Division of TennCare

STATE OF TENNESSEE

Health Link: Behavioral Health Providers and Chronic Disease Management

1/24/18

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Content

- Characteristics of Chronic Medical Conditions
- Barriers and Challenges to Chronic Disease Management
- Measuring Success
- Resources
- Appendix

Characteristics of Chronic Medical Conditions

- Oftentimes life long
- Require significant and consistent adherence to a treatment plan
- Require a member driven plan and focus (Wellness Recovery Action Plan (WRAP))
- Require regular follow up
- Often require lifestyle change(s)
- Benefit from peer-to-peer interactions and social support
- Benefit from common understanding and coordination of care among all providers

Example: Knowing the Next Step

- Over the past two weeks, how often have you been bothered by any of the following problems?
  - Little interest or pleasure in doing things.
    - 0 = Not at all
    - 1 = Several days
    - 2 = More than half the days
    - 3 = Nearly every day
  - Feeling down, depressed, or hopeless.
    - 0 = Not at all
    - 1 = Several days
    - 2 = More than half the days
    - 3 = Nearly every day
- Total point score: _____

So you've identified the problem, now what?

Barriers and Challenges to Chronic Disease Management

- Knowledge Gaps
- Data Gaps
- Communication Gaps
- Implementation Gaps
- Support Gaps

Removing Barriers- Addressing Knowledge Gaps

- Use the Care Coordination Tool to identify the most common medical conditions in the practice
- Identify which members of your staff would benefit from additional education
- Identify who can provide basic education about these conditions to members of your staff:
  - Local PCMH organizations
  - Medical schools
  - Nursing schools
  - Advocacy groups (American Diabetes, Heart or Lung Associations)
- Set up a schedule for education
- Develop a library of resources (some included in the appendix)
- Plan for conversations at the learning collaboratives and with high volume PCMH organizations

Sample Questions for Patients: Asthma

- Are you using your inhalers?
- How did your doctor tell you to use them?
- Have you had to increase their use lately?
- When is your next appointment for follow up?
- Do you have a plan for what to do when your asthma is bothering you?
- How is your breathing today?

[1]http://www.lung.org/lung-health-and-diseases/lung-disease-lookup/asthma/asthma-education-advocacy/asthma-basics.html?referrer=https://www.google.com/
[2]https://www.aafp.org/fpm/2010/0100/fpm20100100p16-rt2.pdf

Sample Questions for Patients: Diabetes

- Has your doctor advised you to check your blood sugar? How and how often? Are you doing so?
- What range has it been in when you checked?
- Have you had high or low sugars lately?
- Do you know what signs to watch for that may tell you that your blood sugar is out of control?
- Do you have a plan for what to do when your sugars are not controlled or you are not feeling well?

[1] http://www.diabetes.org/diabetes-basics/?loc=db-slabnav
[2] https://www.aafp.org/fpm/2000/0900/fpm20000900p51-rt2.pdf

Sample Questions for Patients: Diabetes

DIABETES ASSESSMENT FORM

Name _____ Date _____

Being a person with diabetes means _____

_____

When I think about having diabetes, I feel _____

_____

How do I feel about giving up old habits and starting new ones in order to improve my health? _____

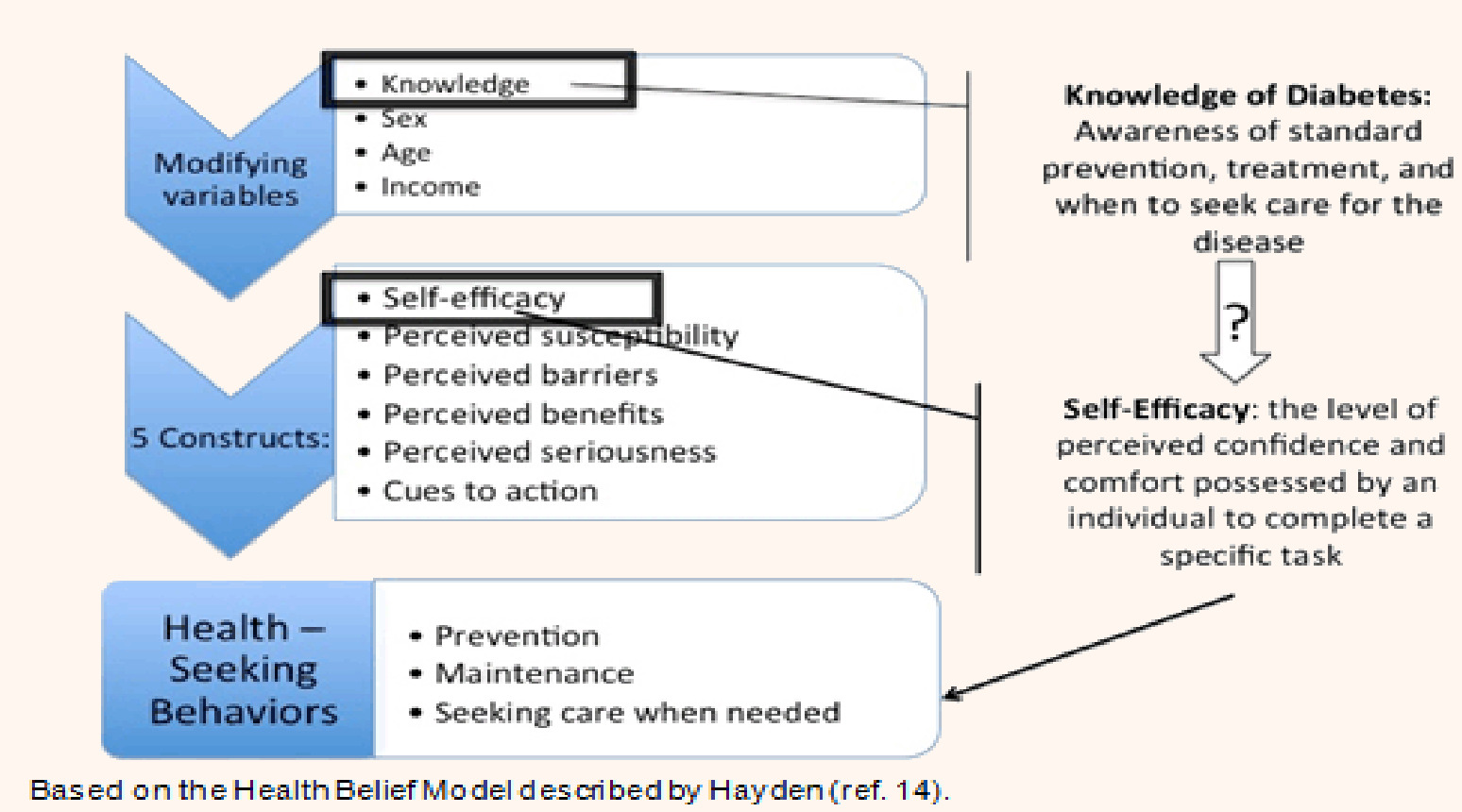
_____

Do I believe it simply doesn't matter if I change my habits? _____

Do I lack self-confidence in my ability to make changes? _____

[1] http://www.diabetes.org/diabetes-basics/?loc=db-slabnav
[2] https://www.aafp.org/fpm/2000/0900/fpm20000900p51-rt2.pdf

Teaching Self-Management Skills of Chronic Conditions



Based on the Health Belief Model described by Hayden (ref. 14).

Removing Barriers- Addressing Data Gaps

- Does the clinical record include all diagnoses and medications? If not, identify where to make a note of these.
- Use the Care Coordination Tool to identify high risk members as well as those with chronic illnesses:
  - Sort clients by risk score
  - Sort clients by common chronic condition
  - Identify clients with recent admissions or ER visits
- Use the Care Coordination Tool data to update the clinical record. Identify who in the organization will do this.
- Consider using the Care Coordination Tool to prepare for the week or next day visits by identifying high risk clients, clients with target diagnoses, clients with gaps in care, etc.

Removing Barriers- Addressing Communication Gaps

- Identify method for regular communication and coordination
  - Non-acute referrals (both directions)
  - Share treatment plans
  - Share medications and changes
  - Escalation protocols
  - Case conferences
- Identify communication path for acute care
  - Central coordination point in your organization
  - Central referral point at the PCP
  - Method for communication – phone, email, etc.
  - Joint discharge planning for all admissions
- Identify process for patient management
  - Transportation
  - Support
  - Follow up plan to avoid duplication or confusion

Removing Barriers- Addressing Implementation Gaps

- Communicate with all practice providers and staff that there may be challenges or hiccups during the implementation of chronic condition management.
- Anticipate questions about how care management and coordination will impact daily operations and workflows
  - Behavioral health providers many need active support as they start to engage clients about the PH conditions
  - Behavioral health providers may not know where to refer members with physical health conditions
  - Physical health providers and staff often assume there are more individuals with behavioral health needs than the behavioral health provider will be able to handle
- An initial spike in referrals is common
  - Help providers and staff think about which individuals may benefit from coordination, especially among those with chronic physical health problems or behavioral health conditions other than depression, anxiety, and other common mental health problems.

Removing Barriers- Addressing Support Gaps

- Engage local chapters of national organizations focused on specific conditions:
  - American Heart Association
  - American Lung Association
  - American Diabetes Association
- Engage health focused community organizations such as the YMCA
- Engage churches and faith based organizations
- Include health care professionals in the schools such as school counselors and nurses
- Explore partnerships with businesses
  - Supermarkets may offer nutritional counseling and shopping support
  - Pharmacies support patient education and share drug information with members

Measuring Success

Start with simple process measures:

- Sample records of clients with recent visits
  - Are all diagnoses (physical and behavioral) included in the record?
  - Are there steps to address chronic health conditions in the treatment plan?
  - Is the member engaged in Health Link appropriately (visits, care coordination, other services?)

Review the Care Coordination Tool for process measures such as PCP appointments

Review quality of care measures or gaps tracked in the Care Coordination Tool:

- Are diabetes measures improving?
- Are gaps in care being closed?
- Is there an increased number of ER visits or hospital admissions?

Measuring Success

Example

Measure	Q1	Q2	Change
% of charts with notation(s) about behavioral health conditions			
% of charts with notation(s) about physical health conditions			
% of members with at least one PCP visit within the last 12 months			
Average number of gaps/member			

Resources

Asthma Basics

- http://www.lung.org/lung-health-and-diseases/lung-disease-lookup/asthma/asthma-education-advocacy/asthma-basics.html?referrer=https://www.google.com/

Diabetes Basics

- http://www.diabetes.org/diabetes-basics/?loc=db-slabnav

COPD Basics

- https://medlineplus.gov/copd.html, https://www.nhlbi.nih.gov/health-topics/copd

Hypertension Basics

- http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/GettheFactsAboutHighBloodPressure/The-Facts-About-High-Blood-Pressure_UCM_002050_Article.jsp#.WlOeHt-nGUk

Heart Disease Basics

- http://www.heart.org/HEARTORG/Support/What-is-Cardiovascular-Disease_UCM_301852_Article.jsp#.WlOed9-nGUk

Resources

SAMHSA-HRSA Center for Integrated Health Solutions *CIHS*

- http://www.integration.samhsa.gov/

AHRQ

- https://integrationacademy.ahrq.gov/resources/new-and-notables/integration-playbook-now-available

MacColl Center for Health Care Innovation

- http://www.maccollcenter.org/

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THANK YOU

Appendix

Wellness Recovery Action Plan (WRAP)

What is WRAP?

- WRAP stands for Wellness Recovery Action Plan. A WRAP plan is based on the individual and is developed to:
  1. Decrease and prevent intrusive or troubling feelings and behaviors
  2. Increase personal empowerment
  3. Improve quality of life
  4. Achieve their own life goals and dreams

Who can use WRAP?

- WRAP is for anyone who needs to achieve self-directed wellness vision despite life's challenges.

Why WRAP?

- WRAP is built on the following key concepts: hope, personal responsibility, education, self-advocacy, and support.

What is involved in a WRAP plan?

- The WRAP plan will include a wellness toolbox, daily maintenance plan, triggers, early warning signs, when things break down, crisis plan, and post crisis plan.

[1] www.mentalhealthrecovery.com/wrap-is/
[2] https://copelandcenter.com/wellness-recovery-action-plan-wrap
[3] https://namiaustin.org/wp-content/uploads/2014/09/Developing-a-WRAP-Plan.pdf

Common Chronic Conditions Affecting Behavioral Health

Condition/ Disease	Definition	Common Diagnostic Tests	Common Medications/ Treatment	Care Coordinator Intervention Examples
Asthma	Long-term and persistent inflammation of the airways. Episodes can be caused by allergens, respiratory infections, changes in weather, stress, etc.	• Lung function tests such as spirometry or peak flow	• Inhaler	• Episode tracker (diary of triggers, time, severity, etc.) • Medication tracker
Cancer	Tumors, or abnormal growth of cells, in a particular area of the body.	• Biopsy	• Chemotherapy • Radiation • Surgery (tumor removal)	• Oncology appointment tracker
Chronic Hepatitis	Inflammation of the liver for more than six months. There are different types (A, B, C, D and E) which are spread in different ways (e.g., via blood, sexually transmitted, etc.).	• Blood test (viral serology)	• Antiviral medications	• Medication tracker
Chronic Kidney Disease (CKD)	Decreased functioning of the kidneys.	• Kidney function tests	• Diuretic (reduces fluid in body) • Dialysis (machine-driven waste removal from blood)	• Dialysis appointment tracker
Chronic Obstructive Pulmonary Disease (COPD)	Persistent respiratory symptoms and airflow limitations which progress over time and are usually caused by exposure to noxious particles or gases (e.g., cigarette smoke).	• Lung function test such as spirometry • Chest X-ray	• Inhaler	• Episode tracker (diary of triggers, time, severity, etc.) • Medication tracker

Common Chronic Conditions Affecting Behavioral Health

Condition/ Disease	Definition	Common Diagnostic Tests	Common Medications/ Treatment	Care Coordinator Intervention Examples
Diabetes – Type 1	Improper use of glucose (a type of sugar in the body), so that not enough insulin is produced.	• HbA1c (indicates average blood sugar level for the past 2-3 months) • Blood sugar tests	• Proper diet (i.e., carbohydrate counting) • Insulin	• Insulin log book (includes medications, meals, exercise) • Endocrinology appointment tracker
Diabetes – Type 2	Improper use of glucose (a type of sugar in the body), so that the body does not respond properly when insulin is produced.	• HbA1c (indicates average blood sugar level for the past 2-3 months) • Blood sugar tests	• Proper diet (i.e., carbohydrate counting) • Metformin	• Insulin log book (includes medications, meals, exercise) • Endocrinology appointment tracker
Heart Disease	Decreased functioning of the heart.	• Electrocardiogram (ECG or EKG) • Echocardiogram • Blood tests • Chest X-ray	• Diuretic (reduces fluid in body) • ACE inhibitors (decreases blood pressure)	• Daily weights (for congestive heart failure) • Medication tracker • Food log
HIV/AIDS	Virus which interferes with the body's ability to fight off infections.	• Blood test (viral serology)	• Antiretroviral therapy	• Medication tracker • Diet and exercise log
Hypertension	High blood pressure which causes the heart to work harder than normal.	• Blood pressure	• Diuretic (reduces fluid in body) • ACE inhibitors (decreases blood pressure)	• Diet and exercise log • Blood pressure tracker • Medication tracker