Stronger Together

Session 2

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Agenda

- Quick Review of Integration
- Chronic Disease Management in Primary Care
- A Glance at Care Pathways and Research
- Substance Use Disorder Treatment in Primary Care

PCBH Lens

GATHER BEHAVIORAL HEALTH INTEGRATION MODEL

Generalist	The goal is to have the behavioral health consultant (BHC) work with patients of any age and any behavioral concern, from anxiety or tobacco use to parenting strategies.
Accessible	The BHC should be available to help the primary care physician at all times during the workday, whether that entails a warm handoff to take over care or just a quick curbside consultation.
Team-based	The BHC is part of the health care team and participates in meetings and huddles about patient care.
High productivity	To make this model work financially, the BHC must be able to see a large number of patients each day. Many of these visits are short.
Education	The BHC educates patients about health issues and is also a teacher and coach for the rest of the health care team regarding patients' psychosocial needs. The BHC supports the primary care physician in continued care of the patient.
Routine	When making referrals to the BHC becomes part of the clinic's normal daily workflow, the BHC becomes an integrated part of the team and the normalization of behavioral health care destigmatizes the process of working with a behavioral health provider.

Integrated Health Goals

- ❑Improve overall health and wellness of patients
- ❑Improve health outcomes for all patients
- ❑Reduce hospitalizations
- ❑Reduce the cost of healthcare
- ❑Reduce bias for receiving behavioral health and substance use treatment
- ❑Enhance motivation and empower patients to live with vitality!

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Acute vs. Chronic Illnesses

Table 1

Differences between acute and chronic disease that are relevant to health care

Acute Disease	Chronic Disease
Sudden onset	Gradual onset
Cure usual	Cure rare
Course short	Course lengthy
Patient passive	Patient active, caregiver
Physician dominant	Team care, patient included
Return to normal likely	Return to normal unlikely
Future uncertainty rare	Future uncertainty common

"Sixty years ago, a new and dominating health problem emerged: chronic disease. It has now reached epidemic proportions, affecting 50% of the population and consuming 86% of health care expenditures."

The Relation of the Chronic Disease Epidemic to the Health Care Crisis - PMC (nih.gov)

Practice Innovations

- ❑Continuity of care by the team to prevent fragmentation between providers, duplication of effort, and waste of time and resources.

- ❑Coordination and integration of care between providers and other caregivers to improve efficiency and avoid gaps in care.

- ❑Partnership between the care team and patient for inclusion of patient goals in the care plan.

- ❑Shared responsibility and contributions from all participants, including the patient.

More Innovations

- Quick, seamless contact between the patient and the care team for remote adjustment of treatment.

- A care coordinator/paraprofessional who is responsible for regular outreach to the patient and for coordination of care.

- Teach the patient disease management and self-care related to their healthcare.

The Findings

- These changes not only improved the quality of care - but decreased costs.
- Patients had enhanced self-care, fewer complications, and greater satisfaction for **both** patients and medical providers.
- More patient involvement, reduced emergency department visits, and fewer hospitalizations.

Specific Studies

When Group Health Cooperative improved coordination of care, access to care, and goal setting with patients, *patient involvement increased, hospitalizations declined 6%, emergency department visits declined 29%, and costs diminished $10.3 per patient per month.*

When Intermountain Healthcare increased self-care, it found improved outcomes for depression and diabetes and *10% fewer hospitalizations*.

The German Health Insurance Program compared results from using the Chronic Care Model for 10,000 patients with diabetes to patients with diabetes receiving usual care over 4 years. The study group *had 50% fewer deaths*, *25% fewer disease complications, and 11% less costs.*

Success Depends On…

- *Behavior* change by **all** involved, not different uses of medication or surgery.
  - Huddles and communication about needs
- The care team needs to partner with the patient and adjust treatment to the patient's needs and wishes.
  - Patient Centered Care Plans
- The patient becomes care team member, executing their treatment plan regularly.
  - BHC for MI
- Care coordinator has regular contact with the patient, to monitor progress on the treatment plan.
  - Shared Documentation in Medical Record

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Chronic Disease Management

Screenings – Identifying risk factors through screening can help prevent disease and lessen the severity of illness through early detection.

Checkups – Monitoring and learning how to manage chronic disease.

Coordinating Treatment – PCP's know their patients' history and coordinates care which avoids redundant medical tests and procedures, unnecessary ER visits, hospitalizations, and medication errors. Can also help manage medications.

Patient education – PC Teams help patients understand and work towards target numbers for heath measures such as blood pressure, cholesterol and weight, improving health outcomes.

These measures are not only management of chronic illnesses, but preventative measures.

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An ounce of prevention is worth a pound of cure.

Benjamin Franklin

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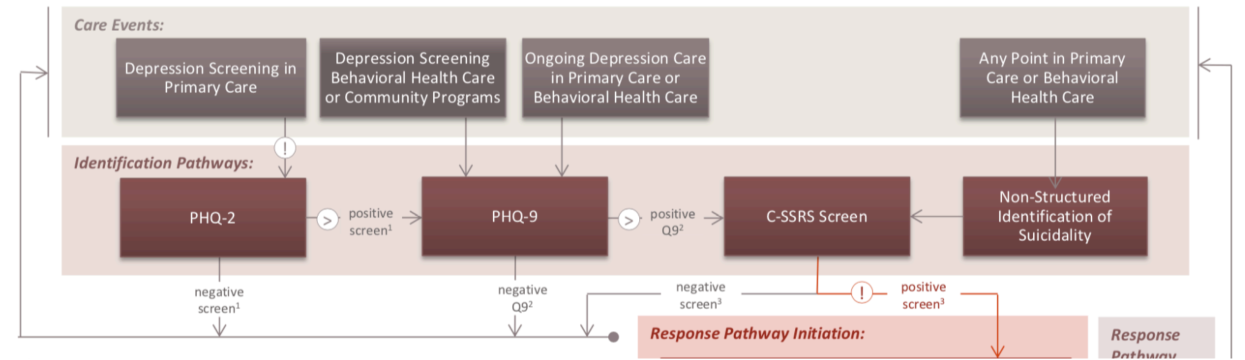
Care Pathway

- PCP – Screen and Diagnose Chronic Illness
- Refers to members of team to support behavioral needs
- Dietician to discuss nutrition
- Clinical Pharmacist for medication information
- Behavioral Health for behavior modification
- Care Management for resource support/follow up
- Team Follows Patient throughout lifetime (or time with the team)

Example Suicide Safer Care Pathway



Substance Use Disorder

- A chronic disease with no cure.
- Both environmental and genetic influences, and the interactions between the two.
- Must be continually managed to reduce the risk of reoccurrence.
- Medical and psychiatric comorbidities are expected.
- Requires life-long management.

Paradigm Shift

ACUTE CARE MODEL

- Enter treatment
- Complete assessment and treatment plan
- Receive treatment
- Discharge

Goal of Treatment: Help patient stop all substance use.

CHRONIC CARE MODEL

- Prevention
- Early Identification
- Referral to Treatment
- Chronic Disease Management
- **Goal of Treatment:** Reduce morbidity and mortality. Maximize function. Improve wellness.

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Substance Use Disorders are Chronic Medical Conditions

“From a neurobiological perspective, drug addiction is a disease of the brain, and the associated abnormal behavior is the result of dysfunction of brain tissue.”

~Christopher Cavacuiti – “*Principles of Addiction Medicine: The Essentials*”

Treatment of Chronic Disease in Primary Care

- Screenings
- Checkups
- Coordinating Treatment
- Patient education

These measures are not only management of chronic illnesses, but preventative measures.

In traditional care of SUD, we do not offer treatment until patients are proven ill enough to meet criteria for treatment.

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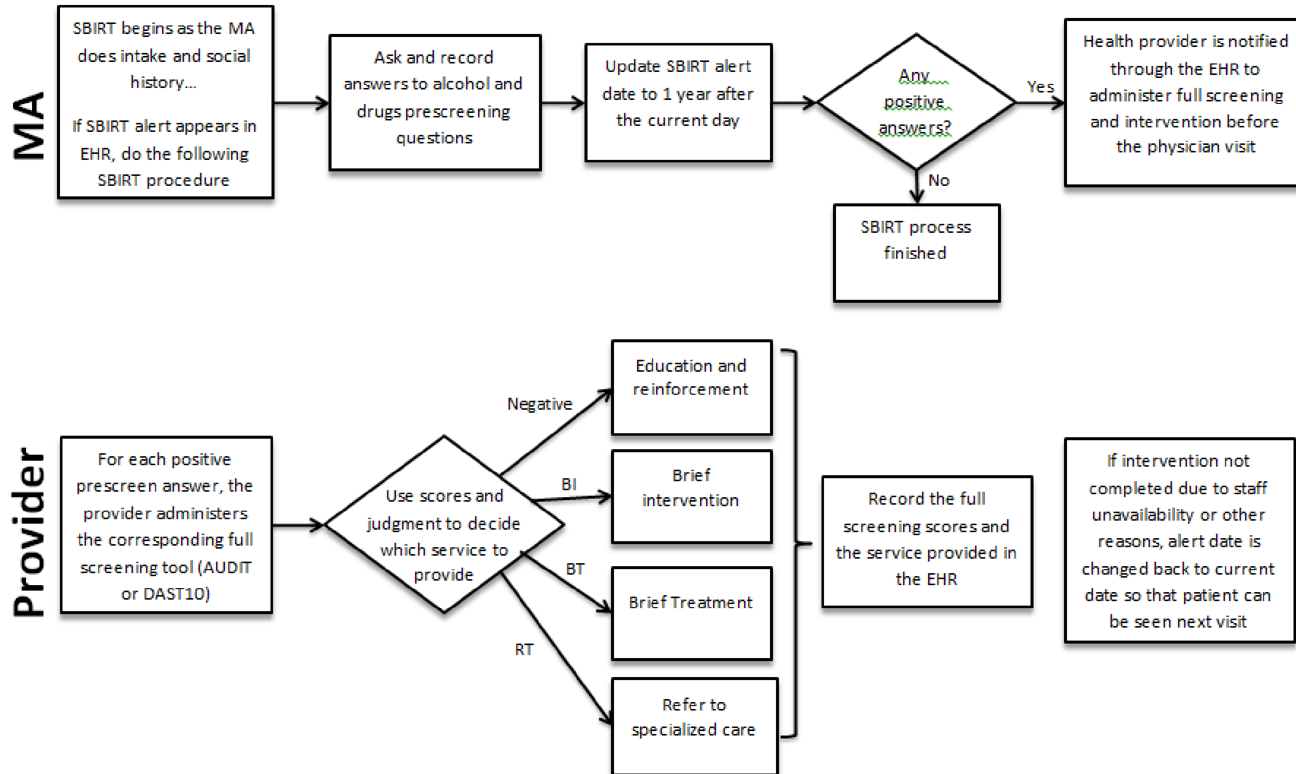
SUD Care Pathway



- Screening – PCP treats the chronic illness with medication, education, and follow up
- Warm Handoff to Clinical Pharmacy (if needed) to discuss medication
- Warm Handoff to Behavioral Health to address behavioral modification
- Warm Handoff to Care Management for Resource Referrals
- Shared Care
- Continue Primary Care and Engage Members of Team as Needed – No Discharge

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DISEASE	SPECIALIST	WHO CARES FOR THESE PATIENTS IN PRIMARY CARE?
Heart Disease	Cardiologist	PCP, Nurses, MA's, Clinical Pharmacist, BH, Care Management
Cancer	Oncologist	PCP, Nurses, MA's, Clinical Pharmacist, BH, Care Management
Diabetes	Dietician, Endocrinologist	PCP, Nurses, MA's, Clinical Pharmacist, BH, Care Management
Alzheimer's Disease	Neuropsychologist, neurologist	PCP, Nurses, MA's, Clinical Pharmacist, BH, Care Management
Substance Use Disorder	Licensed Addiction Counselor, Addiction Medicine Doctor	PCP, Nurses, MA's, Clinical Pharmacist, BH, Care Management

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Administrative and Medicaid Rules

Montana Code Annotated 37-35-201. License required -- exceptions.

Does not prohibit an activity or service performed by a qualified member of a profession, such as a physician, lawyer, licensed professional counselor, licensed social worker, licensed psychiatrist, licensed psychologist, nurse, probation officer, court employee, pastoral counselor, or school counselor, consistent with the person's licensure or certification and the code of ethics of the person's profession, as long as the person does not represent by title that the person is a licensed addiction counselor. If a person is a qualified member of a profession that is not licensed or certified or for which there is no applicable code of ethics, this section does not prohibit an activity or service of the profession as long as the person does not represent by title that the person is a licensed addiction counselor.

Provider Requirements – Medicaid Manual – Policy 115:

Must be provided by an appropriately licensed clinical mental health professional or licensed addictions counselor trained in performing biopsychosocial assessments and operating within the scope of practice for their respective license.

Care Pathways for Chronic Illnesses

- Starts with the patient and PCP
- Engages the entire team in shared treatment
- Includes Social Drivers of Health
- Assess behavioral health needs
- Includes nutritional needs
- Ongoing care for a lifetime

Self Actualization

Esteem
self-respect , confidence, appreciation,Power, recognition etc

Social
Love, affection, friends, family etc

Safety
good health, family security, employment secuirty, financial secuirty etc

Physiological
Air, Water, Food, Sleep, warmth etc

pmvidya.com

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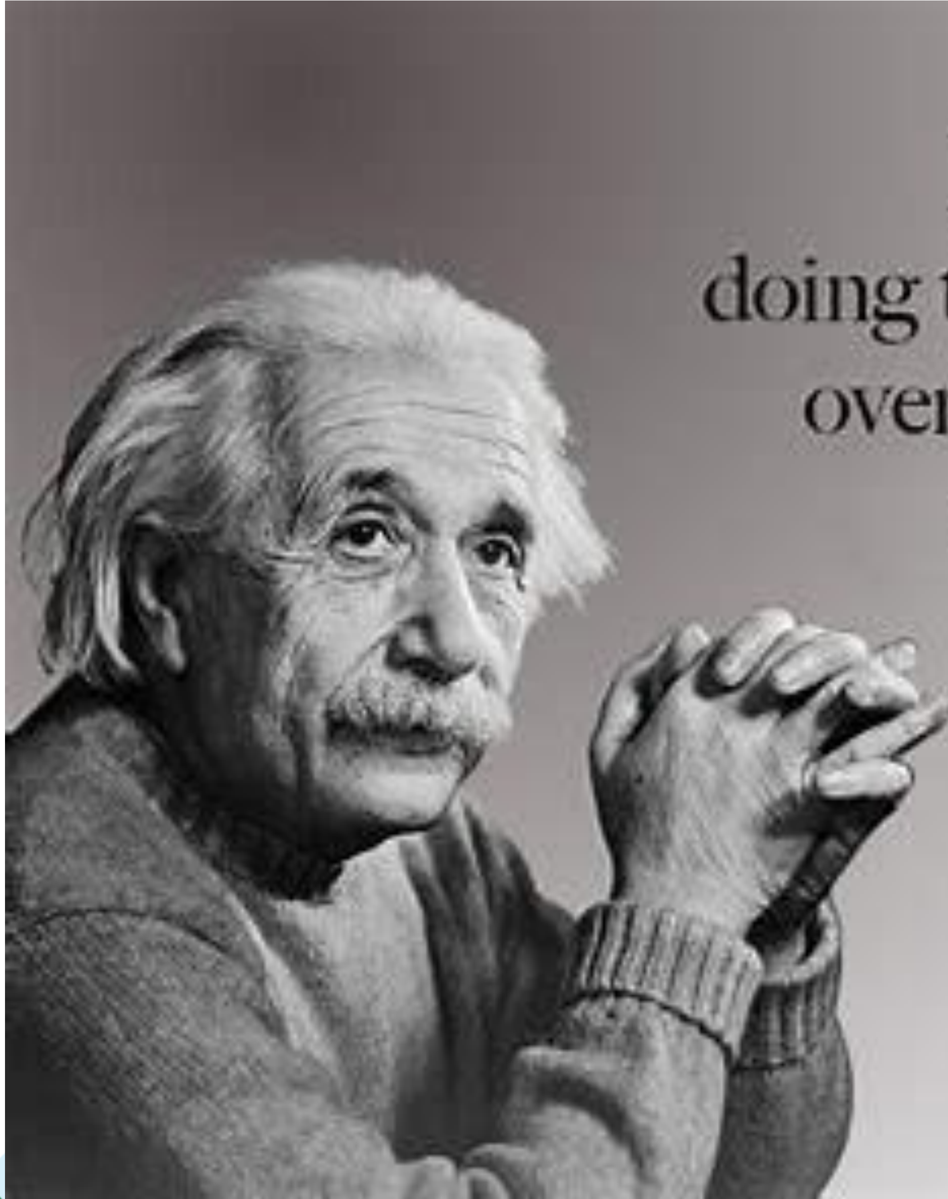
Social Driver’s of Health

- The nonmedical factors that influence health outcomes
  - Safe housing, transportation, and neighborhoods
  - Racism, discrimination, and violence
  - Education, job opportunities, and income
  - Access to nutritious foods and physical activity opportunities
  - Polluted air and water
  - Language and literacy skills



INSANITY:

doing the same thing over and over again and expecting **different** results.

~ Albert Einstein

WWW.SEVENQUOTES.COM

So why do we treat SUD differently?

Implicit Bias:

Unintentional actions based on prejudice and stereotypes. Unconscious act or thought.

Explicit Bias:

Intentional actions based on prejudice and stereotypes. Aware of their bias.

Bias and Health Care

- View patients with SUDs differently
- Have lower expectations for health outcomes
- Perceived Control
- Perceived Fault
- People suffer in the shadows because they are afraid to go to medical for help.

What is Living in Remission?

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Four major dimensions that support a life in recovery:

- **Health:** overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way;
- **Home:** a stable and safe place to live;
- **Purpose:** meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
- **Community:** relationships and social networks that provide support, friendship, love and hope.

…….NAADAC

Behavioral Health's Role

LANGUAGE MATTERS

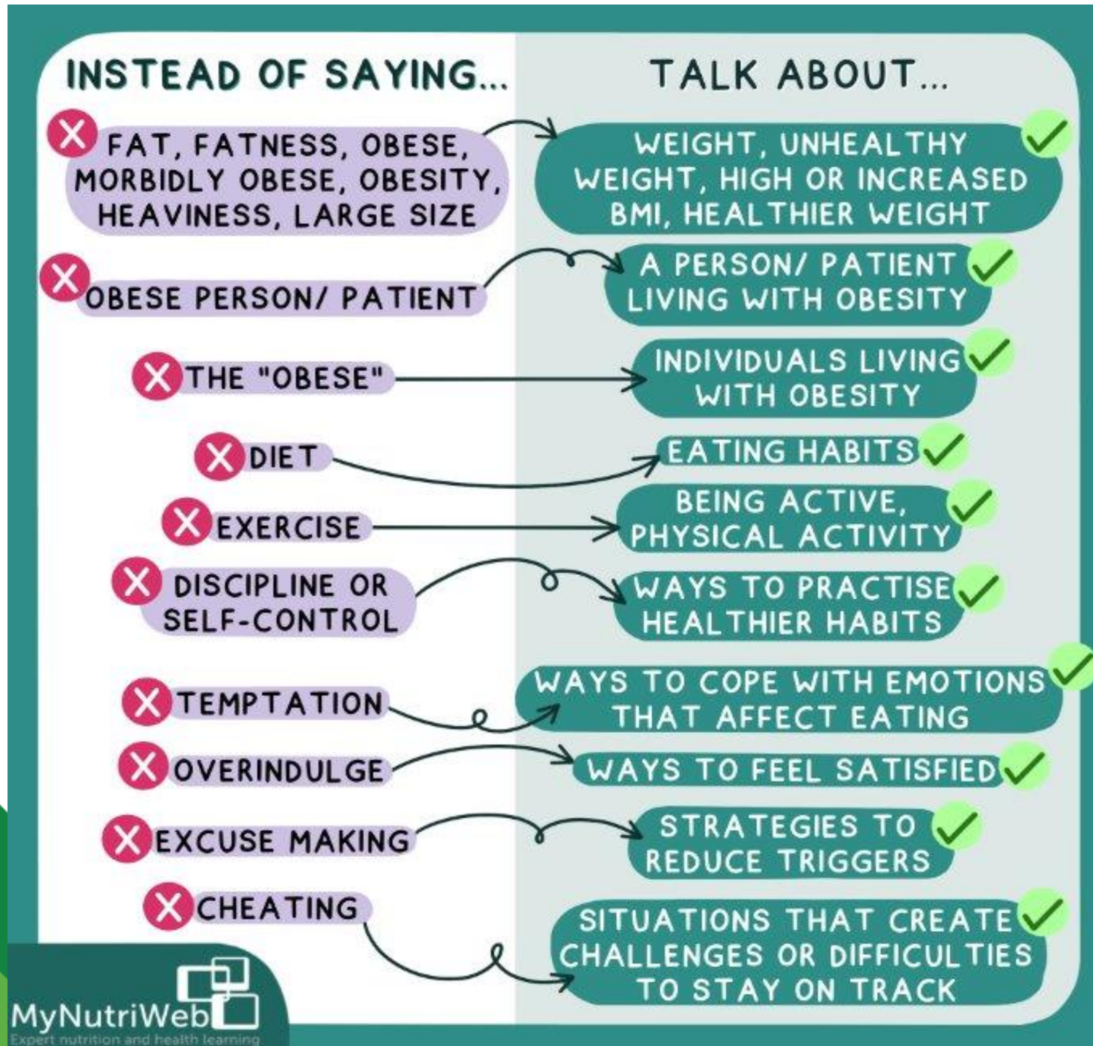
When words are used inappropriately to describe individuals with a substance use disorder, it not only negatively impacts the cultural perception of their disease, but creates stigma that can stop people from seeking help. Language matters. Let's replace terms like "addict" and "junkie" with smarter language that aligns with the science.

Say This	Not That
Person with a substance use disorder	~~Drug addict~~
In recovery	~~Clean~~
Currently using substances	~~Dirty~~
Substance use	~~Substance abuse~~
Not engaging with treatment	~~"Bombed out"~~
Recurrence of symptoms, return to use	~~Relapsed~~
Positive drug screen	~~Dirty drug test~~
Medication assisted treatment (MAT)	~~Medication replacement, substitution therapy~~

Sources:
JAMA: "Changing the Language of Addiction", Michael P. Botticelli, MEd
Howard K. Koh, MD, MPH
Language, Substance Use Disorders, and Policy: The need to Reach Consensus on an "Addiction-ary". John F. Kelly PhD, Richard Saitz MD & Sarah Wakeman MD

- REDUCE BIAS AROUND RECEIVING BEHAVIORAL HEALTH AND SUBSTANCE USE TREATMENT
- Person-Centered Language
  - Teach your co-workers (Front Desk, Paraprofessionals, Primary Care, Pharmacists, etc)
  - Use and Role Model
  - Not just with SUD, but with all things!

Words Matter



DON'T: use stigmatizing language that labels people.

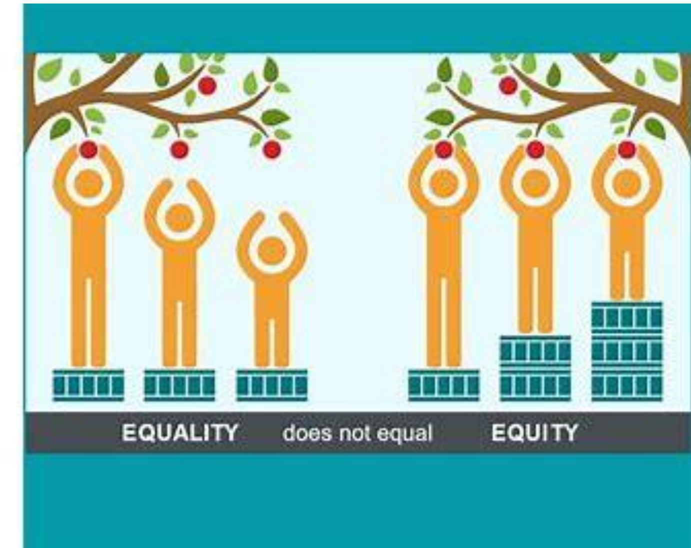
"She's depressed."
"He's bipolar."
"She committee suicide."

DO: use people-first language that shows acceptance.

"She has depression."
"He has bipolar disorder."
"She died by suicide."

Create Access to Care

- Behavioral Modification is a part of *everything* that is treated in Primary Care
- Normalize that BH and SUD is an expected, routine part of a person's healthcare
- Respond quickly and compassionately
- Listen for patients that are difficult for the PCP and offer insight and support



Be an Advocate

- Give gentle feedback to your team-mates as needed
  - MI – Ask, Offer, Ask

Be a Learner

- Engage your team!
  - We all see the situations through a different lens.
  - Trust your team.
- Listen to understand, not to respond.
- We work in a constantly changing field. Be teachable!

I DON'T KNOW WHAT I'M DOING

AND AT THIS POINT I'M TOO AFRAID TO ASK

makeameme.org

Location is Everything

- ❑Proximity to providers improves communication and collaboration.
- ❑“Out of sight, out of mind.”
- ❑Listen to the challenges the team has with different patient populations.
    - ❑Then give input of how you might be able to help.

Compassion and Burnout

- As people grow tired, their compassion is impacted…
- As a member of the BH team, or a team-mate with a different lens, how can you improve compassion fatigue or burnout with your team?
- …Be the most positive, willing person in the pod!

Kindness is Contagious

- Patients are more likely to engage when they know they matter to their team.
- Missed appointments decrease.
- Engagement in care increases.
- Provider outlook improves.
- Work satisfaction improves.
- Anyone, and everyone can be kind.

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Upcoming Trainings

Events Calendar - Montana Primary Care Association (mtpca.org)

A New Pair of Glasses – Stigma with SUD

- Webinar 4/26 at 10:00

SBIRT – Screening, Brief Intervention, Referral to Treatment

- Webinar 5/10 at 8:00

Resources

[Primary healthcare approach to substance abuse management - PMC (nih.gov)]

[The Relation of the Chronic Disease Epidemic to the Health Care Crisis - PMC (nih.gov)]

[Social Determinants of Health at CDC | About | CDC]