Competencies of Integrated Care

- **Stacey Devenney, MA, CDP, CMHS**

Welcome

- **Who do we have in the room?**

Stacey D. Introduction

Audience Introductions

Prompt(s):

Name

Role at Organization

What is one thing you hope to get out of today's training?

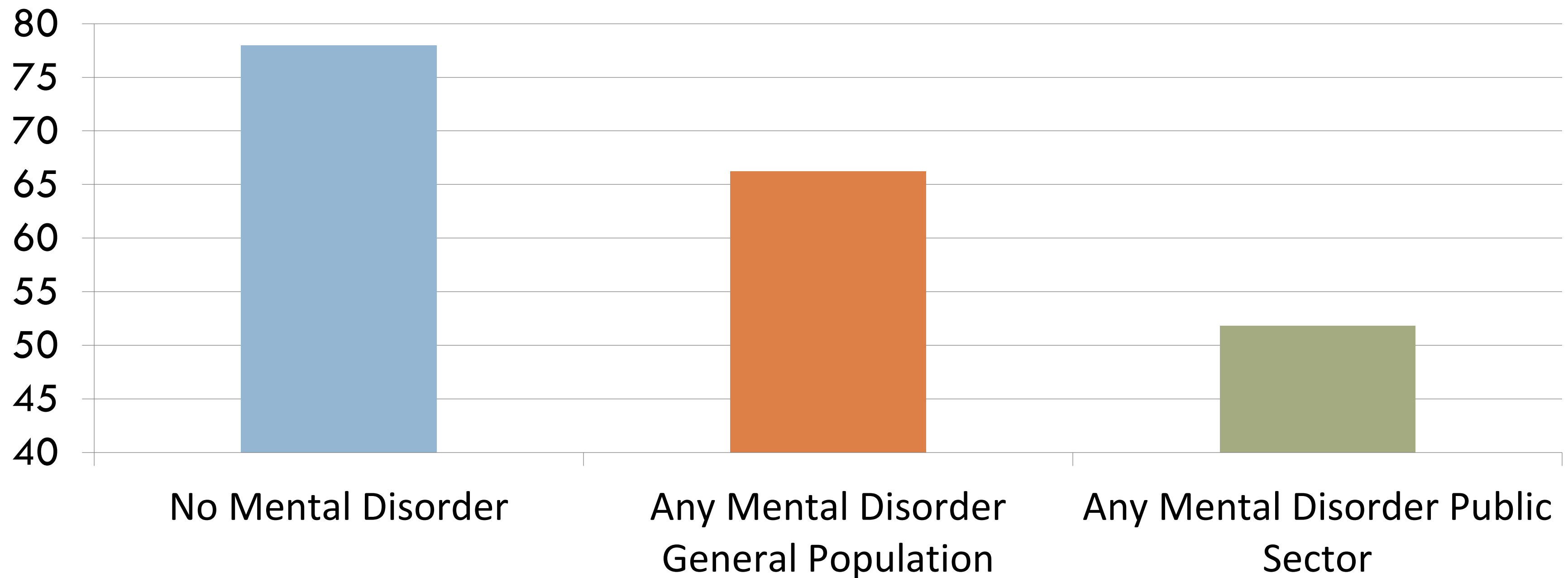
Learning Objectives

- Learn rationale for behavioral health providers accepting responsibility for providing integrated care
- List likely causes for reduced life expectancy in SMI populations
- Understand the Competencies for Integrated Care
- Understand importance of partnering with individuals you are working with

(Re)Introduction to the Mortality Gap

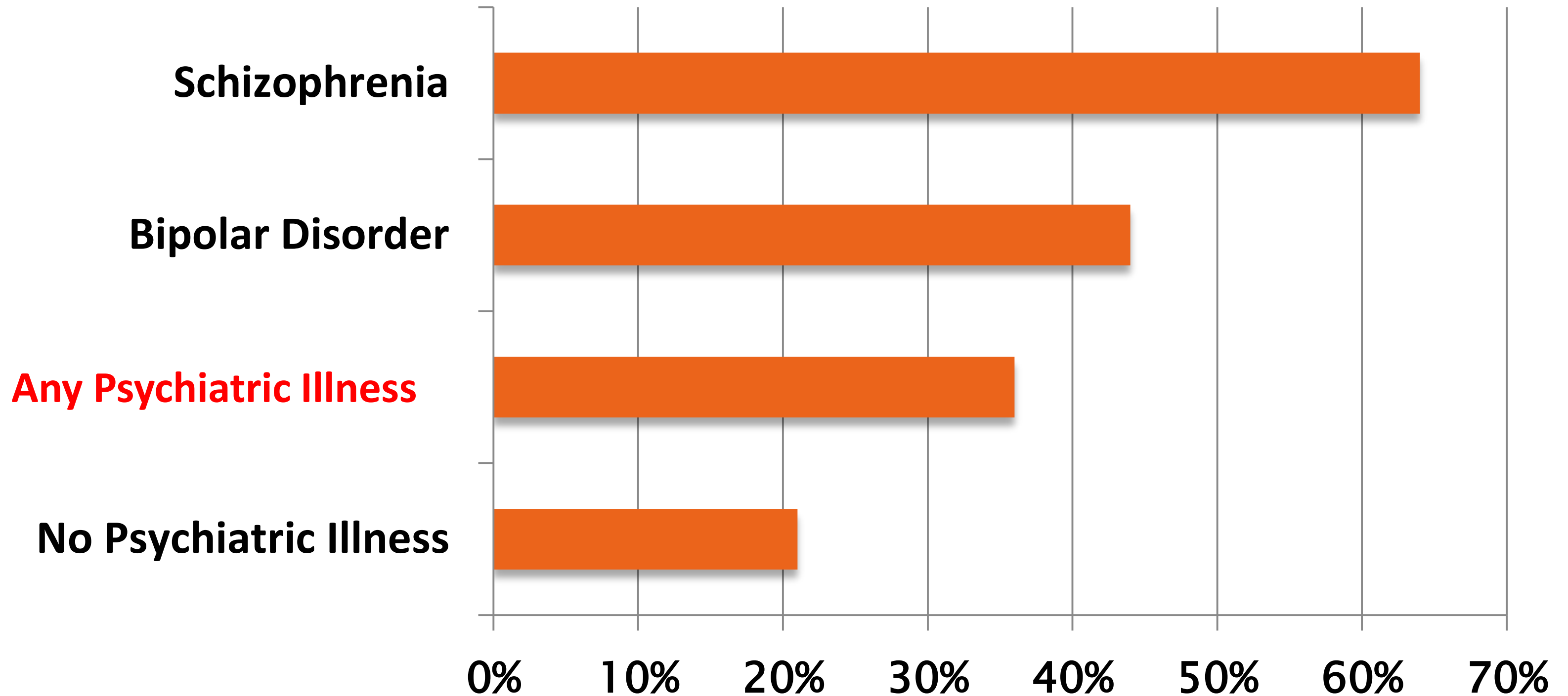
- Can’t pursue recovery goals if dead
- People with behavioral health symptoms receive lower quality primary care services
- Opportunity for frequent touches
- Now part of our mission – this is a key opportunity to reach people!

Life Expectancy of People with Symptoms of SMI: Still Short, Still Not Improving



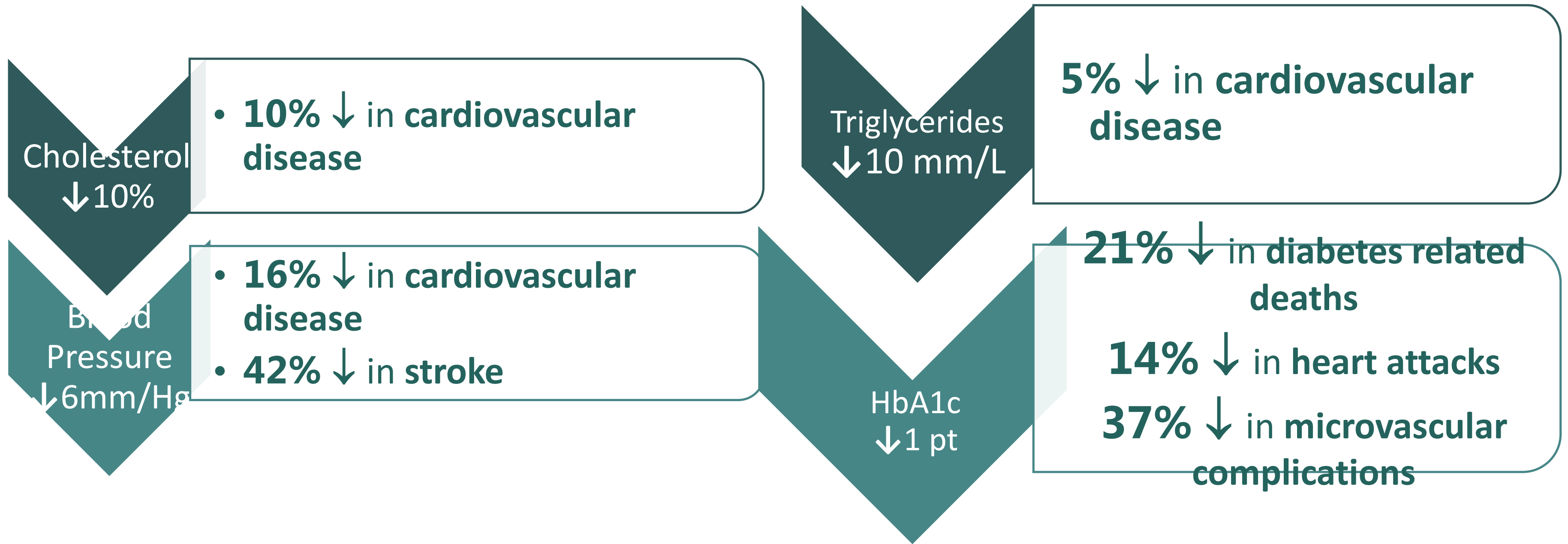
Bar 1 & 2: Druss BG, Zhao L, Von Esenwein S, Morrato EH, Marcus SC. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 June;49(6):599-604; Bar 3: Daumit GL, Anthony CB, Ford DE, Fahey M, Skinner EA, Lehman AF, Hwang W, Steinwachs DM. Pattern of mortality in a sample of Maryland residents with severe mental illness. Psychiatry Res. 2010 Apr 30;176(2-3):242-5

Prevalence of Current Smoking



Dickerson F, et.al,. Psychiatr Serv 2013; 64 (1): 44

Small Changes » Big Difference



“How can I help when I’m not an expert?”

All meaningful behavioral change occurs in the context of a personal relationship.

Competencies of Integrated Care

- Describe unique competencies to develop in order to achieve improved clinical outcomes in delivering integrated behavioral health and primary care for complex individuals.
- Other tools are part of skills needed:

Data Plan
Registry
Clinical Guidelines

Outreach & Engagement

What is ultimate goal
of Outreach and
Engagement?

To have someone engage more fully in their own health, happiness and wellbeing.

Outreach

- Meeting people where they are at both (literally and figuratively)
- Communicating with people through the means that work for them
- Communicating caring

Engagement

- Eliciting people’s beliefs, preferences, opinions, and strengths around their health
- Addressing barriers to high engagement in their own health
- Communicating caring and belief in their self efficacy

Exercise #1

What means of communication matches the person best

What language, questions, phrases or wording will best initially connect with the person

How is caring conveyed effectively

Choose a family member or patient that you wish was more engaged managing their health conditions.

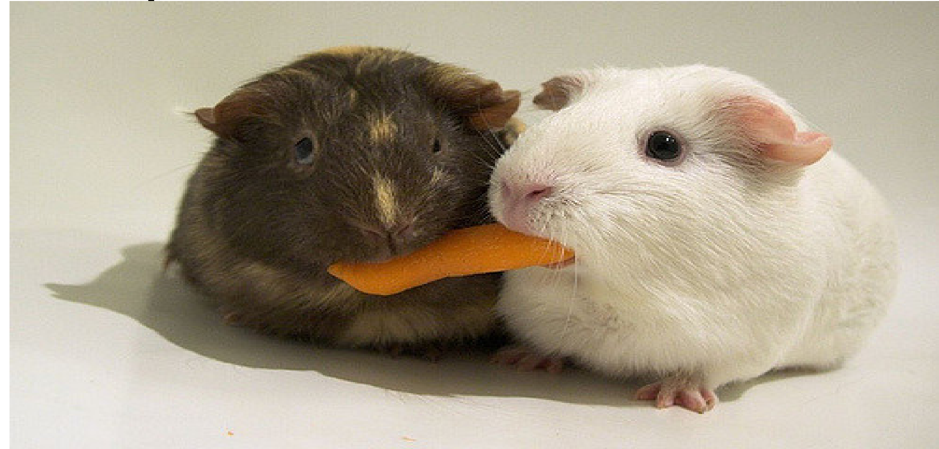
Shared Care Plan

- Developed by the Care Manager in collaboration with the patient/client
- Written in “plain language”
- Specifies medical diagnosis or condition being addressed.
- 1 – 5 Personal wellness goals
- Identifies specific steps or actions to be carried out by the patient, their healthcare team and their network of support
- Updated frequently enough to remain accurate and useful.

The Art of "Sharing" a Shared Care Plan

The "Shared" part of Shared Care Planning means over-arching wellness goals are shared between providers and caregivers where appropriate.

- In 2019, few EMR platforms contain the full functionality for this to happen.
- Providers must therefore develop workflows to share Shared Care Plans, e.g.
  - Patient "wallet cards"
    (example to follow)
  - Registries
  - Plain old paper/fax.



Health Literacy

- **Chronic Conditions:**
  - **Identification**
    - Most common?
  - **Face to Face – What do you do?**
    - Role dependent
  - **What commonly occurs**
    - National Center for Chronic Disease Prevention & Promotion www.cdc.gov/chronicdisease/about/index.htm

Chronic Conditions

- Diabetes
- High Blood Pressure
- Obesity
- COPD
- Hyperlipidemia – high cholesterol

Medication Adherence

- Practical tips and resources to help individuals improve medication adherence:
- Consider medication adherence a vital sign to be checked at each patient interaction
- Attention to patients at each transition of care
- Reviewing prescription refill information to identify non adherence
- Clinician knows how to access information on medications and side effects

Unrealistic expectations = dissatisfaction

Unrealistically High Expectations for Medication Encourages:

- Premature switching of medications
- Poly-Pharmacy
- Non-Adherence

Do Not Overstate Benefits

- "70% of people get 70% better"
- "You are likely to feel better but will still have some remaining symptoms"
- "Most people have some side effects"
- "Medication will not fix everything"
- "If we keep adding meds to fix every single symptom you will end up on so many different meds that it will be hard to function"

Peer Services

- **Using Peer Services –**
  - Liaison/link/intermediary
  - Coordinate to help patients with health care needs
  - Advocates
- **Promoting Natural Supports**
  - Each person has their own unique profile of natural supports & wellness activities
  - Whole person approach assesses gaps, interests, motivation, natural supports & barriers

Measurement Based Care

Use Standard Measures to screen & track patients

PHQ9 -AIC

GAD7 -BMI

AUDIT

Using a Registry:

-Track engagement and adherence

-Track/trend clinical outcomes

-Determine need for change in treatment

Exercise #2: Naomi Watts

-PHQ-9 slowly increases to threshold of 10

-High, plateaued SU-ETOH score and elevated SU-Drug score (although decreasing over time)

-Normal HbA1c

-Uncontrolled BP

-6+ week gap in care – returned with elevated scores

Set a goal for Naomi

Caseload Consultation

-Individual Caseload Consultation

-Systematic Caseload Review

- **What** is the problem?
- **How** will we intervene?
- **Who** will do what?
- **When** will this happen?
- **When** will we discuss this patient again to follow up on action items?

-Population Based Caseload Consultation

- Registry
- Using data

Care Coordination

Effective communication between providers

- Valuing and making time for team communications, including addressing team conflict and problem-solving as well as celebrating successes and each other’s contributions as a team.
- Use of standardized proposal formats, such as SBAR (Situation, Background, Assessment, Recommendation).

Care Coordination - 2

- **Coordination and tracking referrals**
  - Assigning responsibility for tracking the making and follow up of referrals.
  - Assigning responsibility for tracking the making and follow up of referrals.
  - Maximizing communications between providers in a referral relationship.

Transitions of Care

The movement of patients between health care practitioners, settings, and home, as their condition and care needs change

- Improve safety
- Reduce costs
- Improve health outcomes
- Reduce adverse effects

1. Outreach & Engagement
2. Peer Services
3. Shared Care Planning
4. Health Literacy
5. Measurement Based Care
6. Caseload Consultation
7. Care Coordination
8. Transitions of Care

COMPETENCIES OF INTEGRATED CARE

THANK YOU!