

The Indiana Division of Mental Health and Addiction (DMHA) in collaboration with its integration stakeholder cross agency partners submitted a Technical Transfer Initiative (TTI) grant proposal and was awarded funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) through the National Association of State Mental Health Program Directors (NASMHPD). That grant is supporting today's training activities.

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Roles for the PCP in the Behavioral Health Environment

Lori Raney, MD
Collaborative Care Consulting
Dolores, CO

Module 5

Roles for PCPs in the Behavioral Health Environment

- Learning Objectives:
- Understand the range of opportunities for PCP inclusion in the health care team
- Appreciate the PCP's contribution to population management strategies
- Discuss the characteristics of a “best fit” PCP for working with SMI patients in public mental health settings

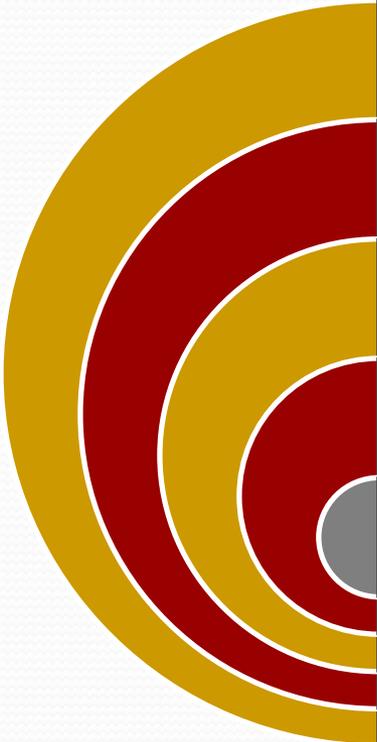
Pre Test

- 1. What roles can PCPs play in the mental health environment?
 - a) Direct service provide
 - b) Educator
 - c) Population management
 - d) All of the above
- 2. Population-based care includes all the following except
 - a) Reviewing benchmarks and comparing the target population
 - b) Establishing metrics of care for a clinic to follow
 - c) Performing physical exams
 - d) Determining clinic priorities based on data
- 3. PCPs best suited for working in public mental health settings would have which of the following attributes:
 - a) Willingness to adapt to the environment
 - b) Interest in working in teams
 - c) Patience
 - d) All the above

Overview

- Direct Care
- Collaboration
- Population Management
- Education
- Leadership

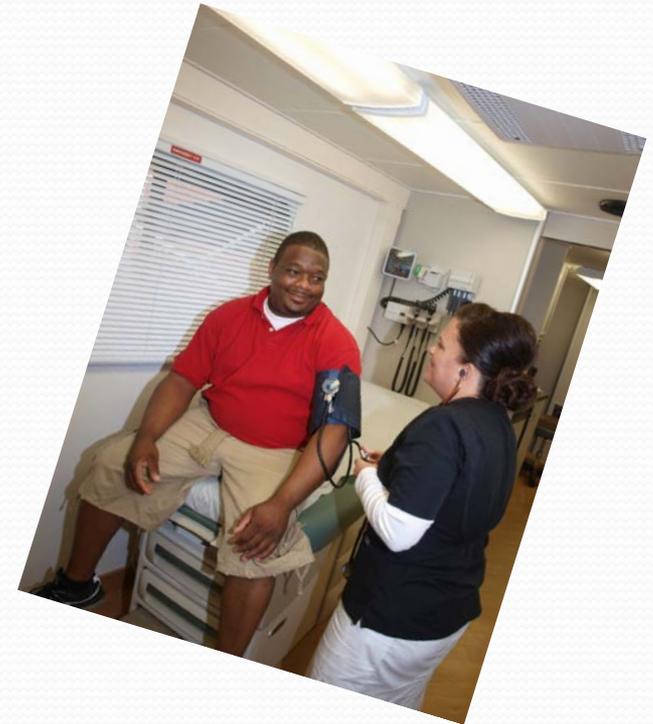
Roles for PCPs in CMHCs



Direct Care	<ul style="list-style-type: none">• Chronic Medical Conditions• Preventive Care
Collaboration	<ul style="list-style-type: none">• Psychiatric Providers• Care Managers, Case Managers,
Population Based Care	<ul style="list-style-type: none">• Establishing Priorities• Track Outcomes, Adjust Care
Education	<ul style="list-style-type: none">• Non Medical and Medical Staff• Patients
Leader	<ul style="list-style-type: none">• Champion Health Care Change• Help Shape System of Care

Direct Care

- Covered in Modules 3 and 4



Mobile Van, Mississippi Region III Health Home Project

Consultation and Collaboration: *Building Partnerships for Health Improvement*

- Clinical Team meetings with Care Managers, Case Managers, Psychiatric Providers, Peer Specialists and others
 - Identify high risk patients who need immediate attention
 - Review those that are not improving and change treatment
 - Patients new to the system
- Chance to influence delivery of care with administrative staff in CMHC – will need their help with directing non-medical staff
- Looking over the shoulder of your colleagues – community-based PCPs, specialists, psychiatric providers to assess quality of care
- Consult with psychiatric medical team for urgent medical problems

Population Management:

Making a Difference For a Larger Population

"What gets measured gets done"

- Metrics – HEDIS 2013 (NCQA) – pick a few for site
- Benchmarking – local, state, national, by provider, etc
- Registries – to track, allows you to see specifics
- Claims Data – to prioritize high utilizers, other gaps
- Use data to establish priorities and then adjust approach



Denominator



Metrics – HEDIS, 10 selected

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		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		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		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	-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		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	-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		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		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		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		70	-33.49

Metrics by Provider

	Prov 1	Prov 2	Prov 3	Prov 4
DRE	70%	65%	20%	80%
ARB/ACE	50%	75%	35%	75%
B Blocker	45%	63%	59%	63%
FLP – CAD	61%	88%	74%	77%
Albumin	77%	66%	56%	33%
HbA1c	88%	76%	66%	90%
.....				

Metrics – Looking for Trends

	Prov 1	Prov 2	Prov 3	Prov 4
DRE	70%	65%	20%	80%
ARB/ACE	50%	75%	35%	75%
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FLP – CAD	61%	88%	74%	77%
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.....				

Using HEDIS Indicators

- Use data to discover care gaps
- Identify training needs to remedy the situation
- First quarter focus on indicator one: Asthma – found the care gap, targeted educational efforts
 - Substantially reduced percentage with care gap
 - Range 22% - 62% reduction
 - Median 45% reduction

*Missouri results, 2012
Joe Parks, MD*

Benchmarking

- The process of establishing a standard of excellence and comparing a business function or activity, a product, or an enterprise as a whole with that standard--will be used increasingly by healthcare institutions to reduce expenses and simultaneously improve product and service quality.

Radiol Manage. 1994 Fall;16(4):35-9

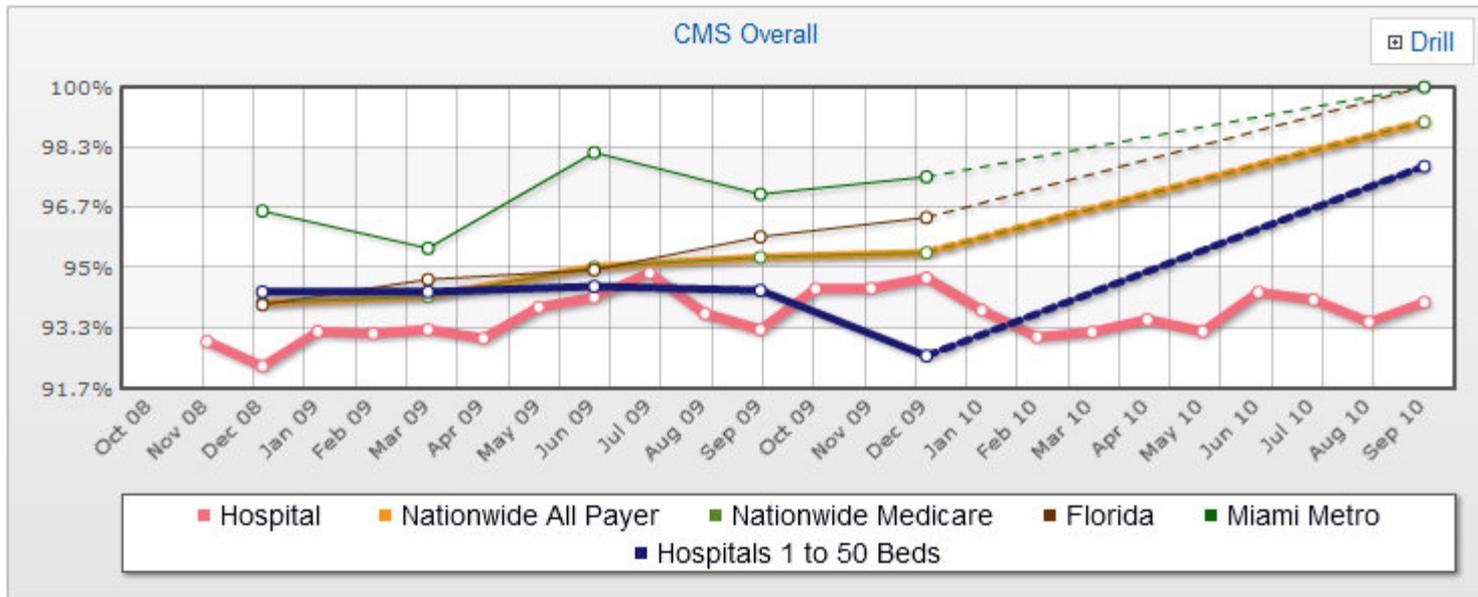
Example



Current Scorecard: **Hospital Scorecard** Time Period: 10/01/2008 - 09/30/2010

Systems Utilization Safety **Quality** Satisfaction

Patient Care Quality



Registries

- Systematic collection of a clearly defined set of health and demographic data for patients with specific health characteristics
- Held in a central database for a predefined purpose
- Medical registries can serve different purposes—for instance, as a tool to monitor and improve quality of care or as a resource for epidemiological research.
- Imposes discipline on us



J Am Med Inform Assoc. 2002 Nov-Dec; 9(6): 600-611

Registry Example: Diabetes

Patient: ROBERT BORNHOLTZ

Invert Layout Graph Print Close

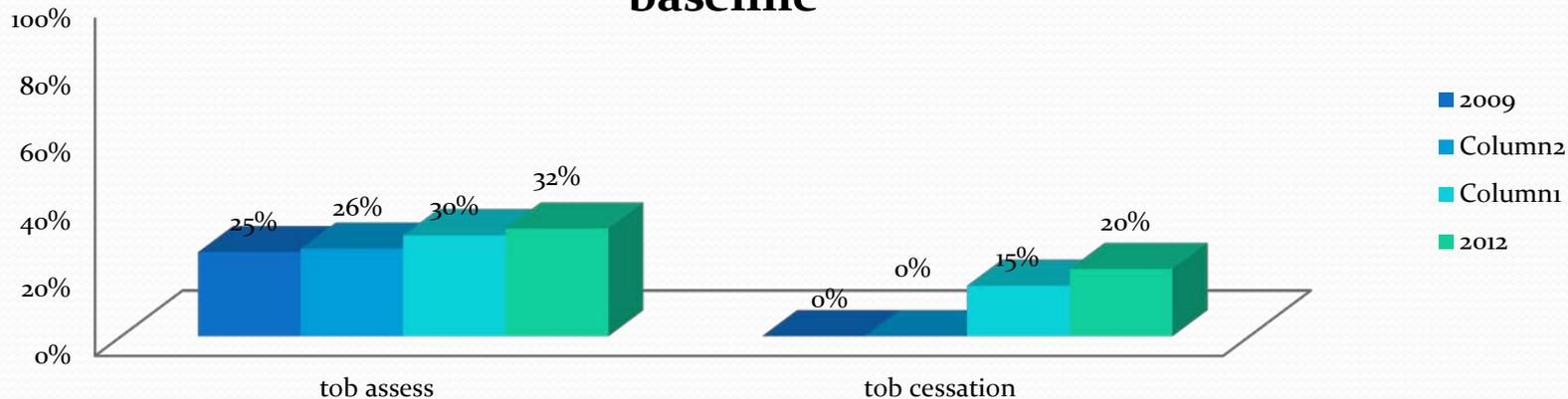
Flowsheet - Diabetic Flowsheet

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, (3yrs & older, Medicare)				Performed:...				Performed:...	
PNEUMOCOCCAL VACCINE						Performed:...			
ZOSTER VACC, SC									

Using Data to Identify Gaps in Care

	DM PATIENTS						All providers Aug-08
	ALL PROVIDERS	Provider A	Provider B	Provider C	Provider D	Provider E	
DM Pt's A1C <7.0, GOAL 40%	48%	51%	41%	43%	61%	0%	47%
DM Pt's A1c <9.0, GOAL 68%	75%	80%	72%	78%	70%	100%	
DM Pt's, BP <130/80, GOAL 25%	35%	41%	32%	47%	21%	0%	
DM Pt's, LDL <100 mg/dl, GOAL 36%	42%	42%	44%	35%	42%	100%	27%
DM Pt's Annual Dilated Eye exam, GOAL 40%	7%	9%	3%	4%	9%	100%	0%
DM Pt's Annual Foot Exam, GOAL 80%	96%	93%	95%	100%	91%	100%	24%
DM Pt's Annual Nephropathy, GOAL 80%	95%	93%	92%	100%	94%	100%	24%
DM Pt's Smoking Status documented and/or advised Treatment, GOAL 80%	93%	96%	92%	96%	94%	100%	55%

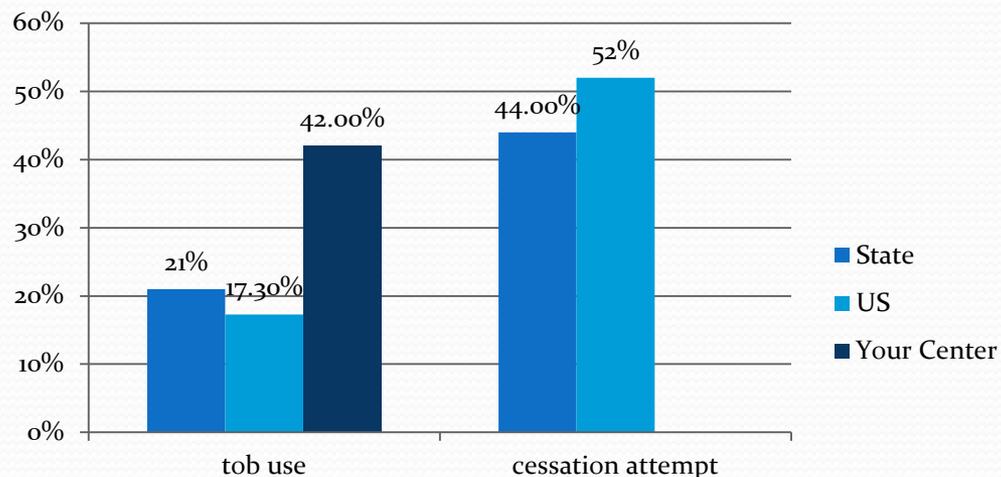
Your Center's Tobacco screening and assistance baseline



Center Goals

- Tobacco use assessment 100% of patients >18y/o
- Cessation assistance 50% of Tobacco users
- Improve documentation

State Prevalence



	Goal	All Providers	PCP ₁	PCP ₂	PCP ₃	PSY ₁	PSY ₁
Smoking Assessment	100%	38%	25%	60%	50%	0%	0%
Cessation Advised	50%	23%	5%	50%	20%	0%	0%

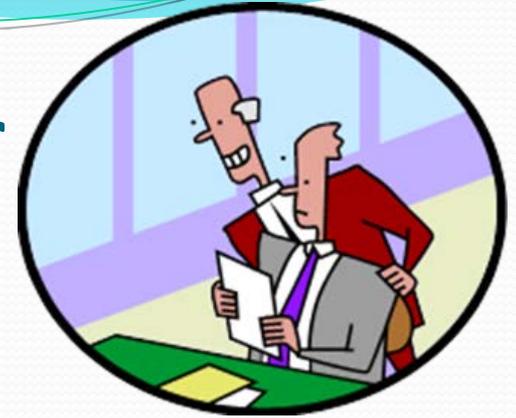
Some History:

*PSY doesn't use the same EMR

*An e-mail was sent out to announce this initiative to providers

*PCP₂ is the chair of the improvement committee

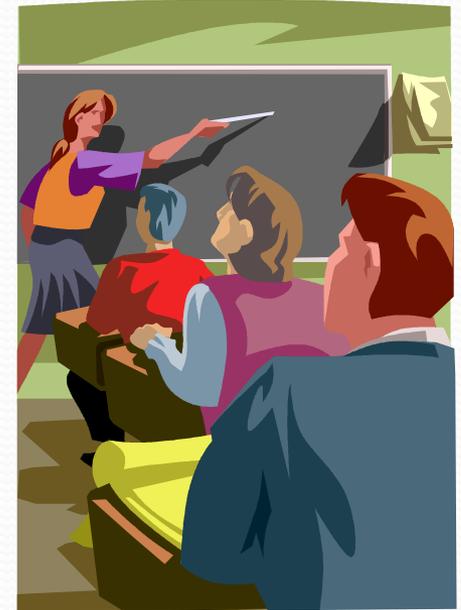
Looking over the shoulder of your colleagues:



- Emphasis how this supplements and does not duplicate or interfere with the care provided by others
- Not looking for “good” or “bad” providers, just helping with things that were missed
- Some will appreciate your help, some will tolerate it, and some may be outright hostile
- “You’re not in command: you are in negotiation”
- Do it because the results can be gratifying, because you want to be an agent of change

Targeted Education

- Use outcomes to determine who needs what:
- Administrators
- Psychiatric Providers
- Case Managers
- Care Managers
- Peer Specialists
- Patients



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

- What are the illnesses and why should I care? What does it have to do with mental illness anyway?
 - **Hypertension** – Systolic? Diastolic? Millimeters of Mercury? Stroke?
 - **Diabetes** – what is that Hemoglobin A one C and why does the abbreviation HbA1c look so weird, 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 this BMI thingy?
 - **Health Maintenance** – You mean you want me to encourage my female patients to get PAP smears?

Educating Psychiatric Providers

<p>1st LINE: Thiazide Diuretics</p> <p>Unless have CHF, DM, Chronic Kidney Dz</p>	<p>HCTZ 12. 5 mg, 25 mg, 50 mg (max)</p> <p>Chlorthalidone 25 mg (max)</p>	<p>QD dosing, Check electrolytes 4-6 weeks, then q 3 mos, then annually</p> <p>Add second agent if partial response</p> <p>\$ 4 list - both</p>
<p>2nd LINE: ACE Inhibitors</p> <p>1st line for above dx</p>	<p>Lisinopril 5mg, 10 mg</p> <p>Enalapril 2.5mg, 5 mg, 10 mg, 20 mg</p>	<p>Start at 5-10 mg/day and titrate up to as much 40 mg per day.</p> <p>Check electrolytes 8-10 weeks. Stop if CR > 2.5</p> <p>Once a day, dry cough, elev CR, angiodema, facial swelling, do not use in pregnancy</p> <p>\$ 4 list</p>
<p>3rd LINE: Calcium Channel Blockers</p>	<p>Amlopidine 2.5 mg, 5 mg, 10 mg (max)</p> <p>Nifedipine LA 30 mg, 60 mg, (max 90 mg)</p>	<p>Very potent, if adding as 3rd agent call PCP first! can cause peripheral edema</p>
<p>4th LINE: Beta Blockers</p>	<p>Metoprolol succinate (XL) 25, 50, 100, 200 (200 mg max)</p>	<p>Once a day, Do not give if Pulse <55, 25 – 100 mg/day usual, can go to max 200 mg</p>
<p>** Remember BP 139/89 is fine for all patients</p>	<p>Adjust meds q 2 weeks, follow q 3-6 mos once stable</p>	<p>If K⁺ falls below nl and BP responding, add 10 meq K⁺ up to total dose 20 mg</p>

Educate Patients

(Formula for Good Health)

Place a ✓ for what you already do and an X for what you commit to working on.

<input type="checkbox"/>	0	Cigarettes	
<input type="checkbox"/>	5	Servings of fruits and vegetables per day	
<input type="checkbox"/>	10	Minutes of silence, relaxation, or meditation per day	
<input type="checkbox"/>	30	Body Mass Index < 30 kg/m²	
<input type="checkbox"/>	150	Minutes of exercise per week (e.g., brisk walking or equivalent)	

What Can A Healthy Lifestyle Do For You?

14 recent studies from the medical literature show that just these 5 simple habits can reduce your chance of developing...

- Type 2 Diabetes by 93%
- Hypertension by 78%
- Heart Attacks by 83%
- Strokes by 79%
- Heart Failure by 47%
- All Cancers by 36-64%

& reduce your overall chance of dying by 40-68%

This is the #1 way to stay healthy and prevent serious disease!

Am Fam Physician. 2010 Sep 15;82(6):610-614

Leadership

- PR, PR, PR – can be difficult sometimes to get the team to follow



If you build it, they will not necessarily come...

Putting co-located primary care provider in place →
Very little business!



• Why not?

- Separate FQHC registration a significant barrier.
- It turns out staff are needed to shepherd the transition, even in the same office suite.
- All CMHC staff didn't have message repeated and repeated and repeated...
- What seems like a lot of CMHC patients is a trickle for the FQHC!

Sample PR

Regional Primary Care Initiative

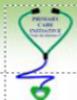
Persons with mental illness die up to **25 years too soon** due to preventable health conditions.

Regional Primary Care Initiative now offers a nationally recognized program to bring needed primary medical services to our clients, right in our Merrillville and East Chicago centers.

- General medical care **at the Regional office.**
- Assistance for consumers in
 - Medication management,
 - Healthy eating,
 - Stress management,
 - Healthy activities,
 - Stopping smoking,
 - Help negotiating the medical system..

Talk to your clients and peers about engaging in this program to live longer and healthier!

Sign up **today** by calling Olga at 219-99999

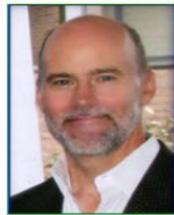


Why Should You Take the Initiative?

by John Kern, M.D., Vice-President of Clinical & Medical Affairs

[To Barb: My title should be "Chief Medical Officer"]

Also—had a little trouble with numbering on next page—help] not sure what should go in this box, maybe intro for me? E.g., Dr Kern has worked in Community Mental Health at Southlake Center and Regional Mental Health for 22 years., etc.



Dr. John Kern

The Regional Primary Care Initiative has 3 parts:

1. Provision of primary medical services directly in our Merrillville and East Chicago main centers, by our partners, the NorthShore and East Chicago Health Centers.. This will make it much easier for us to coordinate our efforts.
2. Care Management:
 - Regular health screening and monitoring by our Regional Primary Care Initiative staff, to ensure that commonly-occurring conditions like diabetes or high blood pressure are treated in a timely, preventative fashion and EFFECTIVELY.
 - Assistance with negotiating the complex health care system, to assure the best medical care is available.
1. Wellness activities: Support and training for clients to help develop skills and habits that foster good health for a lifetime..

[Barb—obviously this should be "3", but I couldn't make it act right]

A 4-year grant from the Substance Abuse and Mental Health Services Administration is supporting the development of this program. We are encouraged to develop original ideas to help meet our goal of better wellness for the people we serve. This kind of care management program represents the state of the art in bringing medical care to our behavioral care world.

If these programs are successful, they will lead to change around the county in the way medical services are provided, and form an important part of health care reform—for the better! We are excited to have this opportunity, we have lots of resources to use to offer all these services, and we are eager to have our clients involved.

Any Regional client is welcome to participate IN ANY PART OF THE PROGRAM, even if they do not wish to use the primary care clinics located here, and want to continue with their present primary care provider.

We urge our clients and families to join with us in developing a new kind of care to make a difference here and all over the country.

Call us, come in, we want to work together with you!

The most exciting work today in mental health is being done in the field of Integrated Care.

This refers to the bringing together of mental health and primary medical services.

Regional Mental Health has been developing programs to bring together these services for several seasons:

- People with mental health conditions have been shown to have shortened life spans, as much as 25 years shorter than the general population.
- These people are generally dying of heart disease or the complications of diabetes.
- Poor health care is the rule, not the exception.
- Up to now, this hasn't been thought of as the responsibility of staff in mental health centers.

We believe that efforts to reach out to medical providers to coordinate care, and efforts to reach out to the people we serve, can improve the quality of medical and psychiatric care, and improve length and quality of life.

Since 2008, we have been coordinating mental health services for the primary care staff at the NorthShore Health Centers in Portage and Lake Station, IN.

Building on the success of this program, we are now introducing the Regional Primary Care Initiative, to coordinate primary health care for Regional clients and support their ability to develop their own healthy life habits.

Caution: Merging Cultures



Leadership – Champion for Improving the Health Status of the SMI Population

“Different models must be tested - the cost and suffering of doing nothing is unacceptable.”

Vieweg, et al., *American Journal of Medicine*. March 2012



PCP Best Suited for This Work?

“My observations are that the key variable is a seasoned/experienced, confident provider who may not fully understand but isn't frightened or put off by issues of mental illness - we've had multiple folks fitting this description who have functioned very well in behavioral health-based primary care clinics.

PBHCI grantee



“The HCH (Health Care Home) has very much become part of the culture now. It is fascinating to attempt to apply baseline medical care on a population based scale. Mainly, I believe our clients benefit from our efforts, which is the way I measure the program.”

PCP Consultant - Missouri

Reflections

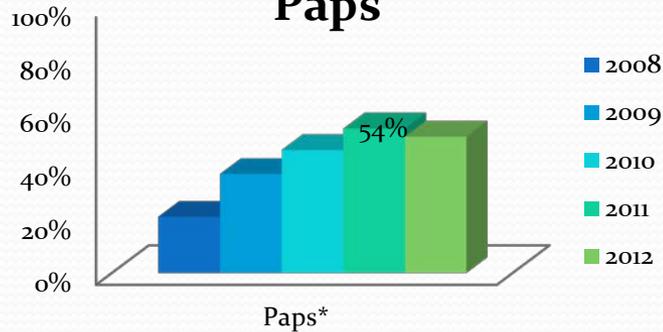
- Is this for me? SMI patients?
- Population based care: What about the 25?,
Make a difference for a larger population
- Humility, discipline and teamwork essential
- Exciting work. “Collaborative care can change you in ways you never imagined.”
- Psychiatric providers need your help taking with these patients
- This can make practicing primary care more rewarding, extend competence into new areas



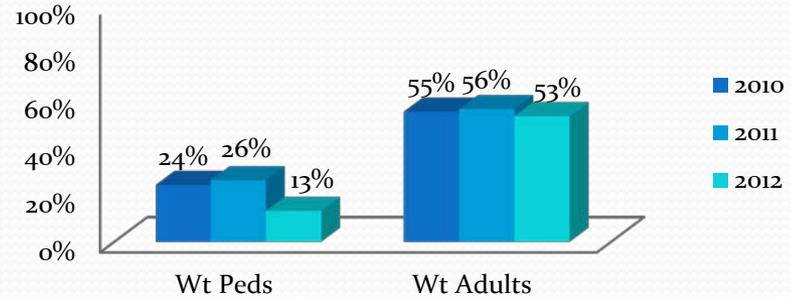
Population Management Exercise

Your Population

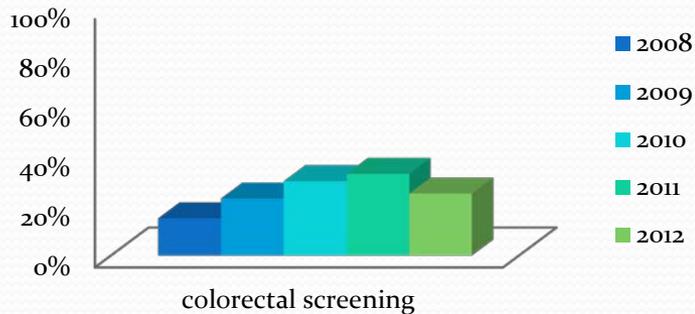
Paps



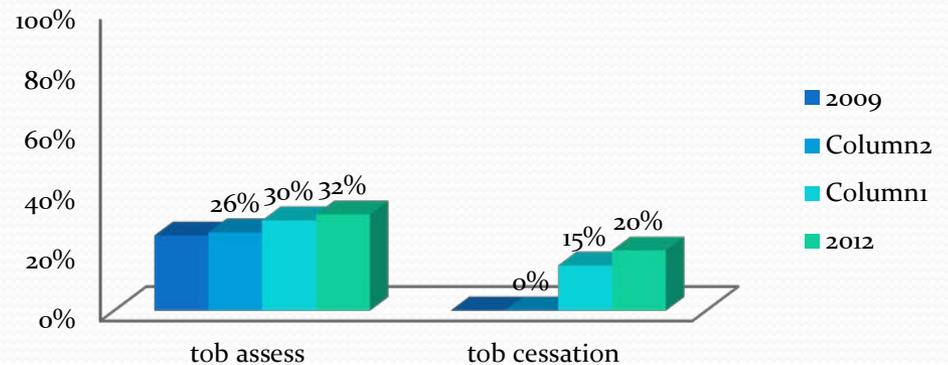
BMI and counseling



Colorectal Screening

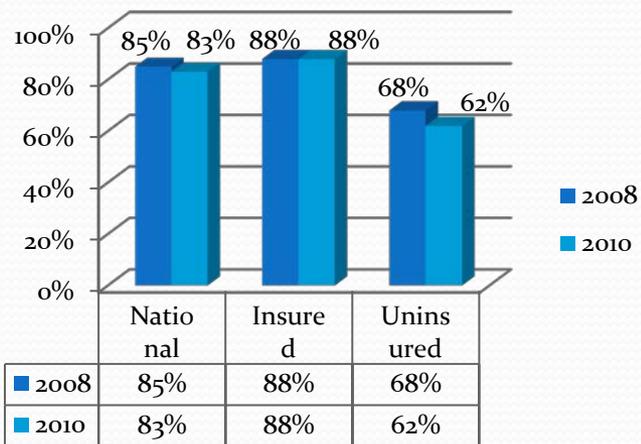


Tobacco screening and assistance

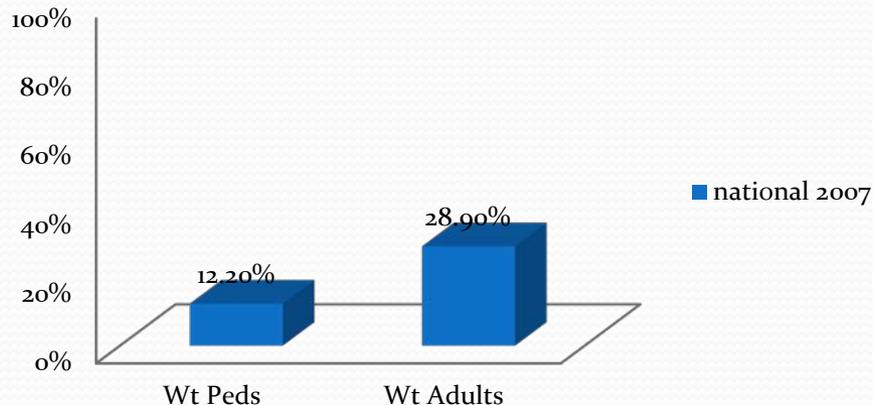


National Benchmarks

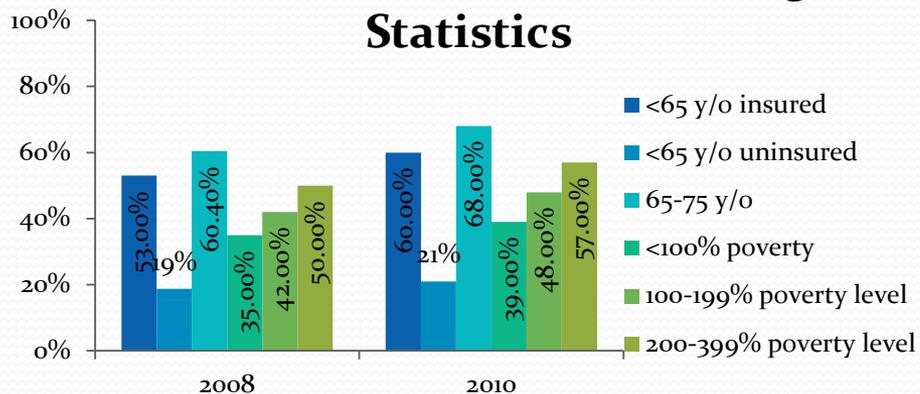
National Pap Smear



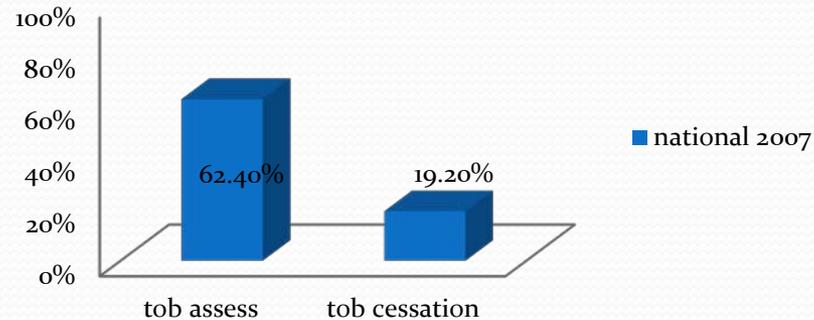
BMI and counseling



National Colorectal Screening Statistics



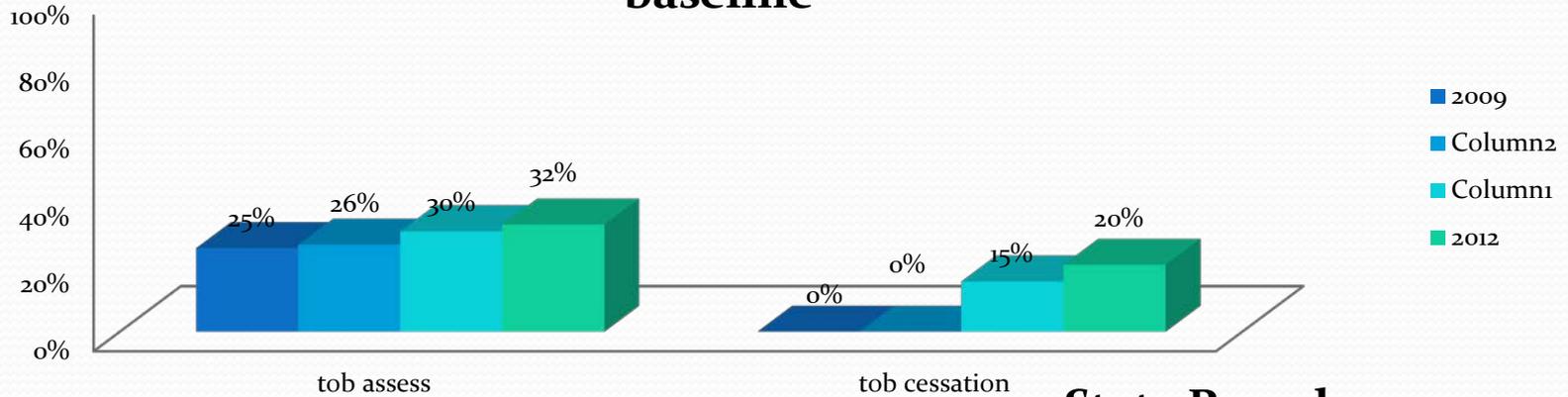
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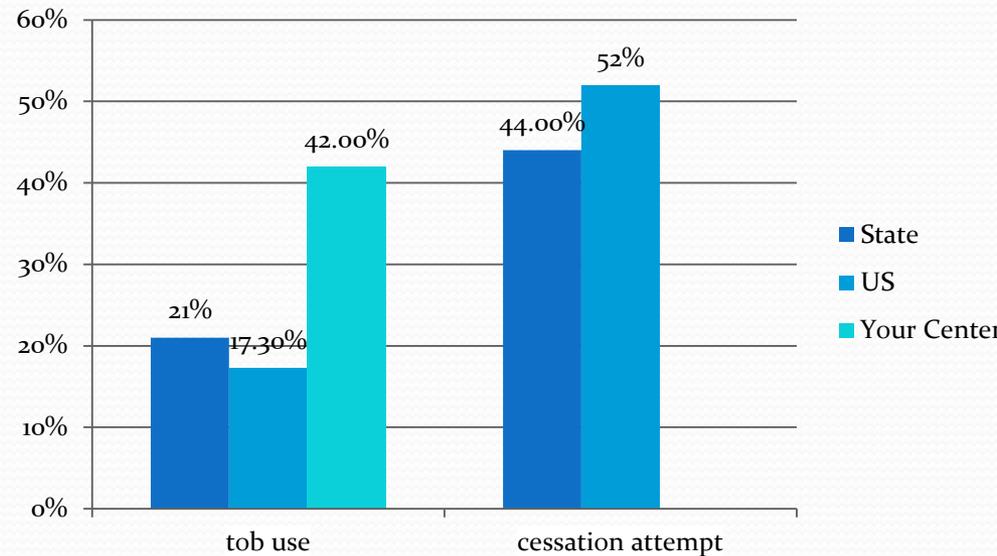
What is your Performance Improvement Plan?

- Select the Measurement you will target 1st
- What is your goal?
- How often will you report progress to your team?
- 3 areas of your NCQA certified PCMH you will leverage to meet your goal?

Your Center's Tobacco screening and assistance baseline



State Prevalence



Center Goals

- Tobacco use assessment 100% of patients >18y/o
- Cessation assistance 50% of Tobacco users
- Improve documentation

	Goal	All Providers	PCP ₁	PCP ₂	PCP ₃	PSY ₁	PSY ₁
Smoking Assessment	100%	38%	25%	60%	50%	0%	0%
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Some History:

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*PCP₂ is the chair of the Improvement Committee

What is your Performance Improvement Plan?

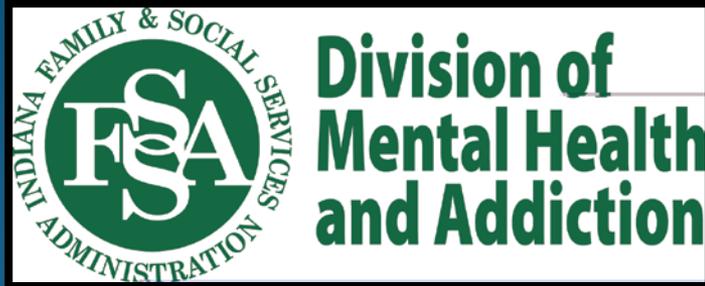
- How will you present this information to providers, blinded or unblinded, and why?
- What things may be contributing to your performance in this measurement?
- What 3 steps will you take first to improve this measurement?

Post Course Questions

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Resources and additional training tools will be available on an elearning system at:

www.indianaintegration.org