Principles, Roles and Processes for Managing Medical Co-Morbidities

Session 2
Learning Objectives

• List the principles for effective evidence-based integrated care in a behavioral health setting

• Describe the role of the nurse care manager in a community behavioral health setting

• Understand the different roles that work with the nurse care manager on an integrated care team

• Describe characteristics of the SPMI population and what to consider as a nurse care manager
Principles for Evidence-Based Integration in Behavioral Health Setting

**Team-Based and Client-Centered**
Primary care and behavioral health providers collaborate effectively using shared care plans.

**Measurement-Based Treatment to Target**
Measurable treatment goals clearly defined and tracked for every patient. Treatments are actively changed until clinical goals are achieved.

**Population-Based**
A defined group of clients is tracked in a registry so that no one “falls through the cracks.”
Client-Centered Team: Behavioral Health Home

- Care Manager/Registry
- Psychiatrist
- Case Manager
- Mental Health Center
- Patient
- PCP
- Primary Care
Measurement-Based Care Workflow Example

**KEY**
- **RN** = Psychiatrist
- Green = Nurse

**Check weight, blood pressure, smoking status & order metabolic labs**

- **A1c > 5.7%**
  - Yes: **A1c > 6.5%?**
    - Yes: **Refer to PCP for diabetes treatment**
    - No: **Counsel**
  - No: **Annual screen**

- **BP > 140/90?**
  - Yes: **Repeat BP**
  - No: **Check BP at next visit**

- **Smoker?**
  - Yes: **Offer treatment**
  - No: **Screen at next visit**

- **BMI > 25?**
  - Yes: **Counsel**
  - No: **Weigh at next visit**

**Re-evaluate medications**

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## Population-Based Care: Registry Example

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<th>Case Number</th>
<th>Active in Care Management Date</th>
<th>Primary Physician</th>
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<th>Next Psychiatrist Appt Date</th>
<th>Standard monitoring labs last done</th>
<th>BMI</th>
<th>LDL</th>
<th>HbA1c</th>
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Nurse Care Manager (NCM)

“The primary responsibility of the nurse care manager is to ensure implementation of the treatment plan for achievement of clinical outcomes consistent with the needs and preferences of the client.”

SAMHSA-HRSA CENTER FOR INTEGRATED HEALTH SOLUTIONS (2014) POPULATION MANAGEMENT IN COMMUNITY MENTAL HEALTH CENTER–BASED HEALTH HOMES
Nurse Care Manager
5 Core Competencies

1. Professionalism and teamwork
2. Clinical competence
3. Problem solving skills
4. Communication skills
5. Technical skills

Gene Gosselin, BSN, MA, Michael Beck, BA, Alyce McKenna, MPH, Judy Debonis, PhD, LCSW, Maryam Navaie-Waliser, DrPH, Sue Jennings, PhD, Ahmar Iqbal, MD, MBA, Gabriela Lira, BA, and Beverly Vandyke Schalk, RN, MEd. Pfizer Health Solutions Inc, 235 East 42nd Street, New York, NY
From: https://apha.confex.com/apha/134am/techprogram/paper_134157.htm
Role of Nurse Care Manager

- Shift from caring for one person to management of population health needs
- Multiple roles and functions
- Tailor to the needs of population and environment
- Targeted assessments
- “Treat to Target” goals
- Standardized procedures and workflows
Nurse Care Manager
Interdisciplinary Team Leaders

• Facilitates weekly meetings (usually one hour)
• Other team members:
  – Physicians, therapists, peer support, MA
• Sets physical health and disease management priorities
• Collaborates integrated treatment plan
• Reviews complex patients
• Delegates function
  – ensuring patient has transportation, attends medical appointments, skill building grocery shopping, meal planning, exercise/activity, smoking cessation etc.
• Facilitates communication between providers
Nurse Care Manager: Team Huddles

- Daily, twice a day, or more when needed (usually 10 minutes)
- Held at beginning and end of day
- Members include providers and support staff
- Review of patients scheduled
- Organize and prioritize work flow
- “Tag team” approach
- “All hands on deck”
Who is the “Patient”?  

‘Patient’ vs. ‘client’ vs. ‘member’ vs. ‘consumer’ vs. ‘customer’

• Think in terms of groups of patients
• Include other providers in patient “unit”
Care Coordination vs. Care Management

Care Coordination
– One patient
– Individual focused
– Direct care
Care Coordination vs. Care Management

Care Management
- Groups of patients
- Population focused
- Delegated tasks

Diagram:
- Nurse
  - Case Manager (50)
  - RN/LVN (50)
  - Care Coord. (50)
- Care Coord. (50)
- Case Manager (50)
Care Coordination vs. Care Management

Care Management
• Population focused

Nurse

Registry

- Elevated Cholesterol
- Elevated BP
- Elevated BMI
- Smoker
- Elevated BS/A1c

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Care Coordination vs. Care Management

Care Management
• Population focused

Nurse — Registry — Provider 1 — Provider 2 — Provider 3 — Provider 4 — Provider 5
What is the Framework?

• Minnesota Public Health Nursing Framework
• Based on public health model applicable to all disciplines
• Multiple levels of interventions
Minnesota Public Health Nursing Framework
Considerations When Working in a Behavioral Health Setting

• Low health literacy levels
• Clinical inertia
• Multiple barriers to care
• Scope of practice concerns
• Culture clashes
“...individuals with certain mental illnesses and lower functioning may have more difficulty understanding health information and have limited numerical literacy.”

Low Health Literacy

• Role of Nurse Care Manager
  – Educator
  – Translator

• Consensus Report
  – Oregon Health and Science University
  – Funded by National Cancer Institute
  – Modified Delphi method
  – 22 professionals, 2 day meeting
  – Reviewed knowledge, skills and attitudes

Health literacy practices and educational competencies for health professionals: A consensus study In : Journal of Health Communication. 18, SUPPL. 1, p. 82-102 21
Low Health Literacy: Best Practices

Spoken Communication
1. Focus on one to three key “need to know” items
2. Avoid medical jargon
3. Elicit questions in a patient-centered manner
4. Assess understanding using teach back

Written Communications
1. Select written materials at 5th to 6th grade level
2. Write for easy understanding
“Failure of health care providers to initiate or intensify therapy when indicated”
Clinical Inertia: Causes

1. Overestimation of care provided

2. Use of “soft” reasons to avoid intensification of therapy

3. Lack of education, training, and practice organization aimed at achieving therapeutic goals
Clinical Inertia: Strategies to Overcome

- Treat to therapeutic targets
- Recognize complexities
- Reminders and performance feedback
Considerations: Barriers to Care

• Mental illness
• Poverty
• Homelessness
• Lack of transportation
• Low literacy level
• Substance use disorders
Considerations: Scope of Practice
California Board of Behavioral Services

• What is a Licensed Clinical Social Worker (LCSW)?

“counseling and using applied psychotherapy of a nonmedical nature”

Section 4996.9 - Clinical Social Work and Psychotherapy Defined
Considerations: Culture Clashes and Turf Wars

Barriers to Integration

– Cultural clashes between behavioral health and primary care provider

Solutions

– Provide trainings for both types of staff to reinforce the benefits of integration for patient care.
– Allow staff members who want to leave go elsewhere and hire staff who are more open to operating in a new, integrated environment. Accept that high turnover will be an issue.

Institute for Healthcare Improvement, September–November 2013, Report: 90-Day R&D Project Integrating Behavioral Health and Primary Care
Whole Person Care

- Personal care and physical well-being
- Accommodation
- Education and training
- Social, cultural, and spiritual
- Finance and money
- Parenting or caring relationships
- Work and occupation
- Medical and other forms of treatment including psychological interventions
# Social Determinants of Health

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<th>Economic Stability</th>
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<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
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**Health Outcomes**
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations
Social Determinants of Health Frame

Happy New Year to you as well!

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