Operational and Clinical Pathways

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PRIMARY CARE DEVELOPMENT CORPORATION

CoE
Center of Excellence for Integrated Health Solutions
Funded by Substance Abuse and Mental Health Services Administration
Operated by the National Council for Behavioral Health

Today's Moderator

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About PCDC

- Primary Care Development Corporation (PCDC) is a national nonprofit organization and a community development financial institution catalyzing excellence in primary care through strategic community investment, capacity building, and policy initiatives to achieve health equity.

Disclaimer

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SAMHSA
Substance Abuse and Mental Health Services Administration

www.samhsa.gov

An Integrative Approach to Addressing Diabetes

- Improve screening and management and partner with patients to better address diabetes
  - Maximize the value of interprofessional teams
  - Enhance what you have (even if it's just you!)
  - Build efficient processes and procedures

(Image courtesy C. Aguilar)

An Integrative Approach to Addressing Diabetes

1. Behavioral Treatment
2. Evidence-based Prescribing Practices
3. Nutrition, Food Insecurity and Health Promotion
4. Integrating Clinical Pharmacy
5. Expanding Quality Improvement
6. Operational and Clinical Pathways
7. Persons with Lived Experience

Why Address Diabetes in Integrated Behavioral Health?

- Patients with behavioral health conditions are disproportionately likely to struggle with diabetes and associated metabolic conditions
- Behavioral health providers are uniquely positioned to impact diabetes
- Integrated care will increasingly involve integrating metrics

Todays Presenters

Maia Morse, MPH, CPC-A, is Senior Program Manager at PCDC, and an expert coach and facilitator for Patient-Centered Medical Home (PCMH) transformation. Currently Maia leads PCDC's billing and coding program and continues to providing coaching and facilitation related to access, quality improvement, and PCMH. Prior to joining PCDC, Maia worked as the Site Manager at Norwalk Community Health Center, where she managed daily operations and provided departmental oversight, throughout the center.

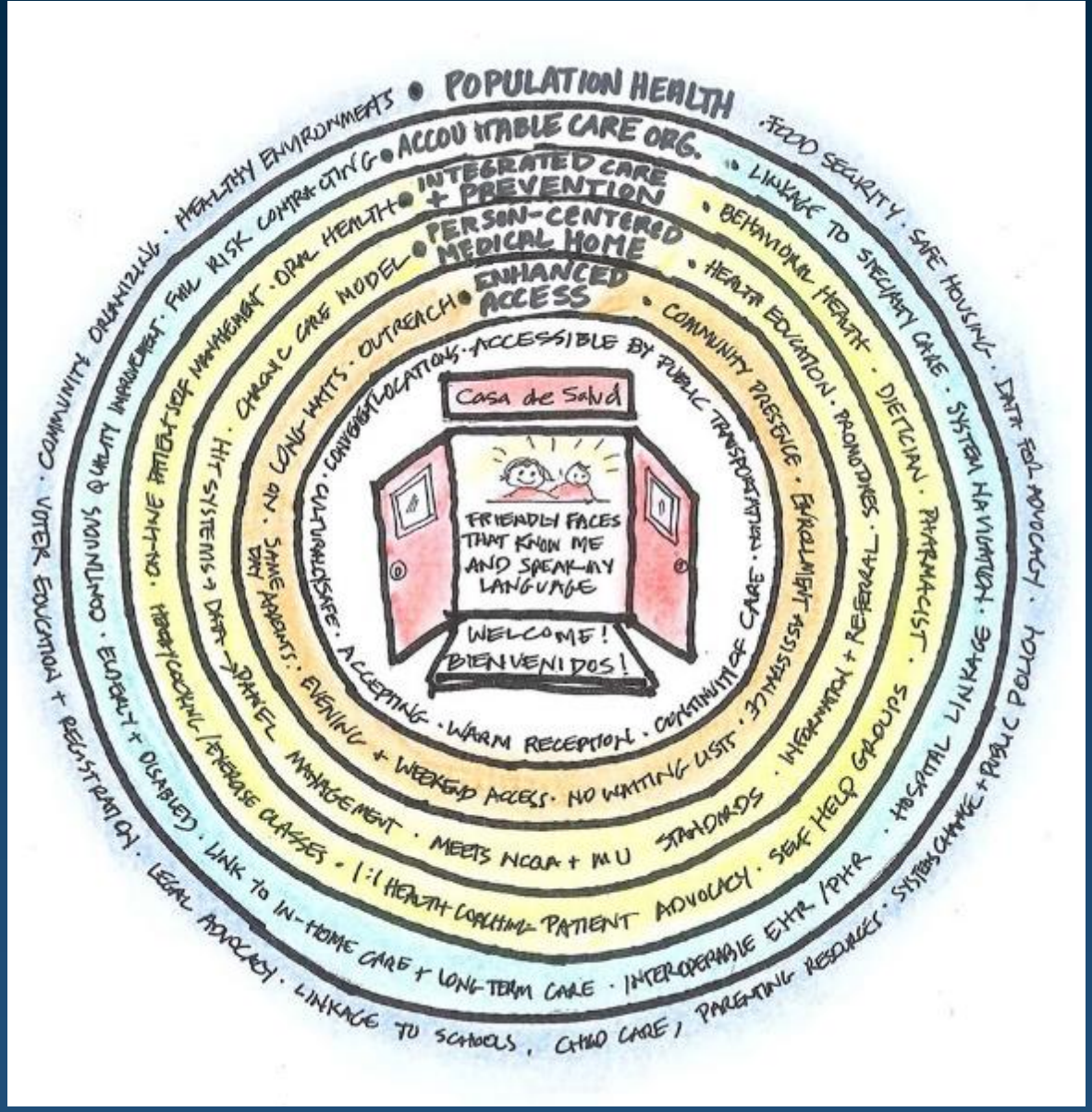
Amy Goodman, LCSW, CPC-A, is a Senior Project Manager at PCDC who has worked for over 20 years in non-profit healthcare. As a Patient-Centered Medical Home (PCMH) content expert, she has led transformation and quality improvement projects across the country. She develops PCMH training tools, analyzes client practice workflows, policies and data to advise practices on opportunities for improvement. Amy has extensive experience working in the Intellectual and Developmental Disabilities (I/DD) field as a behavioral health clinician, multi-specialty practice manager and EHR training manager.

Todays Presenters - Continued

Renee Boak, MPH, CADCI, is Cascadia's Senior Director of Population Health Research and Innovation. Renee has been with Cascadia since 2005 and has led the agency in its initiatives to integrate primary care into its comprehensive community mental health and addictions services. Renee's leadership under the CCBHC grant has resulted in Cascadia opening three integrated primary care clinics as well as the implementation of Medication Supported Recovery services. Currently, Renee oversees the Population Health Research and Innovation team, which seeks to improve health outcomes through innovative practices and pilot programs.

Learning Objectives

- Define Medical Home Concepts
  - Review definition of health homes and CCBHC
  - Identify 6 Concept Areas: Access, Team Communication, Care Coordination, Care Management, Population Health, Quality Improvement
- List Statistics of patients with both diabetes and mental health conditions from a Social Determinants of Health (SDoH) perspective
- Review Case Example: Cascadia BHC
- Discuss Sustainability



Picture Source: https://www.careinnovations.org/resources/whats-a-health-home/

What is a CCBHC?

Medical Home Concepts

- Access
- Team Communication
- Care Coordination
- Care Management
- Population Health
- Quality Improvement

Access

- Empanelment and Access to the Medical Record
  - Practices support continuity through empanelment and systematic access to the patient's medical record
  - The practice considers the needs and preferences of the patient population when establishing and updating standards for access

- Patient Access to the Practice
  - The practice enhances patient access by providing appointments and clinical advice based on patients' needs

Access Examples

- Ways that a practice enhances patient access
  - Providing same day appointment scheduling
  - Having extended hours of operation at the practice
  - Running reports
    - to forecast **third next available appointments** to look at appointment availability and ensuring appointments are available during identified timeframes
    - to review **same day utilization** and extended hour appointments
    - to manage patient **continuity** with their identified primary care physician
    - to review **timeliness of clinical advice** provided by the practice to patients
  - Surveying patients on their access preferences

Team Communication

The Practice's Organization

- The practice commits to transforming the practice into a sustainable patient-centered practice
- Care team members have the knowledge and training necessary to perform their roles, which are defined by the practice's organizational structure

Team Communication

- Communication among staff is organized to ensure that patient care is coordinated, safe and effective

Team Communication Examples

- How the care team communicates with each other
  - Daily huddles where the care team meets as a team
  - EMR dashboard with instant messaging or tasking functions
  - Email, telephone, etc.

- Ways that a practice communicates with patients
  - Posted flyers, brochures, welcome packets
  - Patient portal, text, telephone, mail, etc.

Care Coordination

- Coordinating Care With Health Care Facilities
  - The practice connects with health care facilities to support patient safety throughout care transitions
  - The practice receives and shares necessary patient treatment information to coordinate comprehensive patient care

Care Coordination Examples

- Ways that a practice tracks orders, referrals and hospital visits
  - Review workflows and reports related to tracking lab and diagnostic testing orders and referrals to specialists
  - **Identifying gaps in the process**
  - Review workflows on transitions of care and tracking avoidable ED hospitalizations

Care Management

- Identifying Care Managed Patients
  - The practice systematically identifies patients who may benefit from care management

- Care Plan Development
  - For patients identified for care management, the practice consistently uses patient information and collaborates with patients/families/caregivers to develop a care plan that addresses barriers and incorporates patient preferences and lifestyle goals documented in the patient's chart

Care Management Examples

- Ways that the practice provides care management:
  - Develop risk assessment of patient populations based on mental health, chronic conditions, etc.
  - Run registry lists based on ICD 10 codes, test results and encounter types (i.e., post hospital follow up)
  - Create care plans that address barriers to care, patient self management and patient functional lifestyle and treatment goals
    - Ensure that patients receive a copy of their care plan, which is developed with them and care team staff during their visit

Population Health

- Collecting Patient Information
  - The practice routinely collects comprehensive patient data and uses the data to understand patients' backgrounds and health risks

- Patient Diversity
  - The practice uses information about the characteristics of its patient population to provide culturally and linguistically appropriate services

- Medication Management
  - The practice addresses medication safety and adherence by providing information to the patient and establishing processes for medication documentation, reconciliation and assessment of barriers

Population Health - Continued

- Evidence-Based Care
  - The practice ensures that it provides effective and efficient care by incorporating evidence-based clinical decision support relevant to patient conditions and the population served

- Connecting With Community Resources
  - The practice identifies/ considers and establishes connections to community resources to collaborate and direct patients to needed support

Population Health Examples

- The practice runs lists of patients with mental illness stratified by race and ethnicity or other pertinent social determinants of health. List may consider:
  - Diabetes screening rates
  - Adherence to medication
  - Referral to community resources
  - Confirmation of visit with specialty provider or community resource.

Quality Improvement (QI)

- Measuring Performance
  - The practice measures to understand current performance and to identify opportunities for improvement

- Setting Goals and Acting to Improve
  - The practice evaluates its performance against goals or benchmarks and uses the results to prioritize and implement improvement strategies

- Reporting Performance
  - The practice is accountable for performance and shares data within the practice, with patients and/or publicly for the measures and patient populations identified in the previous section

QI Examples

- Establish QI initiative to increase diabetes screening among patients with depression and severe mental illness
  - Use rapid cycle testing to implement the review of registry lists prior to patient visits in order to flag those patients that should be tested

Some Diabetes Statistics…

People with diabetes are 2 to 3 times more likely to have depression than people without diabetes

People with severe **mental illness** are more than twice as likely to have Type 2 **diabetes**, with even higher risks among patients who are African American or Hispanic, according to a 2018 study led by UCSF

People with severe mental illness have lower rates of screening for diabetes

- Based on estimates that 20 % of the 19 million US adults with SMI have diabetes 70 % of them are not screened for diabetes which means over 2 million Americans have unidentified diabetes.

CASCADIA BHC:

ONE ORGANIZATION'S JOURNEY WITH DIABETES MANAGEMENT

Presented by: Renee Boak, MPH, CADCI

501 (c) 3 Non-profit

900+ employees

18,000 served/year

4 counties (Multnomah/Washington/Clackamas/Lane)

75+ locations

4 health centers

$70M revenue

750+ housing units

CASCADIA
BEHAVIORAL HEALTHCARE
WHOLE HEALTH CARE

MISSION

Cascadia Behavioral Healthcare delivers whole health care – integrated mental health and addiction services, primary care, and housing – to support our communities and provides hope and well-being for those we serve.

VISION

We envision a community where everyone benefits from whole health care, experiences well-being, and has a self-directed, connected life.

SERVICE DELIVERY

HEALTH CENTER BASED

- Central Intake
- Adult Mental Health Outpatient
- Adult SUD Outpatient
- Older Adult Services
- Child and Family Services
- **Primary Care**
  - 3 pc clinics
  - 2 new sites in progress
- Urgent Walk In Clinic

COMMUNITY BASED

- ACT/FACT
- Intensive Case Management
- Forensic Services
  - Psychiatric Security Review Board
- Housing Outreach Team
- Street Outreach Team
- Project Respond/Mobile Crisis
  - Respite Services
- Residential and Supportive Housing

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WHOLE HEALTH CARE

ADMINISTRATIVE SERVICES

- Accounts Payable & Finance
- Billing
- **Business Intelligence**
- Communications
- **Electronic Health Record (x2!)**
  - ***Data reconciliation challenges**
- Grants and RFPs
- Housing
- Information Technology
- Operations
- People and Culture
- Philanthropy
- **Population Health Research and Innovation**
- Quality Management & Compliance

CASCADIA BEHAVIORAL HEALTHCARE
WHOLE HEALTH CARE

MULTI-DISCIPLINARY SERVICE DELIVERY PROVIDERS

Peer Wellness Staff and Certified Recovery Mentors	Qualified Mental Health Associates (QMHAs)/Skills Trainers, Case Managers	Mental Health Counselors (QMHPs)	Licensed Counselors (LCSW, LPC)
Addictions Counselors	Medical Assistants	Care Coordinators/Panel Managers	Nursing Staff
	Psychiatric Medical Providers (LMPs – MDs, NPs, and PAs)	Primary Care Providers (MD, ND, FNP)	

CASCADIA BEHAVIORAL HEALTHCARE
WHOLE HEALTH CARE

POPULATION HEALTH RESEARCH & INNOVATION

Team Members:

- Senior Director
- Director
- Project Manager
- Population Health Analyst
- Evaluator (to be funded through CCBHC expansion grant)
- Complex Care Panel Manager (to be funded through CCBHC expansion grant)

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WHOLE HEALTH CARE

WHY DIABETES?

Pre-CCBHC:

- One electronic health record system
- Some medical diagnoses
- Some risk factors

Post CCBHC:

- Two electronic health record systems
- Medical diagnoses
- Risk factors
- Health outcomes
  - A1c, BMI
- Care coordination
- Population Health team
  - Project management
  - Implementation

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PILOT PROJECT- IMPLEMENTATION

Funding Support	3 grants support project management, panel management, and evaluation
Project Plan	
Key Stakeholders	
Metrics	Frequency of data collection Analysis
Identify participants	Data pull Staff survey

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WHOLE HEALTH CARE

PILOT PROJECT- INTERVENTIONS

- 4 health centers/2 supportive housing programs
  - Staff training/introduction to the pilot
- Targeted outreach
  - Cascadia primary care
  - Health record information (A1c, self report dx, at risk)
- Group therapy
  - TTMI curriculum
  - Co-Facilitated (RN/Peer Wellness Specialist (PWS); PWS and Master's level clinician
- Support
- Care Coordination and panel management
  - Data collection and reconciliation (2 EHRs!)
  - Panel management (support with specialty appts)
- Participant feedback of the experience

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TARGETED TRAINING FOR ILLNESS MANAGEMENT (TTMI) CURRICULUM

Session 1: Orientation and introductions (ground rules, discuss facts and misconceptions about mental health)

Session 2: The challenge of having both a mental illness and DM (stigma of mental health and strategies to cope with stigma, and relationship of mental health symptoms and functioning in response to stress and DM)

Session 3: Personal mental health profile (what does worsening illness look like for you triggers of mental illness relapse, personal action plan for coping with mental illness relapse)

Session 4: Diabetes complications and benefits of change (symptoms of high/low blood sugar and blood sugar monitoring

Session 5: Problem-solving skills and the IDEA (**Identify** the problem, **Define** possible solutions, **Evaluate** the solutions, **Act** on the best solution) approach (talking with your medical and your mental health care providers, role play of communication with care providers)

Session 6: Treatment for mental health and for diabetes (nutrition for best physical and emotional response for health, reading labels)

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TARGETED TRAINING FOR ILLNESS MANAGEMENT (TTMI) CURRICULUM

Session 7: Substance use and its effects on mental health and on DM (replacing unhealthy sugar and fat, problem- solving to feed your body healthfully)

Session 8: Effects of exercise on physical and emotional health (the Importance of daily routine and good sleep habits)

Session 9: Medications and psychological treatments for mental illness (a personal care plan to take care of the mind and the body)

Session 10: Social supports and using your available supports (types of physical activity and your community)

Session 11: Taking care of your feet, staying on track with medication treatments

Session 12: Illness management as a life-style, Acknowledgement of group progress (setting the stage for Ongoing Illness Management and Recovery)

Session 13: Diabetes and oral health (bonus session!)

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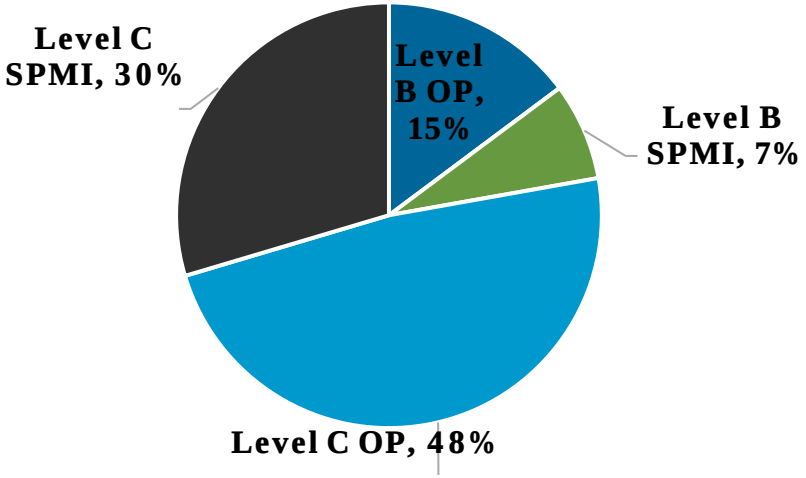
PILOT PROJECT- OUTCOMES

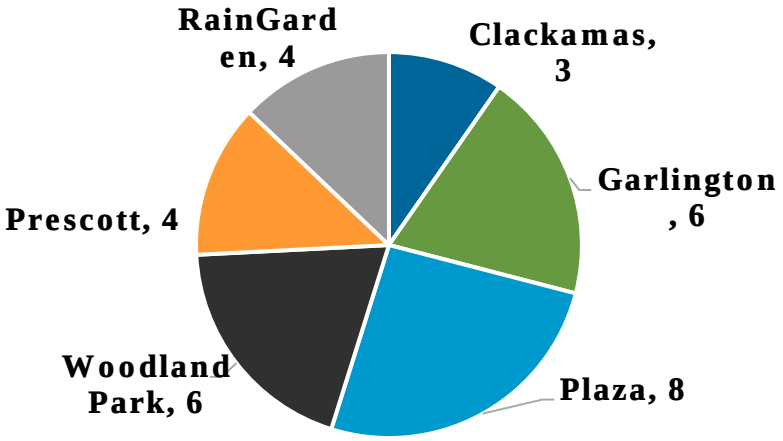
Engaged clients were:

- 56 years old
- 71% White
- 74% Type II diabetes
- 25% recent Dx

Group participation:

- 31 client attended at least 1/3 sessions
  - 84% >= ½; 42%>= ¾
- Full data on 17 participants





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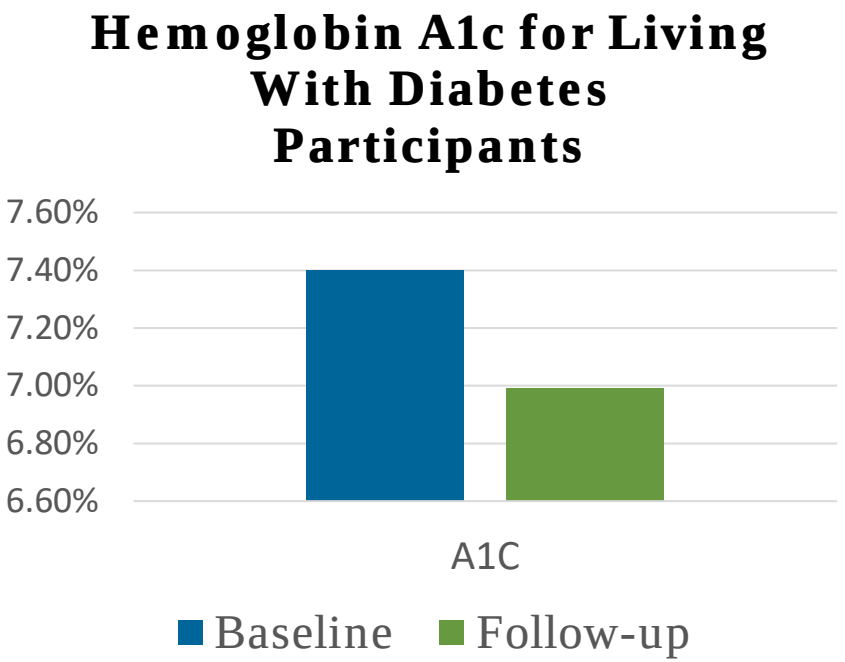
PILOT PROJECT- OUTCOMES

1% decrease in A1c is associated with lower physical health risks:

- 25% ↓ microvascular complications like **retinopathy, neuropathy and kidney disease**
- 19% ↓ **cataracts**
- 16% ↓ **heart failure**
- 43% ↓ **amputation or death** due to peripheral vascular disease

Improvement in mental health symptoms and better management of addiction



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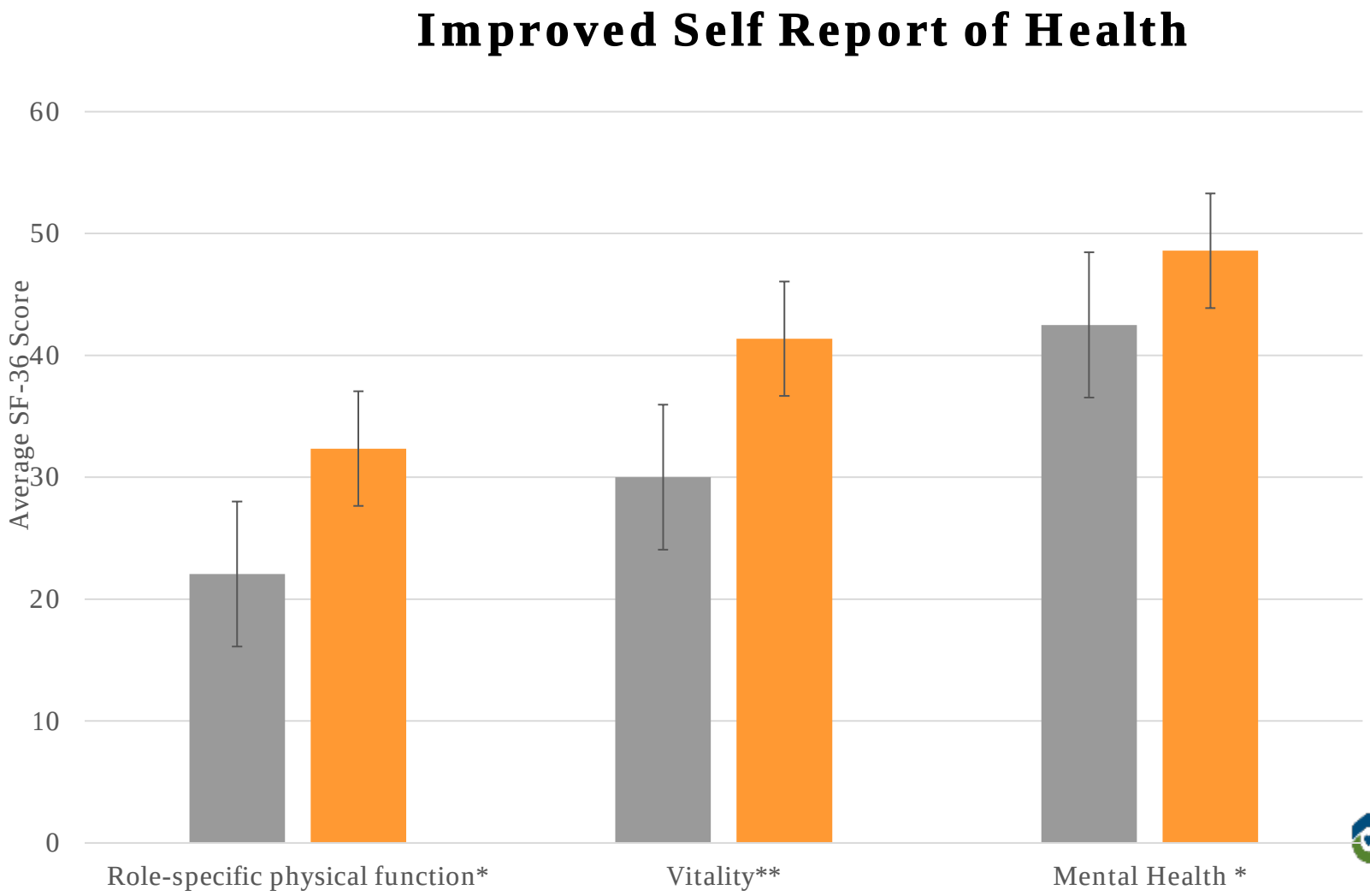
PILOT PROJECT- OUTCOMES



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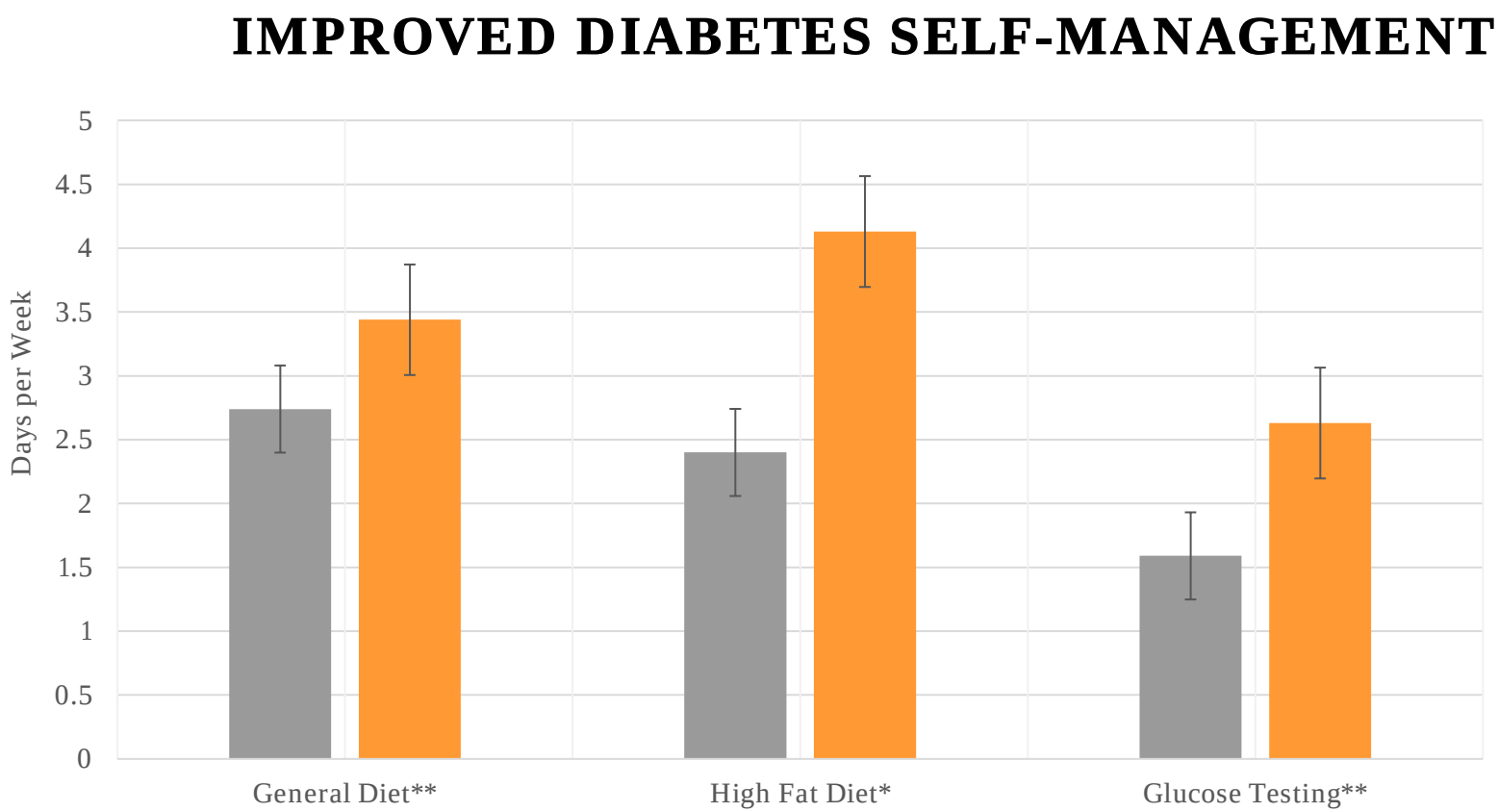
PILOT PROJECT- OUTCOMES



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PARTICIPANT FEEDBACK

- *"My mood and mental health is intricately related to physical health, so if I'm not feeling like I'm very happy I check and see how I am doing physically…"*
- *"The best thing I found out was about my teeth…That was the most helpful. I didn't realize how much diabetes plays with your teeth."*
- *"I learned how to speak up for myself and talk about what my needs are."*
- *"Being a good listener when the doctor tells me what to expect. Taught me to work more with her. … The group leaders shared with me and I shared with the group leaders, it was a mutual thing. It was the little things you don't think about all the time."*

DISSEMINATION OF DATA

- Grant/Funders
- Agency leadership
- Staff
- Clients
- Inside Cascadia (intranet)
- Media
- Colleagues/peer organizations
- Conferences

NEXT STEPS

- After the pilot phase is complete, it transitions to the Health Outcomes program (within outpatient mental health) for on going maintenance
  - Dotted line relationship with Population Health team to monitor outcomes
- Continue to understand health disparities and inequities that exist among Cascadia's population and provide culturally informed services or refer out to a cor
- Considering job description changes (ex: RN for health education)
- Where does the data take us next?

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QUESTIONS???

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THANK YOU

Sustainability

Sustaining A Medical Home Culture

- Practices may have focused their data efforts on producing information related to payment incentives and not yet harnessed their data for quality improvement (QI)
- A trusted and trained team that has the tools to do their work is how a practice can influence the success of their medical home
- An EHR is a business tool that should help to maximize productivity and support reporting efficiency – a practice must have familiarity with their systems to assure proper data entry
- Develop routine display of practice data (i.e., dashboard) in order to share with team members and leadership


Q&A

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