

NATIONAL COUNCIL LIVE

Webinars



NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE



Technology with the Webinar

- > Raise Hand to Ask Questions
- > Type Questions In While We're Talking
- > Polling During the Webinar



The Patient Centered Medical/Healthcare Home (PCMH)

> American Academy of Family Physicians

Definition: “A place that integrates patients as active participants in their own health and well-being. Patients are cared for by a physician who leads the medical team that coordinates all aspects of preventive, acute and chronic needs of patients using the best available evidence and appropriate technology. These relationships offer patients comfort, convenience, and optimal health throughout their lifetimes”.

(<http://www.aafp.org/online/en/home/policy/policies/p/patientcenteredmedhome.htm>)

> National Council Definition Adds: use of the word “healthcare” home to insure that behavioral health is included

(<http://www.thenationalcouncil.org/resourcecenter>)



NCQA Standards for PCMH

- > The principles underlying the NCQA standards acknowledge the need for
 - a personal physician directing a practice,
 - whole-person orientation
 - coordinated or integrated care, provided safely
 - high quality and enhanced access
 - paid for through models that recognize the added patient value
 - value to employers, health plans, and the government

<http://www.ncqa.org/tabid/631/default.aspx>



Issues with NCQA Standards

- > Concentration on information technology at the expense of continuous healing relationship and patient experience of care



Three World Model

- > C. J. Peek suggests that in order to impact healthcare, three worlds must be addressed simultaneously
 - Clinical
 - Operational
 - Financial



IHI Triple Aim Works

- > Berwick (et al) Improvement in healthcare requires three aims:
 - Improving the patient experience of care
 - Improving health
 - Attending to costs and financing



Proposed Metrics for Collaborative Care (Miller et al., 2009)

Metrics

Metrics

Percent Detected

Likelihood of detection
All patients screened
Periodic screening (i.e. annual)
Actionable screening results
Range of conditions detected
PCP training side-effect

Three Worlds of Healthcare (Peek, 2008)

- Clinical
- Operational
- Financial

Percent Treated

Likelihood of treatment
Trust – PCP to MH/BHP
Process integration
Trust transfer for patient
MH stigma – social
MH stigma – education
Overcoming denial
Patient’s logistics
Patient’s ability to pay
Seamless with medical

Percent Improvement

Overall Efficacy
Protocol-based
Treatments used
Tailored to patient
Continuity of care

Cost to the PC practice

Professional training/salary
PCP involvement required
PCP time saved
Use of Brief Interventions
Common Sched/Billing
Common facilities
Common EMR/IT
PCP Coverage

The Triple Aim (Berwick, 2008)

- Care
- Health
- Cost

Berwick, D.M., Nolan, T.M. & Whittington, J. (2008). The Triple Aim: Care, Health, and Cost. *Health Affairs*, 27, 759-769.

Miller, B. F., Mendenhall, T. J., & Malik, A. D. (2009). Integrated primary care: An inclusive three-world view through process metrics and empirical discrimination. *Journal of Clinical Psychology in Medical Settings*, 16, 21-30.

Peek CJ. Planning care in the clinical, operational, and financial worlds. In: Kessler R, Stafford D, eds. *Collaborative Medicine Case Studies: Evidence in Practice*. New York: Springer; 2008.



Access

Identification

Treatment

Improvement

Cost

Practice Experience

Patient Experience

System Experience

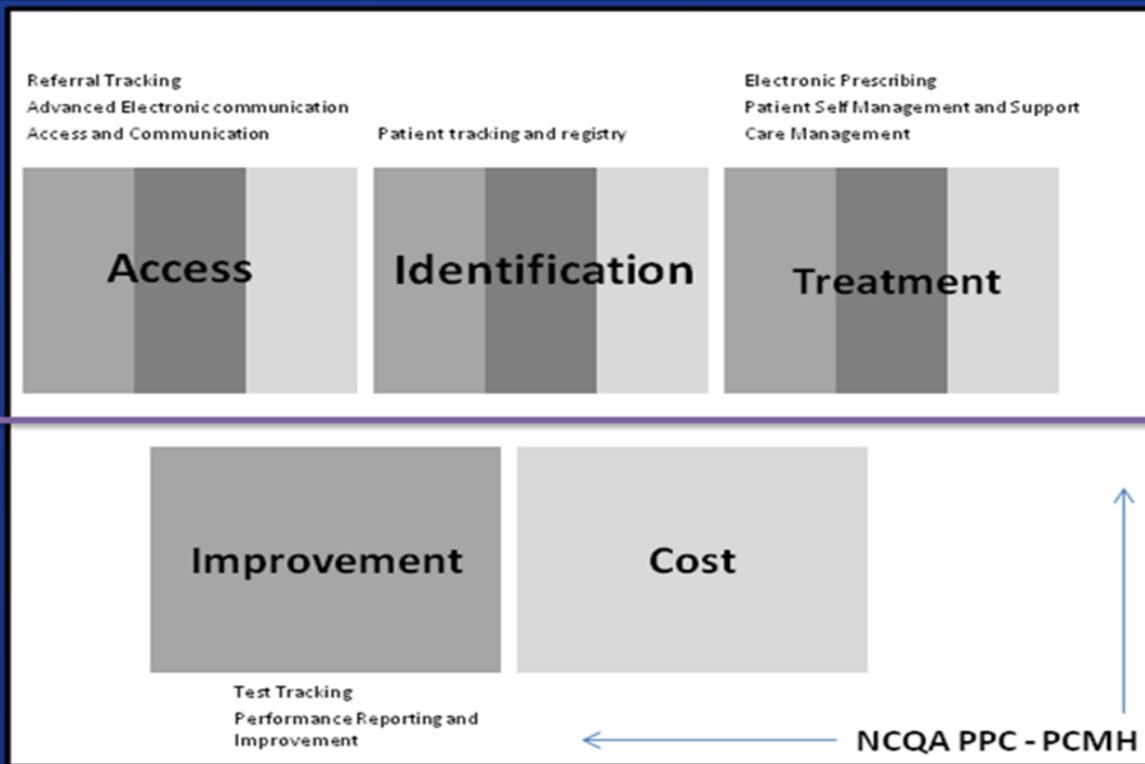
Peek (2008)
Three World's
of Healthcare

- Clinical
- Operational
- Financial

Berwick (2008)
Triple Aim

- Care
- Health
- Cost

Kessler, Miller, Graham, & Pace, 2009 – Under Review



Practice Experience

Patient Experience

System Experience

Peek (2008) Three World's of Healthcare

- Clinical
- Operational
- Financial

Berwick (2008) Triple Aim

- Care
- Health
- Cost



Integrated Care Metrics Based on IHI/Peek/NCQA – Operational Metrics

- > Shared Medical Records
- > Common Waiting Area
- > Shared Scheduling Procedures
- > Single Treatment Plan
- > Phone Follow Up
- > Ability to Bill
- > MH Provider in Medical Staff Activities
- > Shared Office Space
- > Use of EMR and IT



Access Metrics

- > Open Access
- > Procedure for Immediate Referral and intervention
- > Shared Clinical Notes
- > Shared Scheduling



Identification and Referral Metrics

- > Systematic Screening Procedures
- > % Screened
- > % Detected



Treatment Metrics

- > % Referred who initiated treatment
- > % Referred who complete treatment
- > Protocols for evidence based treatment
- > Protocols for disease specific problems
- > Treatment available irrespective of ability to pay
- > Seamless medical care
- > Immediate and regular contact between providers to discuss treatment
- > Consultation
- > Joint appointments
- > Care management functions



Improvement Metrics

- > % Referred who initiated treatment
- > % Referred who complete treatment
- > Protocols for evidence based treatment
- > Protocols for disease specific problems



Financial and Financial Management Metrics

- > Cost
- > Professional training/salary
- > PCP Involvement required
- > PCP Time Saved
- > Use of brief interventions
- > Shared billing
- > PCP Coverage
- > Practice management
- > Tracking outcomes
- > Use of data for practice improvements
- > Case mix tracking
- > Use of data to assess cost outcomes/effectiveness
- > Use of data in financial planning and resource decision making



National Council Work in this Area

- > Learning Collaborative Data Collection Fields
 - RWJ Depression Collaboratives
 - NASMHPD Health Indicators Reports



BMI Indicators

- > % of mental health consumers receiving atypical antipsychotic agents whose Weight/Height/Body Mass Index (BMI) [calculated value using weight and height] is > 25 on initial evaluation
- > % of mental health consumers receiving atypical antipsychotic agents whose Weight/Height/Body Mass Index (BMI) [calculated value using weight and height] is > 25 at 4-6 weeks
- > % of mental health consumers receiving atypical antipsychotic agents whose Weight/Height/Body Mass Index (BMI) [calculated value using weight and height] is > 25 at 12 weeks
- > % of mental health consumers receiving atypical antipsychotic agents whose Weight/Height/Body Mass Index (BMI) [calculated value using weight and height] is > 25 at 6 months

- > POLLING QUESTION: ARE YOU CURRENTLY COLLECTING BMI'S ON YOUR CONSUMERS?



Blood Pressure

- > % of mental health consumers receiving atypical antipsychotic agents whose blood pressure systolic/diastolic reading is $>125/90$ on initial evaluation
 - > % of mental health consumers receiving atypical antipsychotic agents whose blood pressure systolic/diastolic reading is $>125/90$ at 4-6 weeks
 - > % of mental health consumers receiving atypical antipsychotic agents whose blood pressure systolic/diastolic reading is $>125/90$ at 12 weeks
 - > % of mental health consumers receiving atypical antipsychotic agents whose blood pressure systolic/diastolic reading is $>125/90$ at 6 months
-
- > POLLING QUESTION: DO YOU ROUTINELY CHECK BP AT EACH MEDICATION REVIEW APPOINTMENT?



HgA1C - Sugar

- > % of patients in PC with evidence of an assessment for hyperglycemia within 16 weeks after initiating treatment with an atypical antipsychotic agent

- > POLLING QUESTION: ARE YOU CURRENTLY COLLECTING GLUCOSE MONITORING INFORMATION ON YOU CONSUMERS ON A REGULAR BASIS?



Depression/BiPolar Screening

- > % of primary care patients with diagnosis of depression at 12 weeks,
 - > % of primary care patients with diagnosis of depression at 6 months
 - > % of primary care patients with depression with PHQ-9 on initial evaluation
 - > % of primary care patients with depression with PHQ-9 at 4-6 weeks
 - > % of primary care patients with depression with PHQ-9 at 12 weeks
 - > % of primary care patients with depression with PHQ-9 at 6 months
 - > % of patients screened annually for depression in primary care
 - > % of patients treated for depression who were assessed, prior to treatment, for the presence of current and/or prior manic or hypomanic behaviors
-
- > POLLING QUESTION: ARE YOU ROUTINELY USING THE PHQ 9 AS A SCREENING AND OUTCOME TOOL FOR DEPRESSION?



Suicide Assessment

- > % of patients diagnosed with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for risk of suicide
- > % of patients diagnosed with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for current or past alcohol or chemical substance use

POLLING QUESTION: ARE YOU ROUTINELY USING AN EVIDENCE BASED TOOLS FOR SCREENING FOR SUICIDE?



Additional Key Measures

- > % of mental health consumers receiving atypical antipsychotic agents assessed for family history of diabetes, hypertension, cardiovascular disease
- > % of mental health consumers receiving atypical antipsychotic agents assessed for Tobacco Use/History
- > % of mental health consumers receiving atypical antipsychotic agents assessed for Substance Use/History
- > % of mental health consumers receiving atypical antipsychotic agents evaluated for social supports using the LOCUS/IV. Recovery Environment (Level of Stress, Level of Support) score
- > % of mental health consumers receiving atypical antipsychotic agents with an identified primary care provider and a physical examination within the last year
- > % of primary care patients with major depressive or bipolar disorder meeting severity/complexity criteria for specialty MH services (as established by state and local payers) referred for specialty MH care
- > % of patients referred to MH specialty care who attend initial visit
- > % of patients referred to Primary Care from MH who attend initial visit



Behavioral Health Informatics Requirements

SAMPLE Objectives and Measures Required in 2011

- > Maintain an up-to-date problem list of current and active diagnosis based on ICD-9 or SNOMED
- > % of diabetics with A1c under controls
- > % hypertensive patients with BP under control
- > % of smokers offered smoking cessation counseling
- > Record vital signs; calculate and display BMI
- > % of consumers with recorded BMI
- > Prevention measures (flu vaccine, mammogram, colorectal cancer screenings)

SAMPLE Objectives and Measures Required in 2013

- > Manage chronic conditions using patient lists and decision support
- > Preventable ER visits
- > Access for all patients to PHR populated in real time with patient health
- > % of patients with full access to PHR in real time
- > Provide summary care data for visits



Linking Three World, NC and BH Informatics Requirements

> See Excel Spread Sheet



QUESTIONS?