Shoulder to Shoulder:
A Hands-On Model for the Integrated Care of Underserved Populations

Speakers:
Heidi Arthur, LMSW
Terry Conway, MD
Jeffrey Ring, PhD
Pat Dennehy, DNP, RN, FNP-C, FAAN
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Jan. 28, 2015

HMA Information Services Webinar
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HMA Information Services Webinar
Overview

- Culturally responsive health care based on federally mandated Culturally and Linguistically Appropriate Services (CLAS) standards
- Key elements for integrated and coordinated team formation, training, care coordination, and collaboration
- Integrating models for health promotion and chronic disease management
- Compliance with required treatment protocols and practice standards
Culturally Responsive Health Care
Key Features

• Providing care consistent with the patient’s world view
• Addressing patient’s cultural and linguistic needs
• Patient-centered care
• Whole person care
Rationale

• Patient satisfaction
• Practice building
• Practitioner satisfaction
• Avoid malpractice/medical errors/informed consent
• Enhanced treatment adherence/improved outcomes/lower readmission rates
• Social justice
• Health disparities
• U.S. HHS required educ. topic for hospitals
• Federal CLAS standards
Costs of Disparities

• The Joint Center for Political and Economic Studies estimates racial and ethnic disparities to have cost this nation $1.24 trillion between 2003 and 2006—$229.4 billion for direct medical care expenditures associated with health disparities and another $1 trillion for the indirect costs of disparities.
### Table 1

**U.S. Physicians Implementing Select Tools Aimed at Reducing Racial/Ethnic Disparities, 2008**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Provides Interpreter Services</td>
<td>55.8%</td>
</tr>
<tr>
<td>Practice Provides Patient-Education Materials in Languages other than English</td>
<td>40.1%</td>
</tr>
<tr>
<td>Physician Received Training in Minority Health</td>
<td>40.3%</td>
</tr>
<tr>
<td>Physician Receives Reports on Own Patients’ Demographic Characteristics</td>
<td>23.2%</td>
</tr>
<tr>
<td>Information Technology to Access Patients’ Preferred Language is Available and Used Routinely</td>
<td>7.3%</td>
</tr>
<tr>
<td>Physician Receives Reports on Quality of Care for Own Minority Patients</td>
<td>11.8%</td>
</tr>
</tbody>
</table>

1. Excludes physicians who reported having no non-English speaking patients.
2. Population consists of physicians whose practices treat at least one of the following chronic conditions: diabetes, asthma, depression, congestive heart failure. Population excludes physicians who report having no non-English speaking patients.
3. Excludes physicians who report having no minority patients.

*Source: HSC 2008 Health Tracking Physician Survey*
Culturally and Linguistically Appropriate Services (CLAS)

• Published by OMH in 2000
• Enhanced standards published in 2013
• Emphasize opportunities to address disparities at every point of contact along health care services continuum
• Emphasis on health care organizations
• Legal consequences
CLAS Principal Standard

“Provide effective, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practice, preferred languages, health literacy and other communication needs.”

Rev. Dr. Martin Luther King, Jr.

“Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”
Steps Forward

- Know your responsibilities; clarify rationale
- Assess your organization; know your community
- Form your interdisciplinary team of champions
- Explore best practices and resources
- Develop your strategy for change
- Keep an eye on disparity data
- Monitor ongoing evolution, anticipate barriers when possible
- Measure progress
Do the Right Thing: Culturally Responsive Healthcare and Mandated CLAS Standards

• Upcoming HMA Webinar
• Thursday, March 12, 1 p.m. EST
• Jeffrey Ring, Ph.D.
• https://hmais.healthmanagement.com/ or www.healthmanagement.com
Integrated And Coordinated Team Formation And Training
Integrated Care Team

“the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.”

Two Cultures – One Patient

Primary Care

- Continuity is goal
- Empathy and compassion
- Data shared
- Large panels
- Flexible scheduling
- Fast Paced
- Time is independent
- Flexible Boundaries
- Treatment External (labs, X-ray, etc)
- Patient not responsible for illness
- 24 hour communication
- Saved lives
- Disease management

Behavioral Health

- Termination is goal – “discharge”
- Professional distance
- Data private
- Small panels
- Fixed scheduling
- Slower pace
- Time is dependent – “50 min hour”
- Firm Boundaries
- Relationship with provider IS tx
- Patient responsible for participating
- Mutual accountability
- Meaningful lives
- Recovery model
Elements of High-functioning Teams

Lardieri, Lasky, Raney, SAMHSA-HRSA CIHS 2014
Leadership and Organizational Commitment

- Organization is foundation of team
- Commitment to philosophy of integrated care
- SHARED VISION
- Focused attention to team development
- Team input and design
- Buffer the team
Team Development

Focused Development

Formal

Informal
Title Versus Function
Team Process

Clinical case review communication

Day-to-day operational communication

Process communication

Continued assessment of the team process
Team Outcomes

- Quantifiable and measurable
- Evidence-based—don’t re-create the wheel
- Local AND regional AND national
Characteristics of Integrated Team Members

• Flexible—open to changing approach
• Creative
• Value team-based approach—embrace feedback
• Effective communication skills
• Balance between ego and professional strength
• Develop quick rapport with patients and staff
• Trained in brief intervention
Cross-Training is Essential

- Population-specific diagnoses and characteristics
- Screening tools
- Integrated vitals
- Specific techniques (EBPs)
- Team process
- Community resources
Vital Practice Change Tool
Health Promotion And Chronic Disease Management
Primary Care

Mental Health Services

Nursing and Social Case Management

Complementary Care Wellness Center

Four Modalities of Care
Behavioral Health Services at GHS

• Individual and couples counseling/therapy
• Mental health diagnosis, treatment and medication management
• Drop-in urgent care
• Staff with 5150 training for emergent admissions
• Depression, pain groups
• Recovery groups
• Lead clinic case conferences
• Part of the network of city-wide providers
Within our group we planned for health promotion across the continuum of care.

Every door was the right door.

Staff were involved at all levels in process improvement.

Used meetings such as CQI and case conferences to develop and spread a shared vision of excellent care.

Expected clients to improve not only in their chronic disease but how they lived with chronic disease.
Glide Wellness Center Activities

• Recovery groups – drop-in and 90-day outpatient program
• Acupuncture – individual and group
• Chronic pain group
• Meditation
• Massage
• Walking groups
• Weight management
• Diabetes nutrition
• Tobacco education, harm reduction, and cessation groups
Health Promotion and Chronic Disease Management

- Early use of disease registries – through the Chronic Disease Collaborative
- Chronic disease management – diabetes, HTN, and prevention measures
- Preventive care – focus of Wellness Center
- HEDIS measures – SFCCC
- AHRQ study on use of electronic health record with University of Michigan, Michigan Public Health Institute and Alliance of Chicago
- Used dashboards to track process and patient-level outcomes
Taking action where diabetes and mental illness intersect: SF Empower
2012 Schweitzer Fellows – UCSF students
Erin Lutes and Shawna Mitchell-Sisler
Preventive & Health Promotion Services

• Minimum of 10% of award
• Activities informed by needs assessment and guided by data; ongoing adjustment to address populations and needs as indicated
• Tobacco cessation support, nutrition, and exercise interventions are required
• Health promotion programs (e.g. wellness consultation, health education and literacy, self-help/management program)
• Peer leadership and support is expected; activities should be part of integrated person-centered plan created for each recipient
Options for Preventive and Health Promotion Service Interventions

• **Tobacco cessation (required)**
  – Peer to peer Tobacco Dependence Recovery Program:
  – Learning About Healthy Living
  – Intensive Tobacco Dependence Intervention for Persons Challenged by Mental Illness

• **Nutrition/exercise (required)**
  – Nutrition and Exercise for Wellness and Recovery (NEW-R)
  – Diabetes Awareness and Rehabilitation Training (DART)
  – Solutions for Wellness
  – Weight Watchers
  – In SHAPE
  – Stoplight Diet
  – Achieving Healthy Lifestyles in Psychiatric Rehabilitation (ACHIEVE)

• **Chronic disease management**
  – Whole Health Action Management (WHAM)
  – Health and Recovery Peer (HARP) Program
Tobacco Cessation Options

• **Peer-to-peer tobacco dependence recovery program**
  – Offer peer tobacco recovery services to persons served in behavioral healthcare settings who express an interest in reducing or quitting their tobacco use
  – 6 group sessions
  – Two-day training with materials provided
  – Peer specialists

• **Learning about healthy living**
  – Formatted to address tobacco for smokers with a serious mental illness who are either prepared to quit smoking or who are simply contemplating quitting in the future
  – Two different groups – designed for participants to progress from group I to group II
  – Manual available free online
  – Peers or providers
Nutrition Exercise Options

• **Nutrition and Exercise for Wellness and Recovery (NEW-R)**
  – Persons with mental illness who are overweight or obese to improve weight management and wellness
  – 8 weekly sessions – 1.5 hours long each
  – No training necessary and manuals available online
  – Delivered by peers or providers

• **Diabetes Awareness and Rehabilitation training (DART)**
  – Designed specifically for persons with schizophrenia who have diabetes
  – 24-week intervention with three modules: Basic Diabetes Education, Nutrition, and Lifestyle Exercise
  – Focused on self-monitoring, modeling, practice, goal setting, and reinforcement
  – Provided by mental health professional
Chronic Disease Management

• **Whole Health Action Management**
  – Teach skills to better self-manage chronic physical health conditions, and mental illnesses and addictions to achieve whole health
  – 8-week WHAM peer support groups with weekly action plan
  – 2-day training by SAMHSA and materials are online
  – Delivered by Peer Specialists

• **Health and Recovery Peer Program (HARP)**
  – Persons with serious mental illnesses (SMI) have elevated rates of comorbid medical condition
  – 6 sessions
  – 3-day training adapted from CDSMP
  – 7 adaptations from the CDSMP to make it more applicable for persons with SMI
  – Delivered by peers
Treatment Protocols

There’s Nothing Wrong
with a Good Cookbook
Goals for the Next 15 Minutes

• To demonstrate that treatment protocols are an efficient means of bringing evidence-based care (guidelines) into practice

• To show that SAMHSA and others recommend or require them because they create results better than we now produce

• To explain how treatment protocols are an available framework on which to design collaborative and integrated care
The Need to Integrate is Driven by Chronic Health Conditions

• They are what contributes most to the burden of suffering and cost in our patient populations

• There is evidence on how to best prevent, treat, and manage these conditions

• How can a health delivery system transform itself to accomplish this?

Maybe it’s like learning how to cook?
Learn from the Expert/Artist
You wish Grandma would be clearer. She thinks you might be an idiot.
You must use a team to provide large groups with meals that are healthy, tasty and affordable.
Integration is about Chronic Conditions

• Protocols are your friends
  – They are effective and available
  – “We have good doctors and staff and we don’t get into their business”
  – “We can’t do standing orders”

• Protocols reduce clinical variability that is outside the bounds of evidence-based practice
• Both integration partners have a role in carrying out protocols
• Combined with redesign that support collaborative care models
Hypertension Fits Well into Protocol-based Care

• One-third of American adults have hypertension
• It is a major contributor to cardiovascular mortality in nearly 50% of cases
• Effective therapy has been available for over 50 years
• Fewer than half of Americans with hypertension are under control
Initial Tasks of Hypertension Protocols

• Identifying hypertension
  – (USPSTF) screen adults aged 18 and older every 2 years

• Lifestyle change
  – DASH diet
  – Sodium restriction ($\leq 2.4$ gm sodium daily)
  – Weight reduction if BMI $\geq 25$ kg/m$^2$
  – Exercise at a moderate pace (i.e., 30 min/5 days/wk)
  – Limit daily alcohol
  – Smoking cessation
Does this Slide Make You Anxious?

Systolic 140-159 or diastolic 90-99 (Stage 1 HTN)
- LM as a trial
- Consider adding thiazide

Re-check and review readings within 3 months

Systolic >160 or diastolic >100 (Stage 2 HTN)
Two drugs preferred:
- LM and
- Thiazide and ACEI, ARB, or CCB
- Or consider ACEI and CCB

Re-check and review readings in 2-4 weeks

BP at goal?

NO

- Thiazide for most patients or ACEI, ARB, CCB, or combo
- If currently on BP med(s), titrate and/or add drug from different class

Re-check and review readings in 2-4 weeks

YES

BP at goal?

Encourage self-monitoring and adherence to meds
- Advise patient to alert office if he/she notes BP elevation or side effects
- Continue office visits as clinically appropriate

BP at goal?

YES

NO

Medications to consider for patients with hypertension and certain medical conditions
- Coronary artery disease/Post MI: BB, ACEI
- Heart failure with reduced EF: ACEI or ARB, BB (approved for this use), ALDO, diuretic
- Heart failure with preserved EF: ACEI or ARB, BB (approved for this use), diuretic
- Diabetes: ACEI or ARB, diuretic, BB, CCB
- Kidney disease: ACEI or ARB
- Stroke or TIA: diuretic, ACEI

Optimize dosage(s) or add additional medications
- Address adherence, advise on self-monitoring, and request readings from home and other settings
- Consider identifiable causes of HTN and referral to HTN specialist
Defined roles for the health care team are essential and facilitate protocol completion and success

- Primary Care Physicians and APNs
- BH Therapists
- Pharmacists
- Medical Assistants
- Registered Nurses and Care Managers
- Case Managers
- Community Health Workers
- Peer Counselors
Protocols and Redesign: Information Technology

Protocol algorithms can be incorporated into electronic health records systems to create and support:

• Clinical decision support tools
• Registry functions
• Measurement to facilitate quality improvement
Protocols are Available

• Million Hearts
  – http://millionhearts.hhs.gov/resources/protocols.html

• Veterans Affairs/Department of Defense

• AHRQ/ National Guideline Clearing House
  – http://www.guideline.gov/content

• Community Care Collaborative
Putting Protocols into Context

• Which protocol is selected is less important than the decision to select, adopt, implement, and evaluate implementation.

• Treatment should be combined with communitywide approaches to:
  – Sodium reduction
  – Exercise
  – Obesity
  – Tobacco Control
  – Access to Care
  – Other Social Determinants of Health
Q & A

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