



SUMMARY OF THE EMBEDDED PRIMARY CARE PROVIDER'S ROLES

POPULATION MANAGEMENT

A population-based approach to achieve the best outcomes in overall health care delivered in the Health Home (HH) requires analyzing aggregate data as well as evaluation of individual charts for selected patients. This data will serve as a basis for establishing HH priorities for disease management, identifying trends and critical issues in addition to developing plans for improving overall health status. HH data to use in the analysis may include benchmarks, metrics, registries, cost and pharmacy utilization claims data in addition to other tools available to collect various outcomes.

COLLABORATION

Build collaborative relationships with in-house staff including psychiatric providers, care managers, case managers and others so the team can effectively work together to address deficiencies in care discovered by data analysis and reach desired outcomes. Ensure effective working relationships with community-based PCPs and hospitals outside the HH to create opportunities for smooth transitions between care sites, timely sharing of information, and to make sure established treatment goals are being met. The PCP works to develop and maintain these relationships and emphasizes how the HH supplements and does not interfere with or duplicate the treatment provided by other healthcare professionals. The PCP provides quality control in this unique position, using data to look over the shoulder of both the psychiatric providers and community-based PCPs. Without these collaborative relationships, the PCP may struggle to influence the care provided by others, thwarting the efforts to significantly improve the overall health status of the HH population.

CASE CONSULTATION

Meet with Care Manager (CM), qualified health home specialists (QHHS), and other members of the HH team to regularly review the registry and available data to determine patients in need of immediate attention, those that are not improving and those new to the HH. Other staff may request consultation regarding specific patients, including psychiatric providers and community based PCPs.

EDUCATION

Provide education to all behavioral health staff to establish a shared base of knowledge about common chronic medical illnesses in the HH population. This ranges from basic knowledge for case managers, peers, and therapists to more advanced education for care managers and psychiatric provider staff. Development of education materials for patients is part of this effort. Educational topics may be generated from issues discovered by data review. Reviews for community-based PCPS may be included.

PATIENT CARE

In-person examination and treatment may occur at some sites. The PCP may also meet with individual patients to explain test results, treatment course, etc. Home visits may be necessary in some instances. The PCP could help link individuals who do not currently have a PCP to colleagues in the community.



THE EMBEDDED PRIMARY CARE PROVIDER ROLE IN THE OHIO HEALTH HOME

INTEGRATING PRIMARY CARE EXPERTISE FOR IMPROVING OUTCOMES IN THE SMI POPULATION

The Behavioral Health Home (HH) model in Ohio provides the inclusion of an embedded Primary Care Provider (PCP) in the behavioral health setting to ensure optimum medical care is being provided for the SMI population. The PCP works as a member of the HH team consisting of medical and non- medical staff working in a collaborative fashion to deliver these outcomes. This paper outlines the essential job duties of the PCP in a behavioral health setting.

The current Ohio job description for the PCP is as follows:

- Provide health home service including identification of consumers, assessment of service needs, development of care plan and treatment guidelines, and monitor health status and service use.
- Provide education and consultation to the health home team and other team members regarding best practices and treatment guidelines in screening and management of physical health conditions as well as engage with, and act as a liaison between, the treating primary care provider and the team.
- Meet individually as needed with care managers to review challenging and complex cases.
- It is preferred, but not required, that the PCP also functions as the treating PCP and thus may hold dual roles on the health home team.

JOB SUMMARY: The PCP will be responsible for supporting, overseeing and ensuring appropriate medical care is provided to Seriously Mentally Ill (SMI) patients in the HH. They will participate in a collaborative care team which supports the ongoing clinical work of the psychiatric providers, care managers (CM), qualified health home specialist (QHHS), and the community-based PCPs providing treatment for HH patients outside the behavioral health center environment.

QUALIFICATIONS: PCPs include those with degrees including MDs, DOs, NPs, CNS or PAs with training in family practice and internal medicine (preferred areas of expertise).

POPULATION MANAGEMENT: A population-based approach will be utilized to achieve the best outcomes in overall health care delivered in the HH and requires analyzing aggregate data for the HH enrollees as well as evaluation of individual charts for selected high risk patients. This data will serve as a basis for establishing priorities for disease management, identifying trends and critical issues and developing plans for improving health status. Specific tasks may focus on:

- Identify high risk individuals that need immediate attention
- Select the chronic disease, cohort of consumers and interventions most likely to have the greatest effect on improving the management of chronic disease
- Choose initiatives most likely to have significant impact on improving the health status of HH enrollees and determine focus of educational efforts by staff once identified.



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Duties and Responsibilities:

1. The PCP will participate in regularly scheduled (usually weekly) team meetings and case conferences which includes the HH Team Leader, CM, QHHS, and other treatment providers. These team meetings and case conferences will focus primarily on patients who are new to the health home, are at imminent risk and those who are not improving. Tracking systems such as registries, checklists and other methods will be utilized to ensure no one fails to receive appropriate follow-up in this process. A 'treat-to-target' approach, utilizing predetermined goals (ie HbA1c < 7%, BP <140/90) will be used to ensure maximum response to interventions.
2. The PCP will provide prompt response to the CMs for urgent medical problems. This may also include calls from QHHS but it is anticipated the CM will be the first point of contact for the QHHS. A variety of communication strategies may be used for these contacts. Education of CMs on medical issues will be provided to enhance their understanding of medical issues and a resource for the QHHS and patients in the HH.
3. The PCP will serve as a liaison to the community- based PCPs, providing notification of clinical goals not met, information on the HH, gathering of health-related information and other tasks. This will be conducted in a supportive and collaborative fashion. Personal contact with the community-based PCPs is encouraged to build relationships with the HH, including in-person and onsite visits as time allows. Reports outlining recommendations from the HH based on chart reviews and information gathered through existing data bases may be generated and sent to the community-based PCP. Reassurance the intervention of the HH is meant to complement and not replace the community-based PCPs work may be necessary and proactive dialogue is encouraged.
4. The PCP will be responsible for timely review of mandated HH data, assigned metrics (including CMS and State Selected Measures), and other reports that may be requested and prepare responses for the team on any issues identified as needing targeted intervention for improvement. Will assist in developing embedded evidence-based guidelines, standing orders, etc. as needed to meet program requirements and ensure appropriate patient care on a population based level is provided (see detailed explanation above).
5. The PCP will serve as a consultant and educator to the psychiatric medical staff. Tasks may include but are not limited to:
 - o Timely consultation to the psychiatric medical team on urgent medical problems to allow immediate treatment recommendations.
 - o Education of psychiatric medical staff on topics such as treatment of common medical problems. Special emphasis on hypertension, diabetes, and dyslipidemias is encouraged due to the high prevalence of these disorders in the SMI population. Other topics of interest may be identified by the psychiatric medical team and may include providing protocols and algorithms for treatment. Information on registry data, standards of medical practice and state-wide use of specific metrics will be provided to educate psychiatric team on the use of these to measure overall health.
 - o The PCP will strive to demonstrate the complimentary nature of inclusion of primary care oversight and avoid the impression of outside interference with the daily work of the psychiatric provider staff. Attendance at medical staff meetings is strongly encouraged to ensure the PCP is a welcomed and valued member of the medical team.
6. Education and mentoring of non-medical staff will be provided by the HH team on a regular basis to ensure all staff has a shared base of health literacy to assist in assessing health status and understanding of health goals. This may be accomplished by activities such as lunch-and-learns, fliers, regularly scheduled didactic sessions and will include both pertinent medical issues as well as topics requested by the non-medical staff. Protocols to address abnormal findings will be developed. Topics may include hypertension, diabetes, smoking, obesity, diabetes, asthma, etc.



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7. Development and distribution of educational materials with the CM and QHHS for patients at a literacy level appropriate for the patient population. Translation into other languages may be necessary by other staff.
8. Be involved in the development of an Integrated Care Plan (ICP) for all identified patients that includes health goals generated by the person being served and their HH team with PCP input. These goals could be added to the existing mental health Service Plan and updated on a regular basis as goals are met and new issues emerge.
9. Will meet with the HH Director and other team members to provide guidance on medical health issues and to discuss progress, concerns, etc. as needed to ensure team cohesion and knowledge of tasks undertaken and results of these efforts. Population level analysis will be critical to adjust care delivery within the HH to reach desired outcomes.
10. May provide direct examination and treatment of patients. May also participate in individual discussions with patients regarding healthcare issues (such as test results) and conduct home visits if warranted.
11. Participation in monthly conference call or learning community with other PCPs in the Ohio HH project is strongly advised. The PCP is encouraged to share educational materials generated and other tips and ideas with their PCP colleagues across the state. Information shared will help develop consensus on the roles and responsibilities of the PCP as well as best practices for improving health care in the behavioral health environment. Participation in a PCP list serve is recommended if available. Provision of coverage for vacations by other PCPs is recommended for addressing high risk situations.