Principles, Roles and Processes for Managing Medical Co-Morbidities

Session 2
Learning Objectives

• Identify 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

• Recognize 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

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

**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**
    - Yes: Refer to PCP for HTN treatment
    - No: Counsel

- **BP > 140/90?**
  - Yes: **Repeat BP**
    - Yes: BP still > 140/90?
      - Yes: **Re-evaluate medications**
      - No: **Refer to PCP for HTN treatment**
    - No: **Check BP at next visit**
  - No: **Check BP at next visit**

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

- **BMI > 25?**
  - Yes: **Counsel**
  - No: **Weigh at next visit**
### Population-Based Care: Registry Example

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<th>Active in Care Management Date</th>
<th>Primary Physician</th>
<th>RMHC Psychiatrist</th>
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<th>LDL</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
Applicable Framework?

• Minnesota Public Health Nursing Framework
• Based on public health model applicable to all disciplines
• Multiple levels of interventions
Minnesota Public Health Nursing Framework
## Nurse Care Manager in Behavioral Health

- **Screening: Case Finding**
- **Health Teaching**
- **Case Management**
- **Consultation**
- **Collaboration**
- **Delegated Functions**
- **Referral and Follow Up**
- **Surveillance**
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”
Small Group Discussion
Influencing without Authority

Examples: Florence Nightingale, Margaret Sanger

Prompt: “Who is the nurse?”
Think of a time when you facilitated change through influencing others.

Instructions
1. In pairs, take turns discussing.
2. Report out to the larger group.
Who is the “Patient”? 

‘Patient’ vs. ‘client’ vs. ‘member’ vs. ‘consumer’ vs. ‘customer’ vs. ‘family unit’ vs. ‘colleague’ 

• 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

Nurse (1)  Patient (1)
Care Coordination vs. Care Management

Care Management
- Groups of patients
- Population focused
- Delegated tasks
Care Coordination vs. Care Management

Care Management
• Population focused

- Elevated BP
- Elevated BMI
- Elevated Cholesterol
- DB Elevated BS/A1c
- Smoker
Care Coordination vs. Care Management

Care Management
• Population focused

Nurse → Registry → Provider 1

Provider 2
Provider 3
Provider 4
Provider 5
Checkpoint: Group Discussion

Prompt

Recall a time or situation where you were already using elements of population health management.

• What challenges have you had?
• What successes have you seen?
CONSIDERATIONS WHEN WORKING IN A BEHAVIORAL HEALTH SETTING

Low health literacy levels
Clinical inertia
Multiple barriers to care
Scope of practice concerns
Culture clashes
Considerations: Low Health Literacy - Best Practices

• NCM as Educator and Translator
• Spoken Communication
  1. One to three key “need to know” items
  2. Avoid medical jargon
  3. Patient-centered approach
  4. Assess understanding using teach back

• Written Communications
  1. 5th to 6th grade level
  2. Write for easy understanding
Considerations: Clinical Inertia

“Failure of health care providers to initiate or intensify therapy when indicated”

Lawrence S. Phillips, MD; William T. Branch Jr., MD; Curtiss B. Cook, MD; Joyce P. Doyle, MD; Imad M. El-Kebbi, MD; Daniel L. Gallina, MD; Christopher D. Miller, MD; David C. Ziemer, MD; Catherine S. Barnes, PhD; Ann Intern Med. 2001;135(9):825-834.DOI: 10.7326/0003-4819-135-9-200111060-00012
Considerations: 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
Checkpoint: Group Discussion

Prompt

Recall a time when you have experienced clinical inertia.

• What strategies did you use to try and overcome?
• Were they successful?
Considerations: 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”
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
Checkpoint - Discussion

Prompt
Think of a time where you’ve wondered, “Is this in my scope of practice?”
Whole Person Care

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

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

Big Ideas – Session 2
Principles, Roles and Processes for Managing Medical Co-Morbidities

Prompt
Write down any big ideas from this session.
Questions and Discussion
Lunch Break

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