

CHRONIC CARE MANAGEMENT: AN INTEGRATED APPROACH

Cherry Street  Health Services

THE BEGINNING

Three organizations

- Cherry Street Health Services
- Touchstone *innovare*
- Proaction Behavioral Health Alliance

Cherry Street Health Services

- Cherry Street Health Services (CSHS) is a not-for-profit, 501(c)(3) Federally Qualified Health Center (FQHC) that was established in 1988.
- CSHS operated at 12 health center locations in Kent and Montcalm counties and in 68 schools.
- Health services provided include: family medicine, pediatrics, obstetrics and gynecology, internal medicine, behavioral health, general dentistry, optometry, ophthalmology, and general radiology.

Touchstone *innovare*

- Private, non-profit, 501(c)(3) corporation formed in 1998 through the merger of three similar organizations with roots dating to 1956.
- Provided outpatient psychiatric, therapy, case management, and psychosocial rehabilitation services for individuals with serious psychiatric conditions.
- Co-occurring substance use disorders were common in the client population (40%).

Proaction Behavioral Health Alliance

- Private, non-profit 501(c)(3) corporation formed in 1968.
- Originally established as Project Rehab to provide outpatient and residential substance abuse treatment.
- Provided residential treatment for federal and state correctional systems; outpatient counseling for mental health, substance use, and co-occurring disorders; medication assisted treatment (i.e., methadone, suboxone); and employee assistance programs.

Our previous state

Separate Silos

- Location
- Treatment Plans
- Prescriptions
- Coordination



Challenges

- Pharmaceutical interventions alone are insufficient
- Individual's ability and willingness affects outcomes
- Behaviors and environment play a key role

The Chronic Care Model



Developed by The MacColl Institute
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Why?

- Is the Wagner Chronic Care Model the most effective approach to help individuals manage their chronic health conditions?
- Does it make sense to treat multiple chronic health conditions together, rather than separately through different programs for each condition?
- Is a serious neuropsychiatric condition, such as schizophrenia, bi-polar disorder, or substance use disorder, a chronic health condition?

Acute versus chronic

- The distinction is between *acute* care and *chronic* care.
- Chronic care management can be designed to simultaneously address multiple chronic health conditions, including substance use disorders and psychiatric conditions.
- The integration is primarily integration across all chronic health conditions.
- The distinction between *behavioral* and *physical* becomes irrelevant.

Our purpose

- *To help individuals manage their chronic health conditions, so their conditions do not interfere with how they want to lead their lives.*

Integrated care

- One location
- All chronic conditions treated together
- Team approach
- One treatment plan
- One EMR
- Equal access to all providers
- Interventions tailored to stage of change

THE DEVELOPMENT PHASE

The Integrated Development Team (IDT)

- Formed in February 2010
- Team was made up of staff from all 3 agencies
- Design, test, measure, & redesign processes and procedures
- Gain feedback from patients
- Develop practice management procedures
- Develop procedures for coding and billing

The purpose of the IDT

- The IDT was created to find out what an interdisciplinary team, including health coaches, would need to know and to have in order to effectively help individuals manage multiple chronic health conditions.
- IDT members received four to six hours a week of release time from their current positions.
- For funding reasons as well as support and interest from the local public mental health authority (network180), individuals who were current clients of Touchstone or Proaction were invited to participate in this Institutional Review Board (IRB) approved formative study.

The IDT staff

- Internal Medicine Physician
- Nurse
- Psychiatrist
- Medical Assistant
- Health Coach (3)
- Pharmacist

What is a health coach?

- Roots are in substance abuse
- Early 1990's
- Holistic approach to treating chronic conditions
- Helps individuals become informed and activated
- Provide primary interventions when appropriate to the condition
- Fully licensed MSW's

What do staff need to know

- Introduction to Integrated Care
- What is Health Coaching
- Chronic Care Model
- Characteristics of a High Functioning Team
- Motivational Interviewing
- Cognitive Behavioral Therapy
- Trauma Informed Care/Seeking Safety
- Hypertension
- Chronic Pain and Fibromyalgia
- Schizophrenia
- Dementia
- Major Depression
- Eating Disorders
- Diabetes
- Substance Use Disorder/Treatment
- Obesity
- Bipolar Disorder
- Personality Disorders
- Asthma
- Communicable Diseases
- Post Traumatic Stress Disorder
- Pulmonary & Heart Disease
- Adult Education Techniques
- Dialectical Behavior Therapy Skills
- Team Dynamics
- Team Building
- Abbreviations Across Disciplines
- Smoking Cessation

The learning curve

- Terminology confusion
- Feeling overwhelmed by the complexity—So many disease states, so much to learn, and so much that used to be ‘not my problem’
- Lack of one uniform documentation system
- Old habits delivering care
- Reframing existing views on patient behaviors—It is not resistance or non-compliance. Instead, thinking in terms of the stages of change and motivational interviewing.

Team members initial experiences

- “I’ve come to bond with [the other IDT members], I know these people, I care about these people. Where before, they were strangers to me.”
- “I can be much more effective helping someone, because I’m not just...isolating mental health from their other health issues. I can see [patients’ health] more as a comprehensive picture and [the] things I can offer that I couldn’t offer before because I was ignorant of that medical piece.”
- “Mental health and physical health are practicing right next to each other, so we can use each other as resources to help the patient. It’s not that we didn’t try that before, but the nature of the practices [did not] allow that.”

One individual's chronic health conditions

- Morbid Obesity
 - Osteoarthritis
 - Benign Hypertension
 - Schizoaffective Disorder
- Diabetes, Type 2
 - Sleep Apnea
 - Fibromyalgia
 - Polysubstance Abuse

An individual with an extreme number of chronic conditions

1. Insomnia
2. Restless Legs
3. Post Traumatic Stress Disorder
4. Attention Deficit Hyperactivity Disorder
5. Eczema
6. Asthma
7. Polysubstance Dependence
8. Hypoglycemia
9. Borderline Personality Disorder
10. Irritable Bowel Syndrome
11. Amenorrhea
12. Depressive Disorder, Not Otherwise Specified
13. Gender Identity Disorder
14. Allergic Rhinitis
15. Back Pain, Chronic

Participants' initial experiences

- “I like the coordination. I like the idea that no matter who you talk to on your team they are aware of everything about you versus me always having to remember something.”
- “I like the time saving it brings through the system, and money too. Why [should] I have to spend money on going to ten different places, when I can just go to one.”
- “I like the fact that my doctor knows what my psychiatrist is doing and vice versa.”
- “[M]y psych meds [are] down. At one time, I had a table full of pills. Now, I don't have it like that, so the team helped me get down to that. So, I'm on one [medication] now and doing pretty good I guess.”

Participants' initial experiences continued

- “Since I’ve been coming to this team, I stopped drinking, and I feel like that’s a really huge thing.”
- “[M]y diabetes, too, is under control also through the diet [the IDT] gave me. It’s also because I was a drug addict, and I’ve come off of drugs now—that I’m sure influenced it.”
- “You’re dealing with mental problems, and you’re dealing with physical problems, and all those...combine sometimes, and it makes you feel like nothing is going right. To me, when I see Dr. Platt and my psychiatrist and [my] health coach, I feel stronger than I was. Because I didn’t know which way I was going. I had no use for life or people or anything and it caused big problems. But right now, I’m feeling hopeful.”
- “I’ve got friends who could so use this. They are not doing as good as really they need to be from my perspective. I wish I could say, ‘Hey, there is this great place that you can go.’ ”

Lessons learned from the initial development phase

- **Do not begin with a concept, start with the patients.** Otherwise, staff have nothing tangible to which to relate the concept (e.g., the chronic care model).
- **Learning *about* something is not learning to do it.** Staff training needs to be followed by ongoing practice under expert supervision. That means everything, from specific interventions to the language used to discuss patients.
- To break old habits, new behaviors need to be **modeled and reinforced.**

THE PILOT PHASE

Our current state



Cherry Street Health Services

- Federally Qualified Health Center based in Grand Rapids, Michigan
- Largest FQHC in Michigan
- 70,000 patients and 800 employees
- Over 20 locations
- Primary Care Sites, School Based Programs, Integrated Health Sites, Dental, Vision, Women's Health
- Medication Assisted Treatment, Employee Assistance Center, Residential Programs, Targeted Case Management, Clubhouse

The Durham Clinic

- The full team began providing chronic care management in October 2011, coinciding with the Heart of the City Health Center opening.



The staff

- Internal Medicine Physician (1FTE)
- Psychiatrist (0.75 FTE)
- Health Coach (5 FTE)
- Nurse (1.5 FTE)
- Physician Assistant (.5 FTE)
- Medical Assistant (2.5 FTE)
- Supports Coordinator (1 FTE)
- Peer Support Specialist (.5 FTE)
- The following services are also available:
 - Pharmacy
 - Nutrition Counseling
 - Benefits Acquisition
 - Housing and Transportation Referrals
 - Vision
 - Dental

Who are our patients

- The Durham Clinic currently has over 1000 patients and continues to grow.
- All patients have at least one chronic health condition.
- Less than 1/2 have a diagnosis of a severe mental illness.
- Referrals come from both internal and external sources.

Access to primary care

- 209 patients with a Severe and Persistent Mental Illness.
- 109 of those had **NO** primary care physician prior to receiving services in the Durham Clinic.

The huddle



How does it work

- **61 Year Old, African American, Male**
- **Back Pain, Schizoaffective Disorder, Type I Diabetes, Alcohol Abuse, Cocaine Abuse, Hypertension, Hepatitis C, Glaucoma**
- *Patient presented with multiple psychiatric hospitalizations due to reports of suicidal thoughts and auditory hallucinations.*
- *Blood sugar levels running consistently at 300.*
- *Many no shows for scheduled appointments.*
- *Not taking insulin or psychiatric medications.*

How does it work

- **33 Year Old, Caucasian, Female**
- **IBS, Bipolar I Disorder, Bartholin's Cyst, Herpes Simplex**
- *Ongoing anxiety regarding physical health conditions.*
- *Frequent manic episodes.*
- *Three psychiatric hospitalizations during the year prior to joining the integrated team.*

How does it work

- **21 Year Old, Caucasian, Male**
- **ADHD, Asthma, Bipolar I Disorder, Polysubstance Abuse**
- *Patient's father died of cancer.*
- *Patient has refused to see any primary care physician since a teenager due to fear of being diagnosed with cancer.*
- *Patient routinely reported to health coach that he felt he would not live past the age of 21.*

The evaluation

- A quasi-experimental, time series design with a comparison group.
- Approved by the Michigan Department of Community Health IRB.
- The intervention group is comprised of adult patients with chronic health conditions who receive integrated chronic care management services in the Durham Clinic.
- The comparison group includes adult patients with chronic health conditions who receive care as usual at another CSHS site.
- Data is being collected from both the intervention and comparison groups for three years following their enrollment, beginning in October 2011.

Outcome measures

- Depression: Patient Health Questionnaire (PHQ-9)
- Anxiety: Generalized Anxiety Disorder 7-item (GAD-7) Scale
- Substance Abuse: CAGE-AID
- Pain: Brief Pain Inventory
- Body Mass Index (BMI)
- Blood Pressure
- Lipid Profile
- Fasting Blood Sugar, Hemoglobin A1c Test (HbA1c)

Outcome measures

- Patient Activation, PAM-13
- Self-perceived health status, EQ-5D
- Cost and claims data regarding the following:
 - Inpatient admissions and days
 - Emergency room visits
 - Pharmacy
 - Clinic visits
 - No show rates
 - Others as available

PAM 13

1=May not yet believe that the patient role is important.

2=Lacks confidence and knowledge to take action.

3=Beginning to take action.

4=Has difficulty maintaining behaviors over time.

EQ5D

- Measures self reported health status
 - Mobility
 - Self-Care
 - Usual Activities
 - Pain/Discomfort
 - Anxiety/Depression

Individual rates each area in terms of:

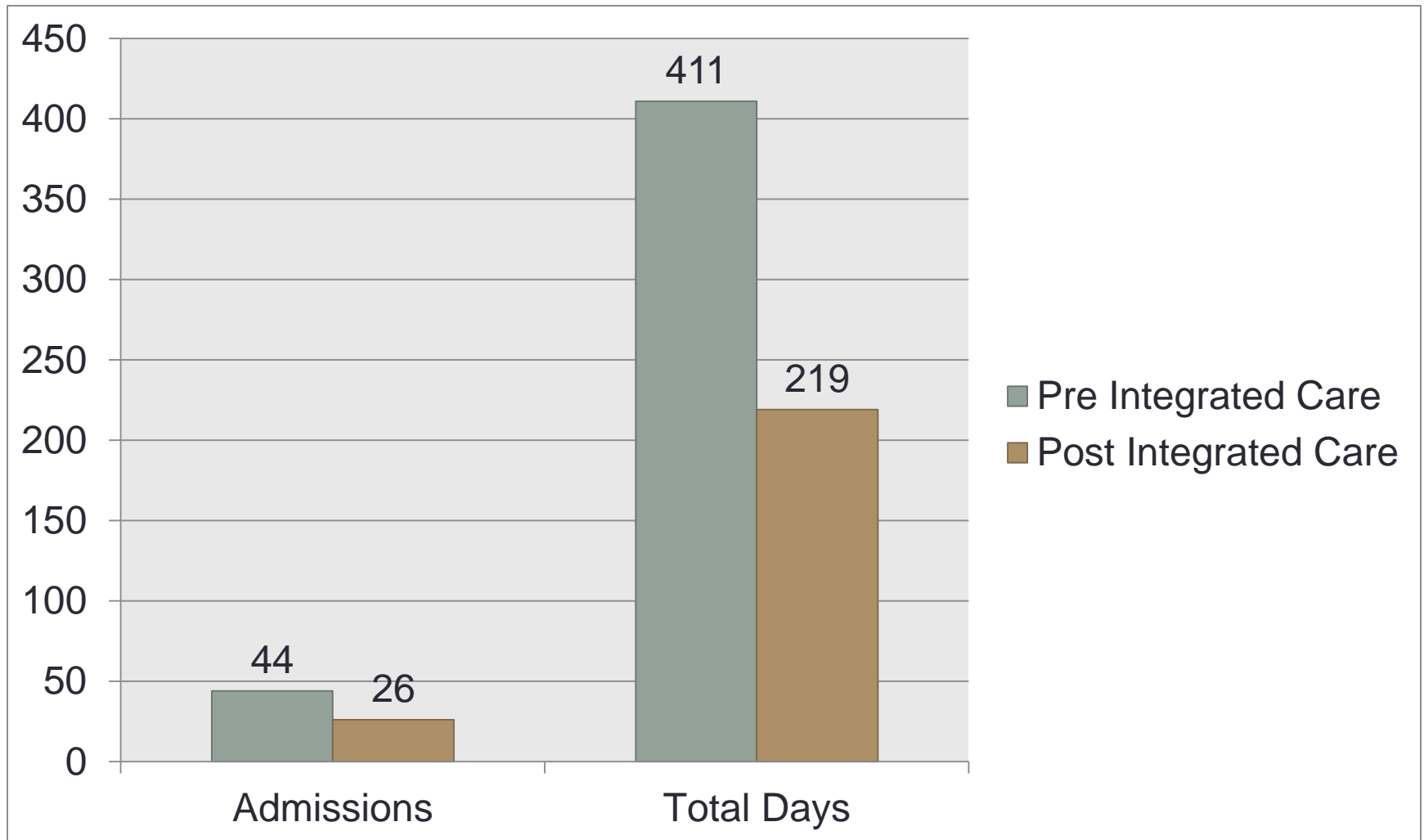
No Difficulty

Some Difficulty

Extreme Difficulty

INITIAL RESULTS

1 year psychiatric facility reductions



Psychiatric admissions

**41% Reduction in
number of admissions**

Psychiatric inpatient days

47% Reduction in Inpatient Days

Total estimated savings

\$167,920.00

Statistically Significant Improvement

- BMI
- Blood Pressure
- Depression
- Anxiety
- Patient Activation
- Health Status
- Substance Use
- 18% Reduction in ER Use

LESSONS LEARNED

Choose the right staff

- **Self-confidence** - to work to the limits of their license and to act as equals with other health care providers
- **Humility** - to know what they don't know and be eager to learn it
- **Willingness** - to create and learn a new language
- **Curiosity**
- **Flexibility** - to quickly change direction

Anticipate resistance

Inside and out

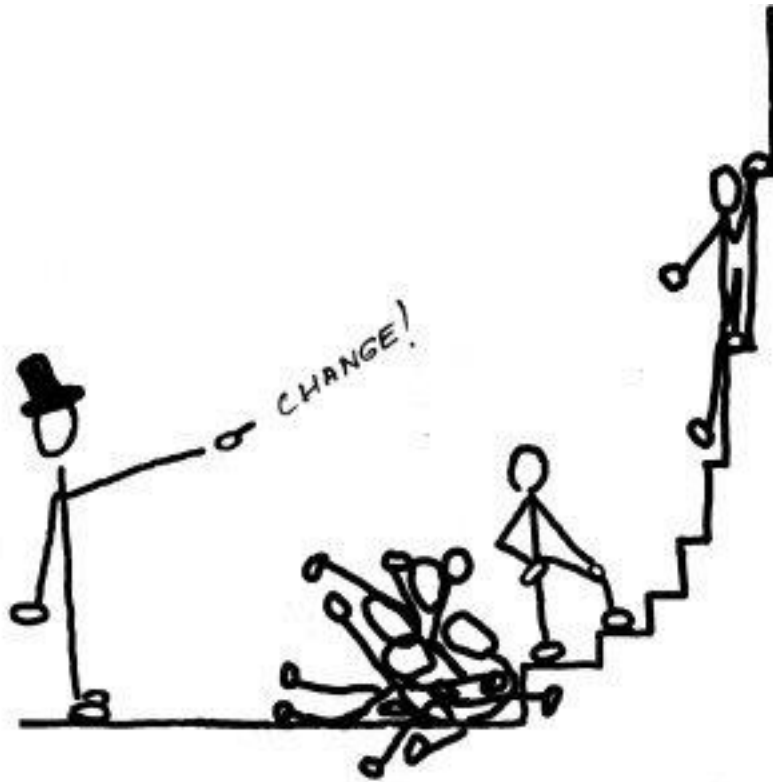
- Attitudes – Competition for patients
- Lack of understanding of integrated health care
- Changing policies – discharge procedures, etc.
- Authorization and billing procedures are still separate

Get commitment



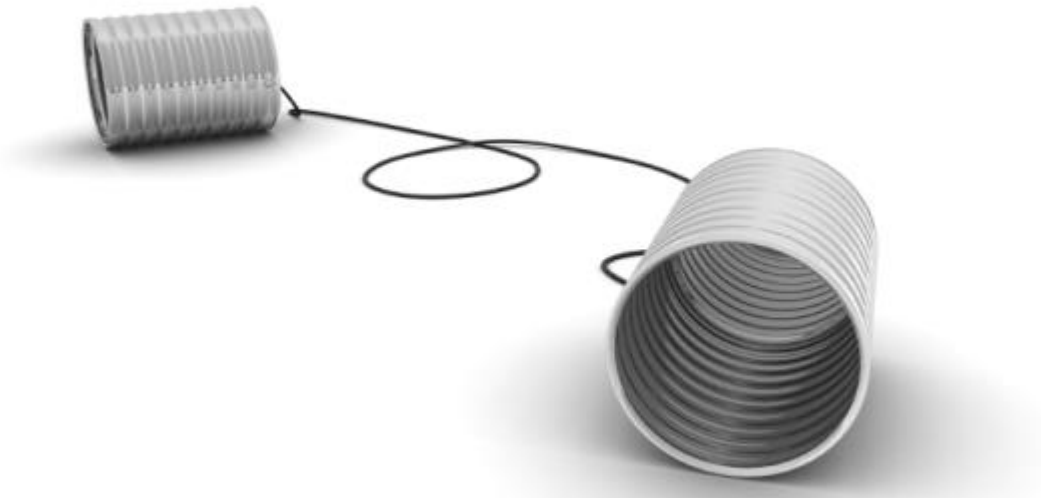
Don't discount

The learning curve



Don't discount

Communication barriers



QUESTIONS?

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