MODULE 13: Chronic Care – Managing Co-Morbidities and High Risk Patients

In this module, we will review the work of Community Care at the program and network levels to transition to a model that not only manages specific diseases but also manages individuals with multiple conditions, including mental health. An outline of the primary components of Community Care’s chronic care model will be described and tools will be shared.

Overview

Nearly 70 percent of North Carolina’s Medicaid budget is consumed by high-cost and high-risk disabled and elderly clients with serious and co-morbid (multiple) medical conditions. Recognizing this reality, the North Carolina General Assembly directed the N.C. Department of Health and Human Services in 2005 to “expand the scope of Community Care of North Carolina’s care management model to recipients of Medicaid and dually eligible individuals with chronic conditions and long-term care needs…” This effort began with nine networks piloting a chronic care model and creating a model for replication and adoption across the state.

Through its regional community-based health care infrastructure, Community Care has the framework to implement a comprehensive chronic care program that addresses many of the important elements identified by the MacColl Institute and Ed Wagner’s research on the chronic care model. According to Dr. Wagner, the Chronic Care Model is comprised of six interrelated system changes: effective team care; planned interactions; self-management support; community resources; integrated decision support; and patient registries and other supportive information technology. The Community Care Chronic Care Model aims to incorporate these system changes into the program components that will be defined in this module.

Community Care recognized the importance of strong community leadership in the development of a chronic care model. The local network leadership was challenged to convene new stakeholders and gain input and feedback into their expanded mission and strategies. Community resources were identified and integrated into the chronic care program and these new relationships and collaborations strengthened our chronic care model. For example, many of the networks developed relationships with the Aging, Disability and Resource Centers, with local
organizations representing the elderly and disabled communities, and with home and community-based providers.

States that are able to implement a comprehensive and robust chronic care program will be in a good position to implement the new health reform provisions directed at improving the delivery and coordination of services for persons who are enrolled in both Medicaid and Medicare (dual eligibles) and who are likely to have multiple chronic conditions.

**Strategies**

Successful chronic care programs must address the challenges associated with the chronically ill population, including:

- The current health care delivery system is inherently fragmented and complex.
- The primary care system has traditionally focused on acute problems.
- Reimbursement and financial incentives are not aligned to promote the management of individuals with chronic conditions.
- Team-based care, often because of reimbursement issues, does not occur as often as it should when managing individuals with chronic disease.

By implementing a sophisticated model of care management – and by using effective evidence-based tools and systems – Community Care has demonstrated that it can improve health outcomes and access while containing Medicaid costs. To improve care management of patients with chronic conditions, Community Care aimed to:

- Reorganize the delivery of care to those with chronic needs in ways that enhance appropriate access.
- Increase service delivery options.
- Improve efficiencies in the identification, assessment and care planning process.
- Reduce variation in care, the rate of institutionalization and the unnecessary inefficiencies and expenses in the current system.

Designed to build upon Community Care’s established foundation, the chronic care initiative emphasized an enhanced care management processes with strong ties to the medical homes and
built new connections with community-based long-term care providers and hospitals. Community Care partnered with those providers and other community professionals to improve how care is organized and delivered and to ensure accountability for managing target populations.

Recognizing that the best system for enabling long-term sustainability and system reform must occur at the community level, North Carolina’s Community Care networks provide an ideal mechanism for the state to ensure access to quality services at the most reasonable cost for its citizens. In the chronic care initiative, the networks are expected to provide a comprehensive and integrated package of screening and assessment, care management and care coordination, in addition to the primary, preventive and medical coordination and treatment provided to all enrollees.

Targeted for this initiative are individuals who are eligible for Medicaid and who are in the aged, blind and disabled (ABD) or CAP-DA (Community Assistance Program for Disabled Adults) eligibility categories. A defined subset, such as those individuals with high cost, high utilization and/or high risk, is being targeted for comprehensive care management. In addition, enrollees who are dually eligible for both Medicaid and Medicare are eligible to participate on a voluntary basis.

The chronic care program is designed to be “patient-centric,” addressing the physical, social, and behavioral health needs of the target population. The networks have reorganized the delivery of care to those with chronic needs in ways that enhance appropriate access, increase service delivery options, improve efficiencies in the identification, assessment and care planning processes, support transitions in care, reduce the rate of hospitalization, and reduce the unnecessary inefficiencies and expenses inherent in the current system.

At the outset, the nine pilot networks created work groups focusing on the following components of a chronic care model:

- Enrollment and Outreach
- Screening, Assessment and Care Planning
Initially, the networks extended existing population, disease and care management initiatives, and community partnerships already in place to patients with chronic conditions. At that point, networks had adopted evidence-based practice guidelines for asthma, diabetes, congestive heart failure, and chronic obstructive pulmonary disease. In addition, they had integrated targeted care management initiatives to help physicians manage and care for the most frail and costly patients. Physicians and practices received regular feedback on their ability to improve both the processes and outcomes of care. In addition to the disease management programs cited above, the chronic care project implemented a focused hypertension/coronary vascular disease management program. Additional information on that program and other disease management initiatives is available in Module 12.

Community Care networks aligned the efforts of comprehensive care management processes that help them manage individuals with chronic and often co-morbid conditions. First, Community Care developed a community-based approach to identify individuals who might benefit most from targeted care management interventions. That approach comprised performing an assessment, identifying individual needs and developing an appropriate plan of care. Depending on an individual’s needs, the plan might include some or all of the following: disease management; pharmacy management; mental health referrals; transitional support; self-management coaching; social case management; interdisciplinary team review; the establishment of a medical home; patient empowerment and education activities; family/caregiver outreach; and/or collaboration with community providers. Each network then established a local interdisciplinary team to help evaluate and manage the needs of individuals with chronic conditions. Community Care’s existing infrastructure of provider networks, case management services,
Web-based case management information systems, and capacity for claims-based quality and cost data feedback provided valuable support to the networks as they launched their programs.

The flow chart below illustrates the process through which Community Care implemented the chronic care program.

The chronic care program is guided by the following principles:

- Working with community providers who have traditionally cared for North Carolina’s low-income residents.
- Building private and public partnerships where community providers can work together to cooperatively plan for meeting patient needs and where existing resources can be used most efficiently.
• Placing responsibility for performance and improvement in the hands of those who actually deliver the care.
• Building a patient-centric model with the tools and processes that can be replicated in other networks and practices.
• Targeting disease and care management initiatives to a subset of the target population where the interventions will have the most impact.
• Ensuring that the “medical home” is supported in such a manner that enables the primary care providers to improve how they manage chronic illnesses.
• Integrating local long-term care and hospital providers and support in the community-based chronic care model.
• Focusing on population management strategies (i.e., disease management, care management, pharmacy management, coordination of behavioral health and implementing evidence-based guidelines) to identify and manage those individuals at greatest risk to positively impact the overall quality and cost of care.

Community Care’s long-term vision for the chronic care program is to create an effective, patient-focused chronic care system for Medicaid and Medicare patients statewide. The chronic care program has created the infrastructure for the quality demonstration project with CMS (646; see mini-module A, “Managing Other Populations,” for additional information). Through the chronic care program, Community Care has partnered with community providers to improve how care is organized and delivered and to create local accountability for managing target populations.

**Target Population Defined**

In North Carolina, the Aged, Blind and Disabled (ABD) population accounts for nearly 70 percent of the service dollars but fewer than 30 percent of the recipients. The average annual recipient cost for an ABD patient is more than five times the average annual recipient cost for families and children. Our ABD population has the following health characteristics:

• Approximately 54 percent are female.
• Forty-two percent have a co-occurring mental illness.
• Forty percent have hypertension.
• Twenty-two percent have diabetes.
• Fifteen percent have asthma.
• Twelve percent have COPD (chronic obstructive pulmonary disease).
• Eleven percent have heart disease or have had a stroke.
• Thirty-three percent have three or more chronic conditions.
• Eleven percent take eight or more prescriptions.
• Forty-five percent have visited the emergency department at least once in the past year.
• Nineteen percent have been hospitalized at least once in the past year.
• Congestive heart failure was the second leading cause of hospitalization.

**Program Redesign Efforts**

The goal of building an effective statewide system of chronic care for Medicaid and Medicare recipients required redesigning efforts at all three levels: the central program office, the network and the practice/medical home. To improve care and promote cost-effective care, the following areas were emphasized:

• Focus on points of transition in patient care (e.g., discharge from hospital to home).
• Examine frequent use of high-cost sources of care (e.g., hospital, emergency department).
• Address medication adherence and reconciliation through use of Pharmacy Home.
• Establish links among community providers, including those in behavioral health and long-term care settings.
• Support the medical home effort with patient information, case management and quality-improvement efforts.

The following Central Program Office redesign features have been incorporated to support the chronic care program:

• Develop an informatics center to provide timely and meaningful data to the networks and practices.
• Provide aggregated program and cost analysis reports to network and practices.
• Develop chronic care training modules for care managers.
• Provide scheduled updates to networks on best practices for the most common diseases.
• Develop and maintain a central clearinghouse of patient education materials.
• Provide additional and specialized consultative help to networks and practices, as indicated.

The Network redesign components include the following:
• Build a team of case managers who can take a holistic approach with complex patients.
• Develop strong relationships with the medical homes, community providers (e.g. hospitals and local management entities) and selected specialty practices.
• Identify and enroll additional practices that can serve Community Care’s target populations.
• Designate an informatics “champion” within each network to serve as a single point of contact.
• Identify a “chronic care physician champion” to lead the effort at the community level.

The Medical Home/Practice redesign support includes, but is not limited to, the following:
• Designate a practice-level “chronic care champion” to lead the effort.
• Designate one or two key practice staff members to serve as a consistent liaison(s) with network.
• Refer high-risk, high-cost patients to network care managers, as appropriate.
• Expedite appointments for patients with care needs or in transition (e.g. hospital discharge).
• Build additional capacity, such as establishing care teams, to proactively manage chronic illness and preventive care.
• Implement patient-centered medical home expectations.

While not exhaustive, these strategies represent some of most important components in a successful chronic care program.

Building Infrastructure and Processes
Early in 2007, the networks piloting the chronic care program received funding to support development activities and to begin identifying a replicable model. Recognizing how complex this population was compared to women and children, additional funding was secured in 2009 in
the form of a per member per month (PMPM) to support the practices and the networks in managing more high-risk enrollees. The practices are now receiving $5.00 PMPM for an ABD enrollee, and the networks receive $8.00 PMPM (of which $3.00 is used to support the central office functions, such as clinical consultants, the Informatics Center, the case management information system, etc.). It became clear that an increase in the PMPM was warranted as the pilot networks demonstrated the need for more care managers to manage those at highest risk and cost. In addition, because the ABD patients have multiple conditions, including co-morbid behavioral health conditions, they cannot be assigned into one disease category as many other enrollees.

Networks are engaging with the Local Management Entities (LME), the organizations responsible for coordinating and managing public behavioral health services in a geographic area, and behavioral health providers in their communities to work together on managing and coordinating the care of enrollees with behavioral health/substance abuse and disabilities. The networks have established local care teams led by a PCP (primary care provider) to support the management and evaluation of care plans for those chronic care patients at highest risk. In addition, the care team reviews the Personal Care Services (PCS) and Home Health (HH) services ensuring that patients receive what is medically necessary. Through their partnerships with community hospitals, network staff members get real-time information that identifies patients who are admitted to the hospital or emergency room; these relationships also allow the networks to participate in discharge planning and help ensure a safe transition back into the community.

To strengthen their ability to serve the needs of the ABD population, Community Care networks either added long-term care and community support providers (e.g., HH services, aging resource centers, etc.) to their existing steering committees or created chronic care stakeholder groups comprising a broad array of community providers focused on ABD patients’ needs.

In concert with the networks’ chronic care leadership, the central office developed a strategic planning document outlining the three design phases to implement the design features needed to implement a chronic care program. The blueprint addresses network infrastructure, population
stratification to target the most impactful patients, transitional support processes, clinical and care management interventions and processes, enrollment and outreach processes, and quality improvement.

**Chronic Care Program components**

Outlined below are the program components Community Care considers essential as well as the infrastructure and processes developed to support them.

- *Enrollment and outreach* – Each network created a plan in concert with its local departments of social services (DSS) to boost enrollment of ABD and dually eligible patients into Community Care (networks with strong partnerships with local DSS offices have higher enrollment rates). The networks received lists of practices that had large discrepancies between eligible and enrolled members that they could use to determine how best to increase enrollment. Some practices were willing and able to create educational materials encouraging their patients to choose a medical home. The patients signed enrollment forms that then were faxed to DSS for entry into the Medicaid enrollment system. Another strategy included individual outreach by care managers to educate patients about the importance of the medical home.

In 2009 the N.C. Division of Medical Assistance began sending “opt-out” letters to potentially eligible patients who were assigned to medical homes based on historical claims data. Patients were encouraged to call a toll-free number to choose a different primary care provider/medical home, if they so desired. Once patients were enrolled, the network and practices provided the following:
  - Welcome letters.
  - Medical home brochures.
  - Educational materials tailored for literacy levels.
  - Screening for communication barriers, such as hearing and cognitive impairment.
  - Hours of operation and 24/7 coverage.
  - Information targeting chronic conditions.
– Refrigerator magnets with medical home information and contact data.

In addition, family members and other caregivers were included in patient care discussions, and practice staff members used communication methods such as “teach back” and motivational interviewing to enhance outcomes.

• Screening/assessment/care plan – All networks have adopted a standardized approach to screening, assessment and care planning (see Module 11 for tools). Community Care has a standard screening and assessment tool available in the Web-based CMIS for completion and ongoing revision and review. The screening tool helps the care managers prioritize outreach and interventions for individuals at the highest risk and with the greatest potential to benefit. This standardized approach helps determine acuity level and the best plan of care for each patient. Developed by the patient’s health care team (led by the PCP) and family members, the plans are designed to be patient/family centered. You can access the following tools by clicking below:
  – Chronic Care Screening Tool
  – Community Care – Care Plan
  – Community Care Assessment

• Risk stratification/identify target population – Due to the size and complexity of the enrolled population, it is important to use tools and processes that stratify the population to enable prioritization of care management activities and interventions. Within Community Care, the entire population is grouped into high-risk and high-cost categories based on Medicaid historical claims data. The Informatics Center produces quarterly Chronic Care Reports with more than 70 data elements providing information on all ABD enrollees regarding cost, utilization and diagnosis data to help define a sub-set of the population for further screening. The report identifies approximately 17 percent of the population for screening and designates the top five percent as the highest priority.

Examples of screening criteria include but are not limited to:
  – Two or more chronic conditions.
– Inpatient admission in past six months.
– Three or more ED visits in past six months.
– Three or more outpatient providers within a six-month period.
– No PCP visit within the past year.
– Two ADL (activity of daily living) deficits requiring hands-on assistance.
– Eight or more prescriptions over the past month.

• *Patient-Centered Medical Home (PCMH)* – The essence of our chronic care program is the value and importance of a PCMH in caring for patients with chronic conditions. A PCMH helps ensure the following:
  – Every patient with a chronic condition has a primary care provider.
  – Evidence-based care is provided in the medical home.
  – Disease management of chronic illness(es) such as (diabetes, congestive heart failure, chronic obstructive pulmonary disease, hypertension, depression, etc.) occurs.
  – PCP actively participates in clinical performance improvement activities.
  – Patient tracking and successful referrals across delivery settings and providers.
  – E-prescribing.
  – Electronic health information records are available to optimize patient care and management.
  – Patients are educated on self-management for their chronic condition(s).

Please refer to Module 8 for more information on medical homes in Community Care.

• *Transitional support* – A transition occurs any time a patient moves from one care setting to another or when s/he moves from one area to another within the same care setting. Effective transitional support is critical to managing chronic illness because:
  – “Handoffs” are inherently dangerous due to gaps in communication.
  – Such communication gaps and glitches can result in serious harm to patients.
  – Problems that occur are often expensive to correct.
Recent research has found that transitional support sometimes can help to prevent unnecessary readmissions and improve patients’ medication adherence. Based on research and Community Care’s experience, we know that 18 percent of Medicare patients nationally are readmitted to the hospital within 30 days, and 50 percent of these patients did not see a physician before readmission. Up to 30 percent of readmissions occur at different hospitals, and the second hospital frequently has no useful patient data from the first hospital. Further, nearly 40 percent of patients are discharged with one or more test result(s) pending, and more than one-third of prescriptions provided at discharge are never filled. In addition, a large proportion of patients with chronic diseases have significant overlap between physical health and behavioral health issues. Finally, most patients are cared for by hospital staff during their stay and communication back to their PCPs is often infrequent and/or incomplete.

The Community Care networks have become the “glue” connecting the PCP/medical home to the community. To support more effective transitions, networks have implemented the following:

- Forged links with nearly all North Carolina hospitals to obtain timely information about their hospitalized patients.
- Embedded care managers in hospitals with large numbers of ABD admissions, and participated actively early in the discharge planning.
- Scheduled visits with patients in the hospital and then followed up with home visits within three days of discharge.
- Performed “medication reconciliation” on hospitalized patients that seek to make sense of all the different medications the patients may take (from the medicine cabinet, the PCP’s list, hospital discharge instructions, specialists and behavioral health providers, over-the-counter meds, etc).
- Built relationships in the community to share information among a variety of local agencies, including LMEs, behavioral health providers and long-term care support providers.
- Updated the patients’ medical homes about hospitalizations, other prescribed medications, social and environmental concerns, and other agencies providing services such as PCS, home health care and behavioral health support.
The primary role of the care manager in the transitional care process is to:

- Facilitate interdisciplinary collaboration among providers during transitions.
- Encourage the patient and caregiver to play a central and active role in the formation and execution of the care plan.
- Promote self-management skills and direct communication among the patient and caregiver, the PCP and other care providers.
- Achieve medication reconciliation by consulting with the network pharmacist, hospital, PCP, specialists, and the patient and his/her caregiver.

Thus far, we have identified the outcomes and best practices for the transitional support effort:

- All networks get “real-time” data from most hospitals in their communities.
- Care managers are embedded in large tertiary hospitals and work as part of hospital discharge planning teams.
- Embedded care managers in practices with large numbers of ABD patients support the PCPs in managing the highest risk and cost patients.
- Post-discharge home visits not only support medication reconciliation efforts but also provide care managers with valuable knowledge about the patients’ home environments and support issues.
- Preliminary data analysis shows an eight percent reduction in 30-day readmission rates.

Attached are tools that support and standardize the continued development and implementation of Community Care’s transitional support program:

- Transitional Care Model (two templates)
- Home Visit Scripts
- Network Chronic Care Transition Process
- Transitional Support Patient Education Tool
- Hospitalization Risk Assessment
**Pharmacy home** – The pharmacy home component of the model is designed to ensure that high-risk patients with complex medical problems and multiple medications have a “pharmacy home” that helps coordinate their pharmacotherapy regimens. Individuals are eligible for the pharmacy home program if they: (1) take more than eight medications per month; (2) receive prescriptions from three or more practices; and/or (3) are referred to the program by a clinician or a care manager.

The ABD population enrolled in Community Care takes an average of more than seven medications per month. The importance of managing poly-pharmacy and poly-prescriber concerns in this population cannot be overstated. In 2007 an increase in the PMPM enabled each network to hire a pharmacist (PharmD) to support the medical homes and networks in the pharmacy management programs. In addition, the central program office has a PharmD who leads this effort and works with all network pharmacists to create standardized expectations and processes. Because of the challenge of managing behavioral health medications, the program office has added a PharmD with this expertise to support the networks.

A multi-disciplinary team of Community Care staff, network staff and PCPs supports the Pharmacy Home. The pharmacy home’s foundation comprises four key pharmaceutical care providers: the central office pharmacist, network pharmacist, care manager and primary care provider. The team works closely with all physician practices to coordinate each patient’s pharmaceutical care.

The following processes guide the pharmacy home initiative:

- Identify the patient’s current medication list and relevant medical conditions by Medicaid claims and, if necessary, chart audits and direct communication with practices (network pharmacist).
- Review the medication list and offer suggestions for improvement (e.g., duplications, medication interactions, generic substitutions (network pharmacist).
- Send recommendations either to the patient’s care manager or PCP (network pharmacist).
Schedule a meeting with the patient to explain the changes. In addition to providing a portable and legible medication list, such interactions can improve medication adherence. Conduct follow-up meetings as needed (care manager, network pharmacist).

Provide recommendations and other information as appropriate to the PCP so prescriptions can be changed, added or stopped (network pharmacist, care manager, PCP).

Communicate changes to the pharmacist and/or care manager for follow-up, as needed.

Please refer to Module 9 for more information on Community Care’s Pharmacy Home program.

- **Care management** – Implementing care management support, processes and interventions is a vital part of a successful chronic care program, and identifying the target population that can benefit is the first step. But it is the application of the care management model that is most able to affect care pathways and patient outcomes.

In Community Care, local care managers work to support the efforts of the medical homes and PCPs. The care management support and coordination efforts help the PCPs care for the most complex and vulnerable patients. The PCPs know the care managers and can communicate with them one-on-one; in some instances, the care managers may be located in the medical home (especially in large volume practices). The Community Care program emphasizes the importance and flexibility of face-to-face interactions between patients and their care managers that also include home visits to perform environmental assessments, fall prevention screenings and medication reconciliation.

Some of the guiding principles in Community Care’s care management effort include, but are not limited to, the following:

- Incorporate a standardized approach to assessment, screening, care planning, care coordination and management priorities.
- Integrate targeted case management for high-risk patients.
- Ensure effective disease management practices occur in the medical homes via the adoption of evidence-based best practices for chronic conditions.
- Educate and support care managers to help them practice at the top of their license and be able to take care of patients with multiple conditions (i.e., generalist vs. specialist approach). Note: Several networks are implementing the John Hopkins model of “guided-care nursing” that helps manage the highest-risk patient populations.
- Target interventions where they will have the greatest impact, and integrate population stratification methods that help identify patients who will benefit most.
- Develop, implement and support patient self-management strategies.

In summary, the care manager’s primary role is to: facilitate interdisciplinary collaboration across transitions; encourage the patient and caregiver to play a central and active role in the development and execution of the care plan, promote self-management skills, and direct communication among the patient, caregiver, PCP and other care providers, and promote medication compliance.

Please refer to Module 11 for more detailed information on care management strategies, including population stratification, comprehensive health assessments and care plans. In addition to the information and attachments in Module 11, attached to this module are the following documents:

- Chronic care case management decision tree.
- Sample chronic care activity report.

- Mental Health Integration – Community Care’s chronic care program addresses the mental / behavioral care needs of enrollees with chronic conditions. In fact, more than half of enrollees with a chronic condition (e.g., diabetes, congestive heart failure or chronic obstructive pulmonary disease) also have a co-morbid mental health diagnosis such as depression or anxiety disorder. The Mental Health Integration program aims to improve the screening and treatment of mental health conditions in the primary care setting and enhance
the medical care of individuals with behavioral health problems.

Integrating mental health services into a primary care setting offers a viable and efficient way to ensure that patients have access to needed behavioral health services. Additionally, mental health delivered in an integrated setting can help minimize the stigma and discrimination that often accompany such diagnoses while simultaneously increasing opportunities to improve overall health outcomes. Successful integration requires the support of a strengthened primary care delivery system as well as long-term commitments from policymakers at the federal, state, private and local levels.

Several Community Care networks collaborated on a series of pilot programs to create an initial model of mental health integration. The pilots aimed to:

- Increase the comfort level of PCPs in identifying and treating patients with depression who present in their office.
- Improve communications between PCPs and behavioral health care providers at the local levels.
- Design and adopt standardized screening, assessment, reporting and communication tools.
- Implement psychiatric telephone consultations.
- Implement co-location models, when feasible.
- Ensure, through improved coordination, that patients are able to access care at a point in the system where their health and behavioral health needs can be optimally met.
- Develop and adopt uniform process and outcome measures for program evaluation.

Each network targeted both the adult and pediatric population (cohorts broken out by age: birth to age five and five and older) using the Four Quadrant Clinical Integration Model as the foundation for communication, collaboration, assessment, referral and clinical management of care. Using Community Care’s Web-based case management system, the networks and LME staff were able to document and share information. To ensure that data
collection was consistent across projects, common forms and tools were developed, including a telephone consultation form, behavioral health assessment form, case consultation request form, and provider surveys. Based upon the patient’s age, a common set of primary screening tools were chosen: the Ages and Stages Questionnaire (ASQ); Parents’ Evaluation of Developmental Status (PEDS), Pediatric Symptom Checklist (PSC), and Patient Health Questionnaire (PHQ-9). Each pilot implemented a universal screening tool and a clinical pathway for depression.

Some of the lessons learned in the pilot include, but are not limited to, the following:

- PCPs do not have the same relationships with behavioral health providers as they do with other specialty providers, such as cardiologists or endocrinologists.
- Building relationships between physical and behavioral health care providers is of paramount importance for a successful program. Further, although it takes time to develop these relationships, once they are built both communication and referrals are enhanced. Some networks held “brown-bag lunch-and-learns,” or evening socials for primary and behavioral health providers to interact and share best practices.
- The LME must be represented on a network’s board and/or steering committee so partnerships and collaborative efforts begin early.
- PCPs do not always have the confidence to prescribe and titrate behavioral health drugs, such as antidepressants. Having psychiatric telephonic consultation readily available helped increase the PCP’s knowledge and comfort.

The lessons learned in the mental health integration pilots helped guide the evolution of Medicaid mental health policy and target statewide training and technical assistance more effectively. These early pilots led to the development of another pilot effort in mental health integration: the co-location project in which a behavioral health provider worked within a PCP’s practice to provide onsite care to patients with both physical and mental health needs. In the co-location initiative, more than 50 primary care practices (pediatric, family practice, internal medicine, health departments, community health centers and rural health centers) participated in a pilot that aimed to provide and measure the following:
– Build practice infrastructure to incorporate the behavioral health needs of patients in the primary care provider office setting.
– Increase the number of primary care practices who use evidenced-based screening tools to identify patients.
– Seek to develop and implement an agile therapeutic model with enhanced referral processes for more complex patients to specialty mental health services.
– Demonstrate that practices and therapists both provide evidenced-based care.
– Improve both the self-management and functional ability of targeted patients.
– Develop a sustainable integrative model at the practice level.
– Demonstrate the model’s cost effectiveness.

Three behavioral health providers and three partnering primary care practices participated in a reverse co-location model in which the PCP worked within the specialty behavioral health clinic. This pilot aimed to provide and measure the following:
– Increase the number of patients with access to primary care services.
– Increase the number of patients that receive an annual medical exam.
– Demonstrate that patients receive the preventative care services in accordance with the U.S. Prevention Services Task Force guidelines.
– Monitor guidelines adherence for patients with antipsychotic prescriptions.
– Create value in the model for mental health providers.
– Demonstrate the model is cost effective.

Community Care co-location pilots work in partnership with The ICARE Partnership to maximize resources and avoid duplication of effort. ICARE (Integrated, Collaborative, Accessible, Respectful and Evidence-based) is a project focused on statewide education about and assistance for integrated collaborative care, local model development, and process and policy change. Useful information such as training opportunities, validated screenings tools, clinical algorithms, referral information, community linkages and job postings can be found on the ICARE website.

The co-location sites received start-up grant funds (not exceeding $25,000 per practice) to offset the initial cost of co-locating a psychiatrist, psychologist, mental health social worker,
or mental health physician’s assistant/nurse practitioner in a participating primary care practice. As of third quarter 2010, the initiative is in its final phases and has demonstrated that sustainability is much easier in a pediatric rather than an adult setting. We believe the model would be easier to replicate and sustain in adult practices if there were parity in coverage outside of Medicaid (Medicare and commercial payers). Many payers do not provide the same behavioral health coverage as the Medicaid program. Policy recommendations resulted from the project included the need to change Medicaid policy to enable two providers to bill for services on the same day (the primary care and behavioral health providers).

Recognizing the value and importance of behavioral health integration in managing individuals with chronic conditions, the central office and networks began hiring psychiatrists in 2010 to lead a comprehensive statewide effort. This initiative seeks to build the capacity and infrastructure needed to improve quality of care and contain the costs of that care while simultaneously increasing the ability to identify patients with behavioral and physical health care needs. Evidence-based best practices in managing behavioral health conditions will be identified and implemented, and the program will monitor and report on identified performance metrics. We expect more information on this effort to be available on Community Care’s website in 2011.

The following attachments are included in this module:

- A toolkit for a PCP’s use to treat low- to moderate-level depression
- A “follow-up phone call for depression” toolkit
- Network psychiatrist job description
- PHQ-9 from the Case Management Information System
- Mental health integration paper – “Evolving Models of Behavioral Health Integration in Primary Care”

- Informatics Center (IC) – Community Care’s investment in the development and implementation of the Informatics Center (see Module 7 for more detail) has reduced data
fragmentation and helped create health care “systems” that are coordinated and comprehensive. A centralized Informatics Center affords the chronic care program access to meaningful information, and networks are able to set common goals, share performance data and provide comparisons to each other and to national benchmarks. Further, the Informatics Center has enabled Community Care to use and share performance data to drive improvement, identify target populations and support the providers and care managers in optimizing best practices. In addition, the Informatics Center allows providers to share patient-specific data across the health care team and help coordinate care for patients for whom they share responsibility.

The term “informatics” encompasses all aspects of electronic data use within the Community Care program, including the collection, processing and representation of health care data from multiple sources for multiple stakeholders. As the Community Care program has expanded in scope and evolved over time, so have our systems for collecting, managing, processing and reporting data. Diligent interpretation of data and efficient exchange of information have proven to be critical to the overall program’s success.

A steady principal source of information about the enrolled population is Medicaid claims data. Community Care provides networks with quarterly “Case ID” reports in Microsoft Excel® and/or Access® formats, which list patients meeting specified criteria (e.g., patients with diabetes, hypertension and a recent hospitalization). In addition to creating parameterized reports to stratify the population and identify high-cost/high-risk individuals, the informatics center houses the Web-based case management information system. This tailored platform has evolved into a Web-based portal accessible to all networks that allows care managers to maintain health records and single care plans that stays with patients as they move from one area of the state to another.

- **Self-Management of Chronic Disease** – A chronic care program must implement processes and strategies to educate and support patients so they can take an active role in managing their condition and recognize and act when they need to seek medical care. Often, it is the patient’s ability to make the appropriate behavior change that determines whether they
achieve optimal health outcomes. For example, a patient with diabetes must adhere to an appropriate diet and take their medications to manage elevated sugar levels. The networks and care managers have integrated patient-centered education and coaching interventions into their population-management activities with favorable results.

Self-management as a component of a chronic care model is extremely important in the Medicaid population due to the percentage of individuals with multiple chronic conditions, co-morbid behavioral health concerns, higher social and economic barriers, lack of ability to navigate the system, cultural differences and increased levels of defensiveness. The goal of self-management support is to help patients improve their health outcomes and reduce or avoid costly crises. The Institute of Medicine in 2004 defined self-management support as “the systematic provision of education and supportive interventions by health care staff to increase patients’ skill and confidence in managing their health problems, including regular assessment of progress and problems, goal setting and problem-solving support.”

Many networks are testing and implementing strategies of coordinated care that enhance patients’ self-management abilities. Typically these programs:

- Teach patients about proper self-care and to recognize symptoms that need to be addressed by health professionals.
- Promote medication compliance and adherence.
- Explain how to communicate effectively with providers.
- Build understanding of when and how to seek support when needed.
- Help patients learn to schedule and keep necessary appointments, tests, exams, etc.
- Modify living environments.
- Use coaching styles that are best able to address treatment adherence and lifestyle changes.

Examples self-management strategies being developed and integrated into the Chronic Care Model include, but are not limited to, the following:
- The implementation of the Stanford Model of Self-Management of Chronic Disease that requires master trainers who are able to “train the trainers” at the community level. Trainers (including lay health trainers) then hold local sessions to educate patient groups on chronic illness care and self-management skill-building.

- Utilizing tele-health monitoring devices in the homes of patients with congestive heart failure as part of their self-management support.

- Testing self-management intervention software with modules for patients to access.

- Integrating the group medical visit at the practice level so individuals can gain experience and build confidence in sharing their experiences in managing their diseases with peers and others suffering from chronic illnesses.

- Utilizing telephonic health-coaching interventions.

- Teaching motivational interviewing skills to care managers and others in the health care team.

- Adopting communication tools in the medical home, such as the “ask-back” and “teach-back” methods.

- Beginning to determine how best to measure patient activation, such as Judith Hibbard’s Patient Activation Measurement (PAM) tool.

The self-management programs aim to change patient behavior and work best when supportive coaching and educational interventions are combined. Ensuring the network and PCP staff have the necessary skills to facilitate and support a patient’s change in behavior is important. Training the care managers to develop this skill set is an important first step (Note: Many networks chose to hire staff already skilled in behavior modification).

Included as an attachment to this module: