
<td>6</td>
<td>&gt; 89</td>
</tr>
<tr>
<td><strong>PHQ9</strong></td>
<td>3</td>
<td>0 – 14</td>
<td>2</td>
<td>&gt; 9</td>
</tr>
<tr>
<td><strong>Audit</strong></td>
<td>2</td>
<td>0 – 14</td>
<td>2</td>
<td>&gt; 8</td>
</tr>
</tbody>
</table>

**HRQL – Health Related Quality of Life**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Score</th>
<th>Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>1</td>
<td>0-4</td>
</tr>
<tr>
<td>Physical</td>
<td>2</td>
<td>0-20</td>
</tr>
<tr>
<td>Mental</td>
<td>4</td>
<td>0-30</td>
</tr>
<tr>
<td>Overall</td>
<td>1</td>
<td>0-10</td>
</tr>
</tbody>
</table>

**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

|---------|----------|---------|-------|-------|---------------|-------------|-------|-------|-------------|-------------|-----|----------|-------------|-------------|-----------|

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

*Note: The latest score is not available but not from the last PRQ.

Red: Most recent score is above 10 and has not improved by 5 points from the initial assessment score. Or if the 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.
# Metrics – HEDIS

<table>
<thead>
<tr>
<th>CL ID</th>
<th>Description</th>
<th>Flagged</th>
<th>OK</th>
<th>% Flagged</th>
<th>% OK</th>
<th>Goal</th>
<th>Var</th>
</tr>
</thead>
<tbody>
<tr>
<td>DM01</td>
<td>Use of inhaled corticosteroid medications by persons with a history of COPD (chronic obstructive pulmonary disease) or Asthma.</td>
<td>56</td>
<td>48</td>
<td>52.94</td>
<td>47.06</td>
<td>70</td>
<td>-22.94</td>
</tr>
<tr>
<td>DM02</td>
<td>Use of ARB (angiotensin II receptor blockers) or ACEI (angiotensin converting enzyme inhibitors) medications by persons with a history of CHF (congestive heart failure).</td>
<td>6</td>
<td>8</td>
<td>42.86</td>
<td>57.14</td>
<td>70</td>
<td>-12.86</td>
</tr>
<tr>
<td>DM03</td>
<td>Use of beta-blocker medications by persons with a history of CHF (congestive heart failure).</td>
<td>8</td>
<td>6</td>
<td>57.14</td>
<td>42.86</td>
<td>70</td>
<td>-27.14</td>
</tr>
<tr>
<td>DM04</td>
<td>Use of statin medications by persons with a history of CAD (coronary artery disease).</td>
<td>12</td>
<td>5</td>
<td>70.59</td>
<td>29.41</td>
<td>70</td>
<td>-40.59</td>
</tr>
<tr>
<td>DM05</td>
<td>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 (gastroesophageal reflux disease).</td>
<td>73</td>
<td>81</td>
<td>47.40</td>
<td>52.60</td>
<td>50</td>
<td>2.60</td>
</tr>
<tr>
<td>DM06</td>
<td>Presence of a fasting lipid profile within the past 12 months for patients with CAD (coronary artery disease).</td>
<td>12</td>
<td>5</td>
<td>70.59</td>
<td>29.41</td>
<td>70</td>
<td>-40.59</td>
</tr>
<tr>
<td>DM07</td>
<td>Presence of a DRE (dilated retinal exam) within the past 12 months for patients with diabetes mellitus.</td>
<td>75</td>
<td>51</td>
<td>59.52</td>
<td>40.48</td>
<td>70</td>
<td>-29.52</td>
</tr>
<tr>
<td>DM08</td>
<td>Presence of a urinary microalbumin test within the past 12 months for patients with diabetes mellitus.</td>
<td>103</td>
<td>23</td>
<td>81.75</td>
<td>18.25</td>
<td>70</td>
<td>-51.75</td>
</tr>
<tr>
<td>DM09</td>
<td>Presence of at least 2 hemoglobin A1C tests within the past 12 months for patients with diabetes mellitus.</td>
<td>81</td>
<td>45</td>
<td>64.29</td>
<td>35.71</td>
<td>70</td>
<td>-34.29</td>
</tr>
<tr>
<td>DM10</td>
<td>Presence of a fasting lipid profile within the past 12 months for patients with diabetes mellitus.</td>
<td>80</td>
<td>46</td>
<td>63.49</td>
<td>36.51</td>
<td>70</td>
<td>-33.49</td>
</tr>
</tbody>
</table>
# Registry Example: Diabetes

<table>
<thead>
<tr>
<th>Date</th>
<th>HEMOGLOBIN A1C</th>
<th>Microalbumin/Creat Ratio</th>
<th>Triglycerides</th>
<th>HDL Cholesterol</th>
<th>LDL Cholesterol Calc</th>
<th>Cholesterol, Total</th>
<th>LDL/HDL Ratio</th>
<th>VLDL Cholesterol Calc</th>
<th>Blood Pressure</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/16/2012</td>
<td>6.4</td>
<td>172</td>
<td>27</td>
<td>57</td>
<td>119</td>
<td>2.1</td>
<td>57</td>
<td>34</td>
<td>135/84</td>
<td>275.40 lbs</td>
</tr>
<tr>
<td>04/27/2012</td>
<td>6.5</td>
<td>182</td>
<td>26</td>
<td>53</td>
<td>115</td>
<td>2.0</td>
<td>36</td>
<td>36</td>
<td>152/86</td>
<td>275 lbs</td>
</tr>
<tr>
<td>01/25/2012</td>
<td>6.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>140/86: 13...</td>
<td>277.80 lbs</td>
</tr>
<tr>
<td>10/24/2011</td>
<td>6.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>31</td>
<td></td>
<td></td>
<td>122/78</td>
<td>278 lbs</td>
</tr>
<tr>
<td>07/22/2011</td>
<td>6.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>65</td>
<td></td>
<td></td>
<td>130/78: 13...</td>
<td>280.60 lbs</td>
</tr>
<tr>
<td>05/20/2011</td>
<td>5.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>118</td>
<td></td>
<td></td>
<td>124/77</td>
<td>279.60 lbs</td>
</tr>
<tr>
<td>01/07/2011</td>
<td>111</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>128</td>
<td></td>
<td></td>
<td>122/70</td>
<td>266.60 lbs</td>
</tr>
<tr>
<td>12/31/2010</td>
<td>128</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>28</td>
<td></td>
<td></td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td>10/06/2010</td>
<td>185</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>46</td>
<td></td>
<td></td>
<td>104</td>
<td>104</td>
</tr>
<tr>
<td></td>
<td>189</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>189</td>
<td>189</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Foot Exam Performed</th>
<th>Flu Vaccine, (3 yrs &amp; older, Medicare)</th>
<th>Pneumococcal Vaccine</th>
<th>Zoster Vacc, SH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performed:...</th>
<th>Performed:...</th>
<th>Performed:...</th>
</tr>
</thead>
<tbody>
<tr>
<td>28</td>
<td>104</td>
<td>189</td>
</tr>
<tr>
<td>28</td>
<td>104</td>
<td>189</td>
</tr>
</tbody>
</table>
## Diabetes Patients

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

**PRIMARY CARE**
- Continuity is goal
- Empathy and compassion
- Data shared
- Large panels
- Flexible scheduling
- Fast Paced
- Time is independent
- Flexible Boundaries
- Treatment External (labs, x-ray, etc)
- Patient not responsible for illness
- 24 hour communication
- Saved lives
- Disease management

**BEHAVIORAL HEALTH**
- Termination is goal – “discharge”
- Professional distance
- Data private
- Small panels
- Fixed scheduling
- Slower pace
- Time is dependent – “50 min hour”
- Firm Boundaries
- Relationship with provider IS tx
- Patient responsible for participating
- Mutual accountability
- Meaningful lives
- Recovery model
Culture Counts

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

Integration Scores for PBHCl Grantees

- Collaboration on Tx Plans - Low
- Collaboration on Pt Goals – Med
- Overall Leadership Collab – Med
- Overall Provider Collab – Med-Low
Principles of Team-Based Health Care

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

**Personality Traits**
- Honesty
- Discipline
- Creativity
- Humility
- Curiosity

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

- Establish Priorities
- Develop Collaborative Relationships

PSYCHIATRIST ROLES

- Medical Leadership
- Shared Medical Oversight
- Collaboration with other Team Members in Comprehensive Care Management

- Education
- 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