Integration That Works: Improving Patient Outcomes through Collaborative Partnerships

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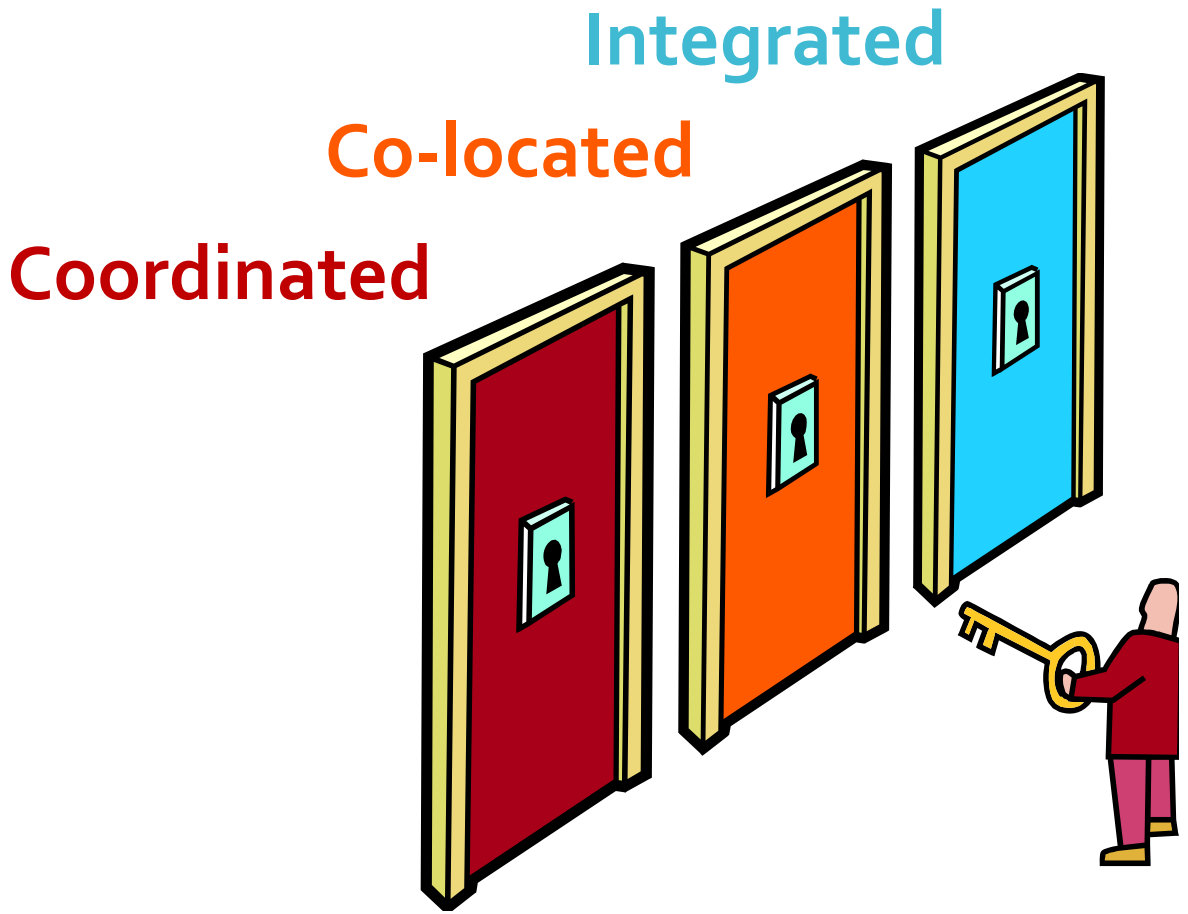
Collaboration and Integration

"The health care we want to provide for the people we serve—safe, high-quality, accessible, person-centered—must be a team effort. No **single** health profession can achieve this goal alone. These new competencies will build a path to a collaborative health care workforce and the improved care that we all desire."

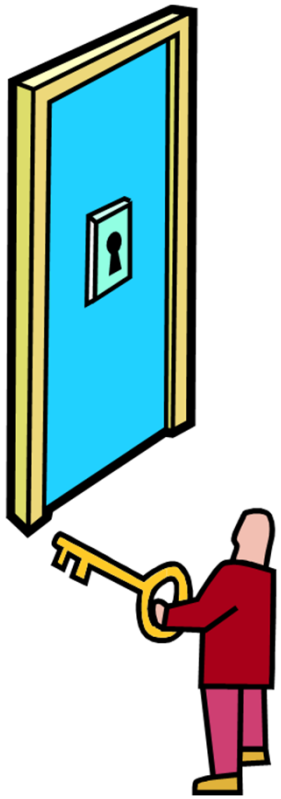
- Carol A. Aschenbrener, M.D. Executive Vice President Association of American Medical Colleges

Models of Integrated Care



The Coastal Family Health Center / University of Southern Mississippi Model

Integrated



This collaboration sought to create health services across all levels of operations and management that assists patients get the care they need, in ways that are user-friendly, improve outcomes and provide value.

System Change

Where integration happens.

Clinic Level Integration

Clinic level change can be obtained through building individual relationships with key individuals, system change is a different story

Initial Challenges for Clinic Integration

- Space
  - Where does the social worker go?
- Role confusion
  - What does the social worker do?
- Supervision
  - Who supervises them in clinic

Initial Challenges for Clinic Integration

- Protocols
  - How to access the social worker
  - What (who) can they help me with?
  - Handling a crisis

Merging Separate Missions

As a primary care provider CFHC mission is to provide quality medical care

Social Workers focus on improving psycho-social issues.

In the beginning the USM Social Work team unsure of how to approach leadership to offer suggestions that would impact behavioral health.

Strategies

- Phase 1
  - Individual partnership between CFHC MH Director and USM Program Director
- Phase II
  - Development of a multidisciplinary integration team.
- Phase III
  - PI & CEO planning to create a responsive leadership structure
- Phase IV
  - USM Director & COO routine meetings
  - Quarterly PI and CEO check ins

Current Initiative

Program focuses on PCP manageable mental health services and creating behavior change in patients with chronic health conditions.

Ongoing Considerations

- Staffing Levels
- Turnover
- Buy-in

Clinic Integration

Success!

- Social workers located in the same hall as providers.
  - In most clinics patients pass offices upon exiting exam room.
- Shared patient record (EHR)
- Patient care achieved through health care teams
- Medical protocols include behavioral health.

Goals

- To coordinate services that empower patients to effectively manage their mental health and medical condition.
- To incorporate a social work perspective in treating patients with chronic medical conditions.
- To change patient behavior and provide support to make necessary lifestyle changes for improved overall health and wellness.

Target Patient

- Depression
- Anxiety
- Situational life events
- Chronic medical issues with underlying emotional health concerns

Services

- Screening and Assessment
  - Quality of Life
  - Depression
  - Anxiety
  - Alcohol and Drug
- Referral
- Brief Intervention
  - Mental Health
  - Behavior Change
  - Education
- Crisis Intervention

All social work services have been adapted to match the flow of the clinic.

Chronic Care Services

- Bio-psychosocial approach to chronic disease management designed to better detect the full range of patient need
- Includes assessment, education, self-management skills training, and developing patient directed behavior change goals

Behavioral Health

- Mental Health Services
  - Consultation with PCP
  - Solution focused Treatment (brief)
  - Family supports
  - Education
- Crisis
  - Assessment of risk
  - Stabilization and monitoring
  - Referral
- Referral
  - SMI services
  - Community Resources
- Other
  - HCH screening
  - Prescription assistance

Population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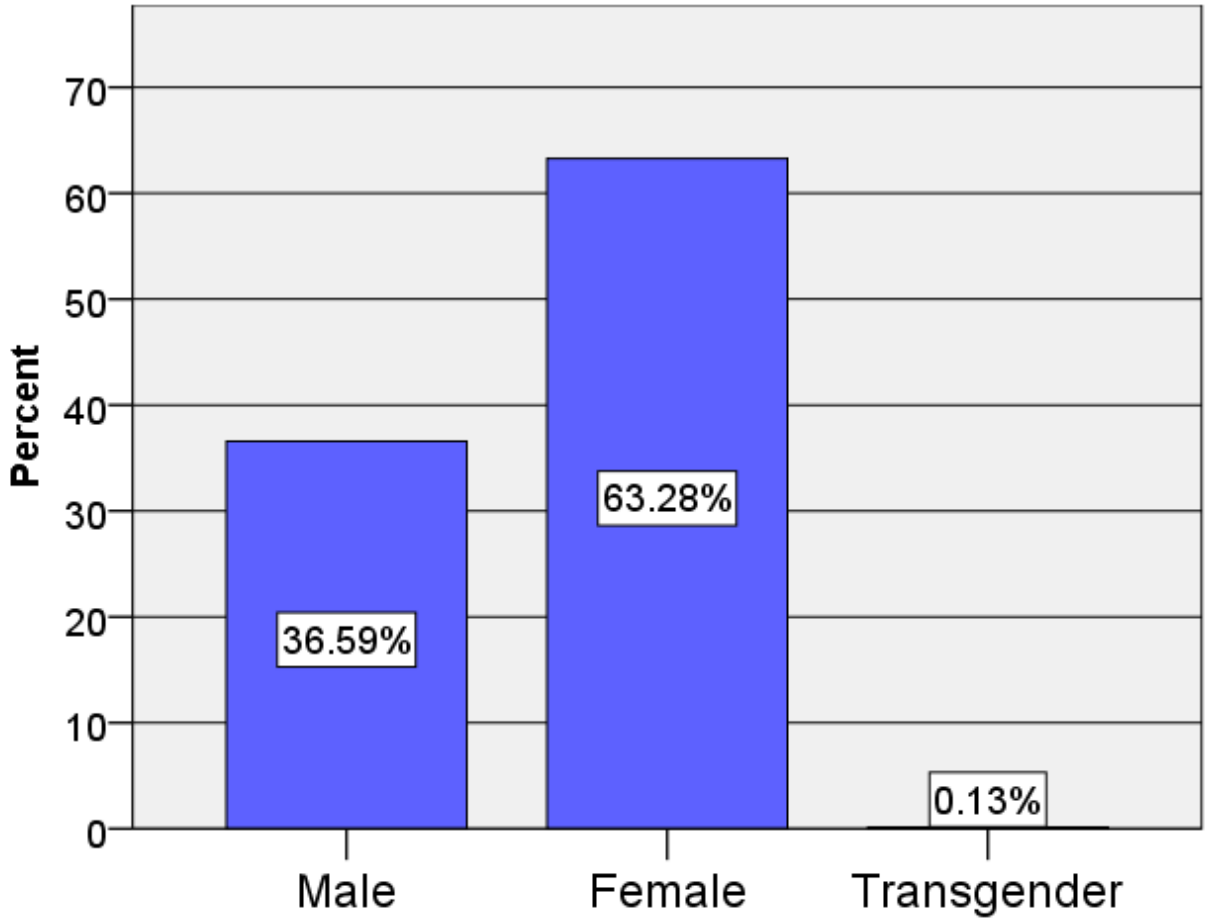
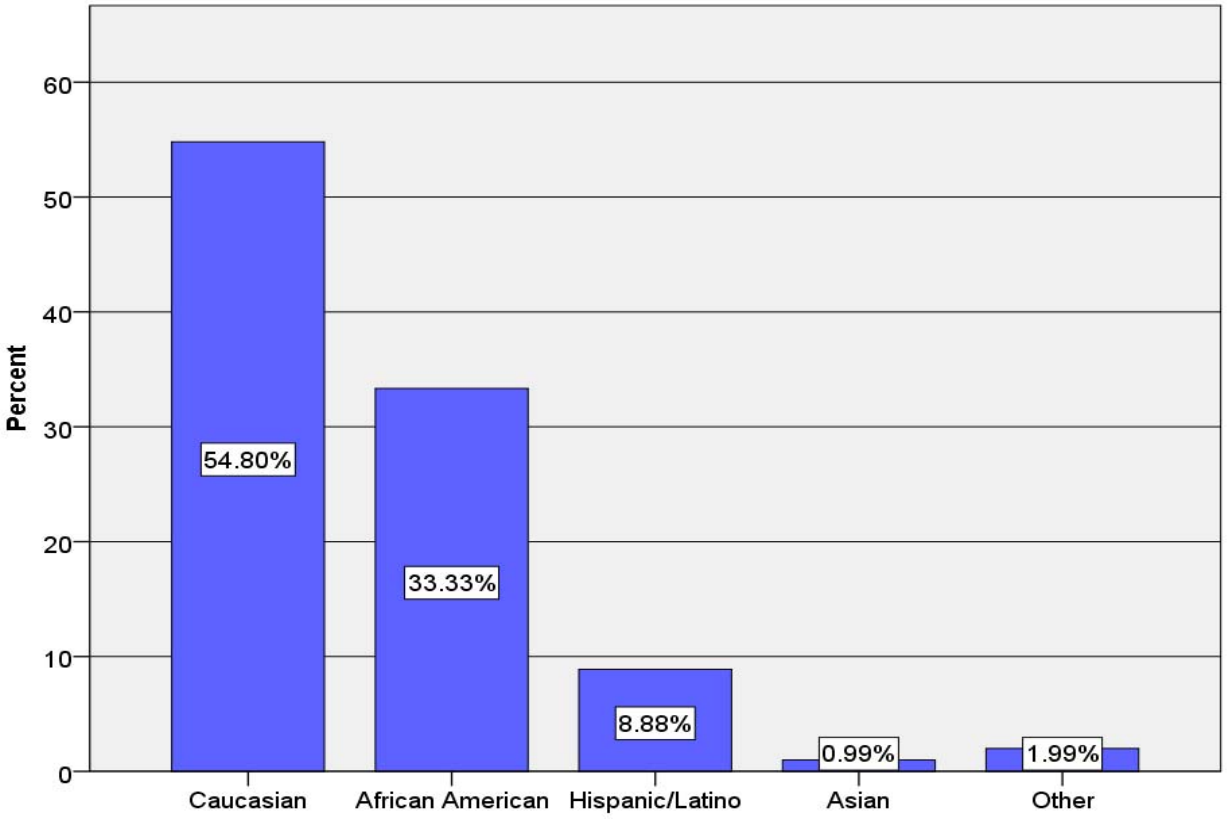
Time: 24 months
(4/3/2015 – 4/3/2017)

- Total unique patients seen (N): 1533
- Total new chronic care patients: 666
- Mean age at baseline: 41.88 yrs.

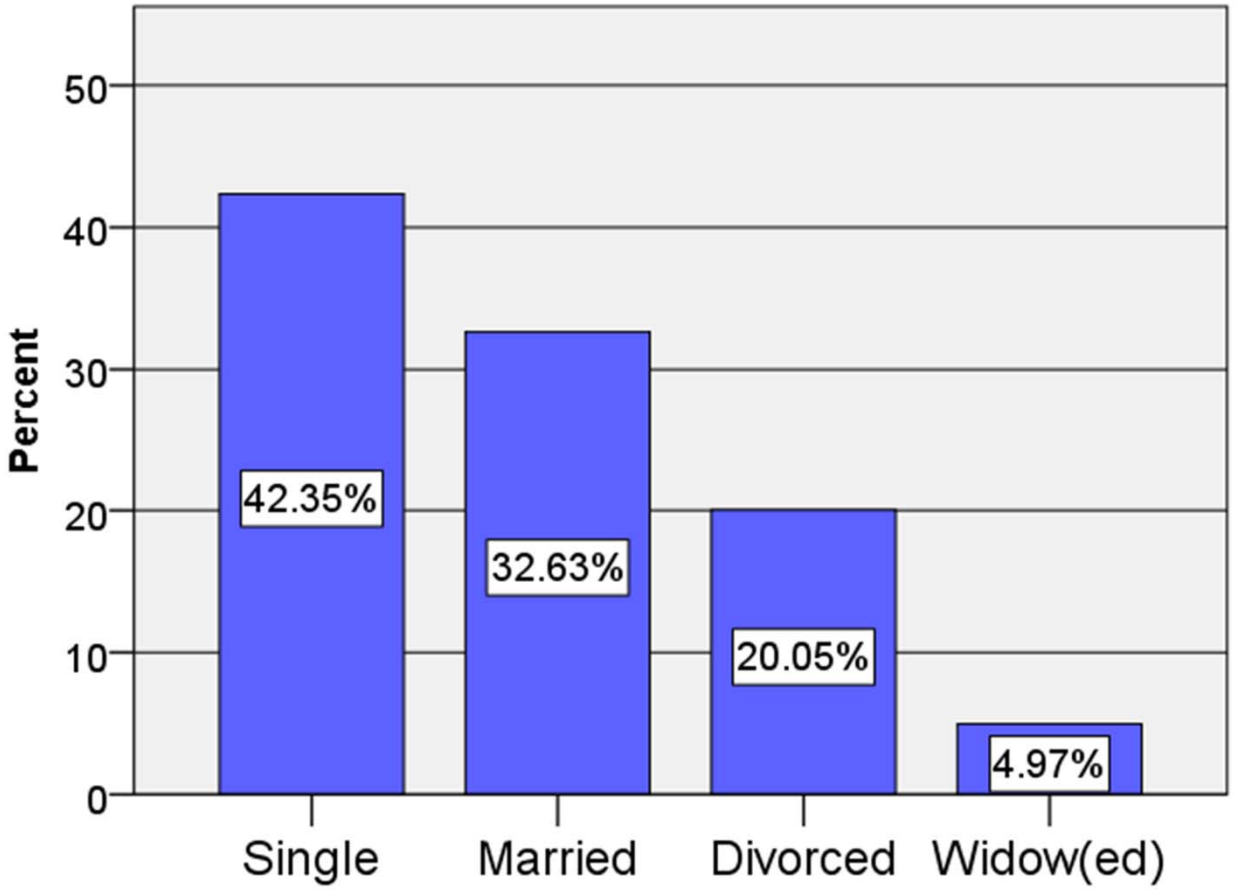
Gender (n=1517)



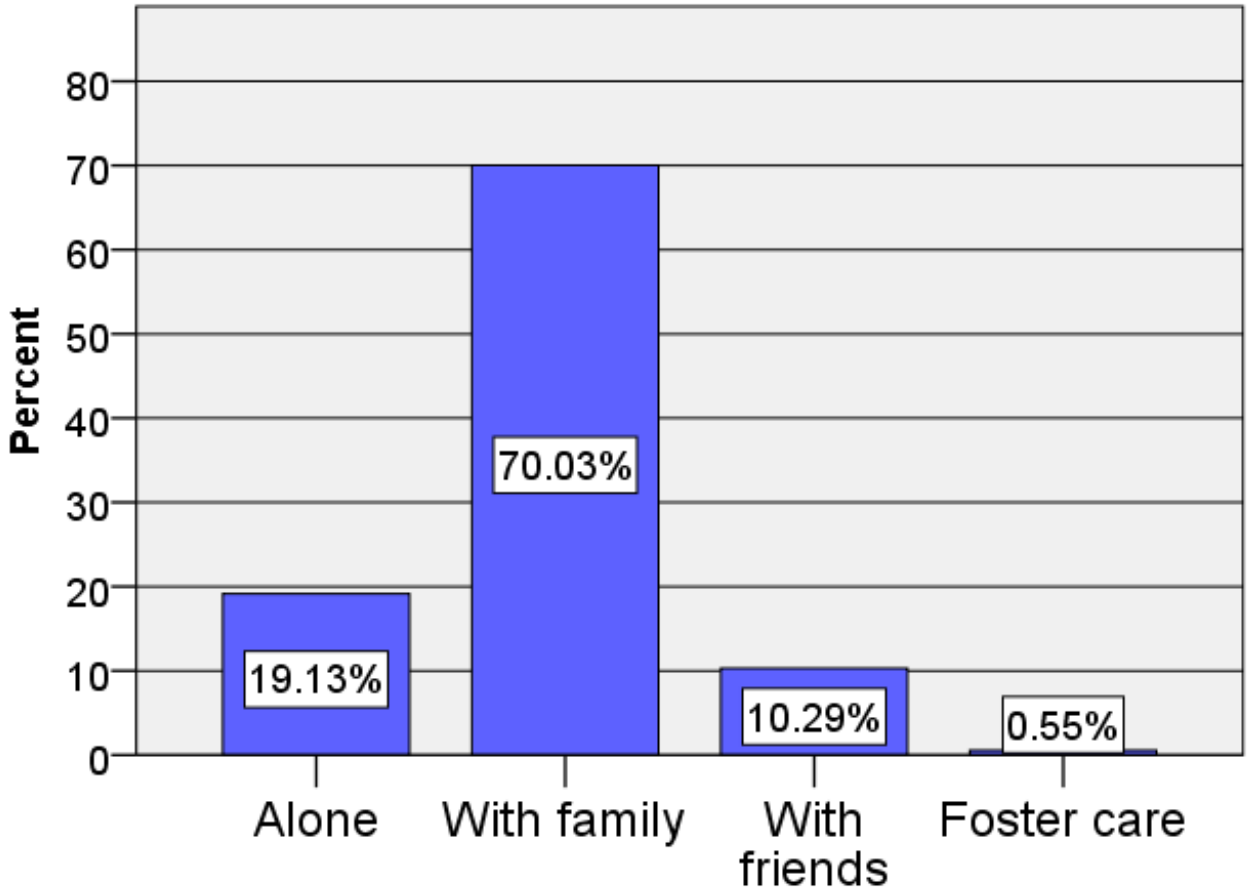
Ethnicity (n=1509)



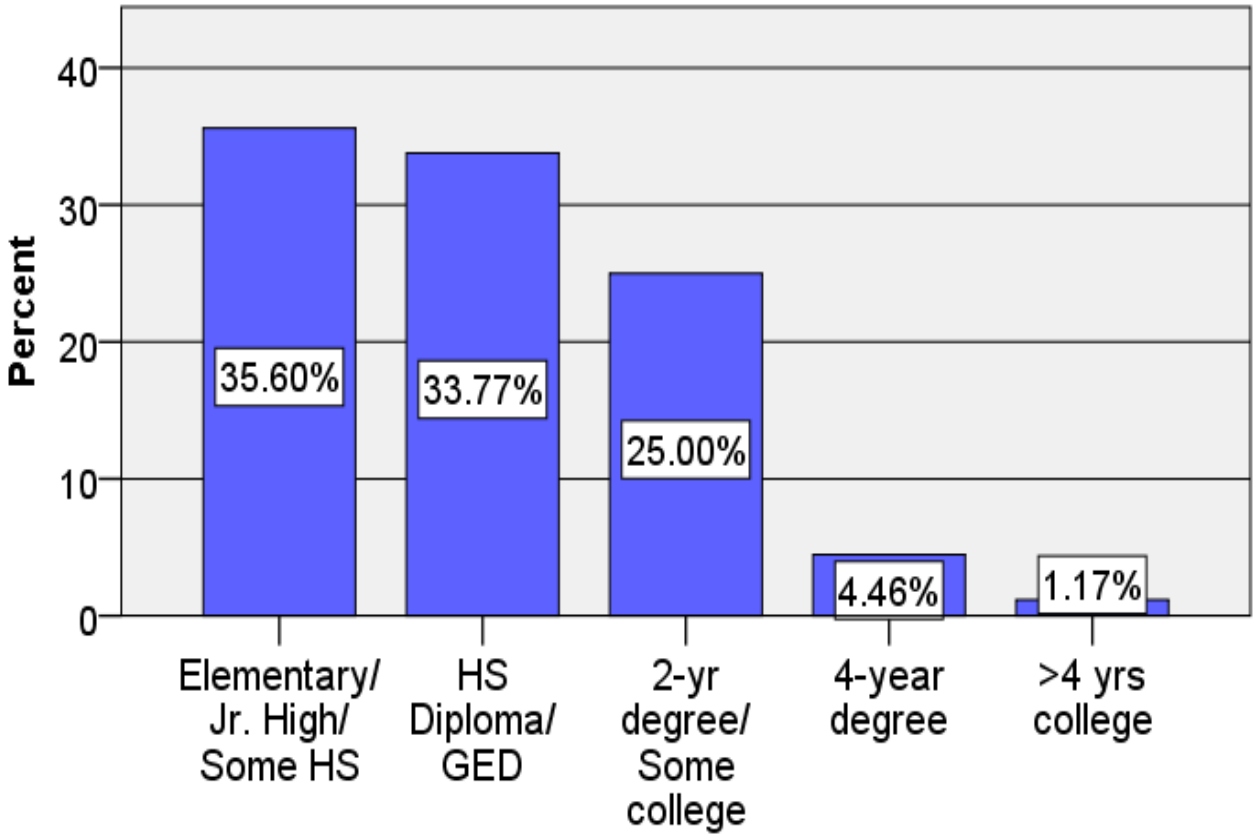
Marital Status (n=1287)



Living Arrangement (n=1448)



Highest Level of Education (n=1368)



Methods

- Instruments/Measures
  - Duke Health Profile – overall health
    - **Physical health**, mental health, social health, perceived health, **general health**, self-esteem, anxiety, depression, anxiety-depression, pain, and disability
  - Patient Health Questionnaire (PHQ-9)
  - Generalized Anxiety Disorder (GAD-7)
  - The Summary of Diabetes Self-Care Activities (SDSCA)
  - A1C
  - Weight

Outcomes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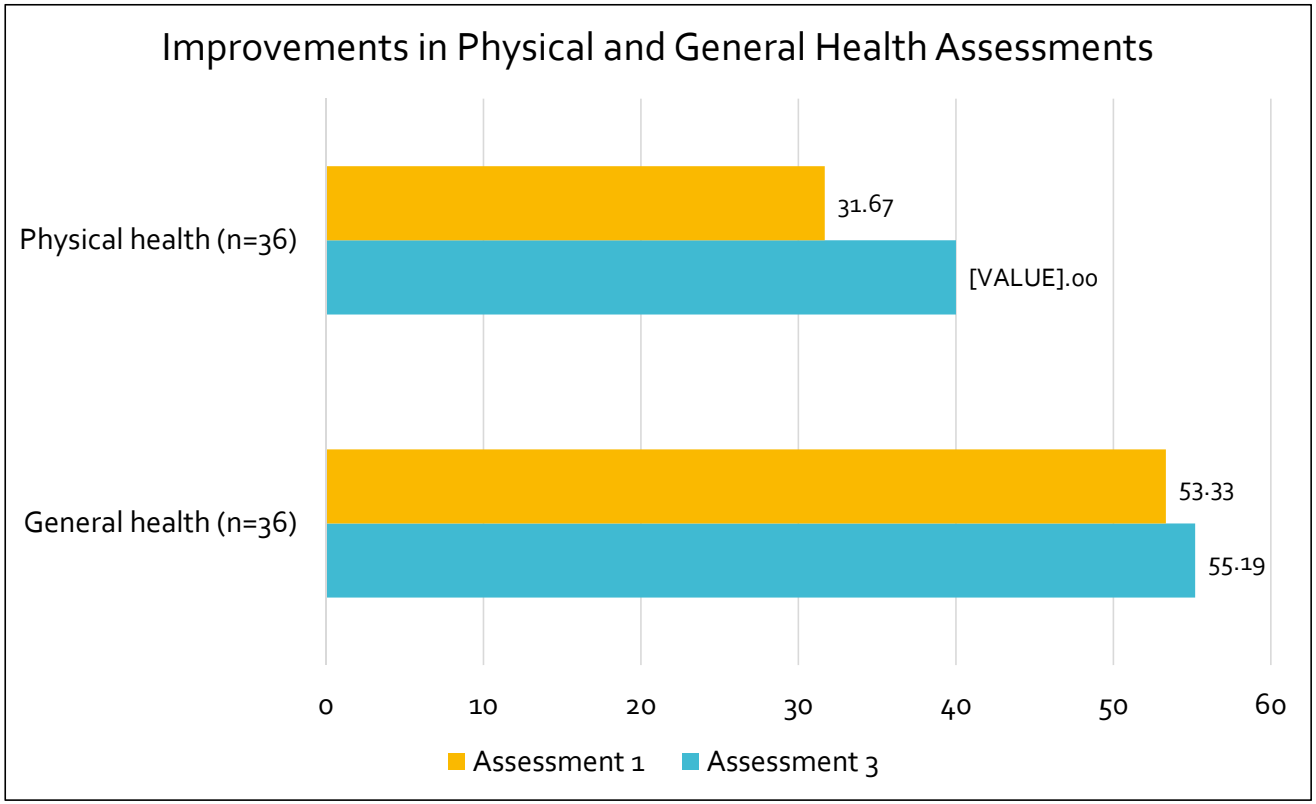
The Duke Health Profile

Physical health –sig. difference
$t(35) = -2.474$, $p = .018$

General health – non-sig. difference
$t(35) = -.888$, $p = .380$

Physical health –Scores improved by an avg of 8.33

General health –Scores improved by an avg of 1.85



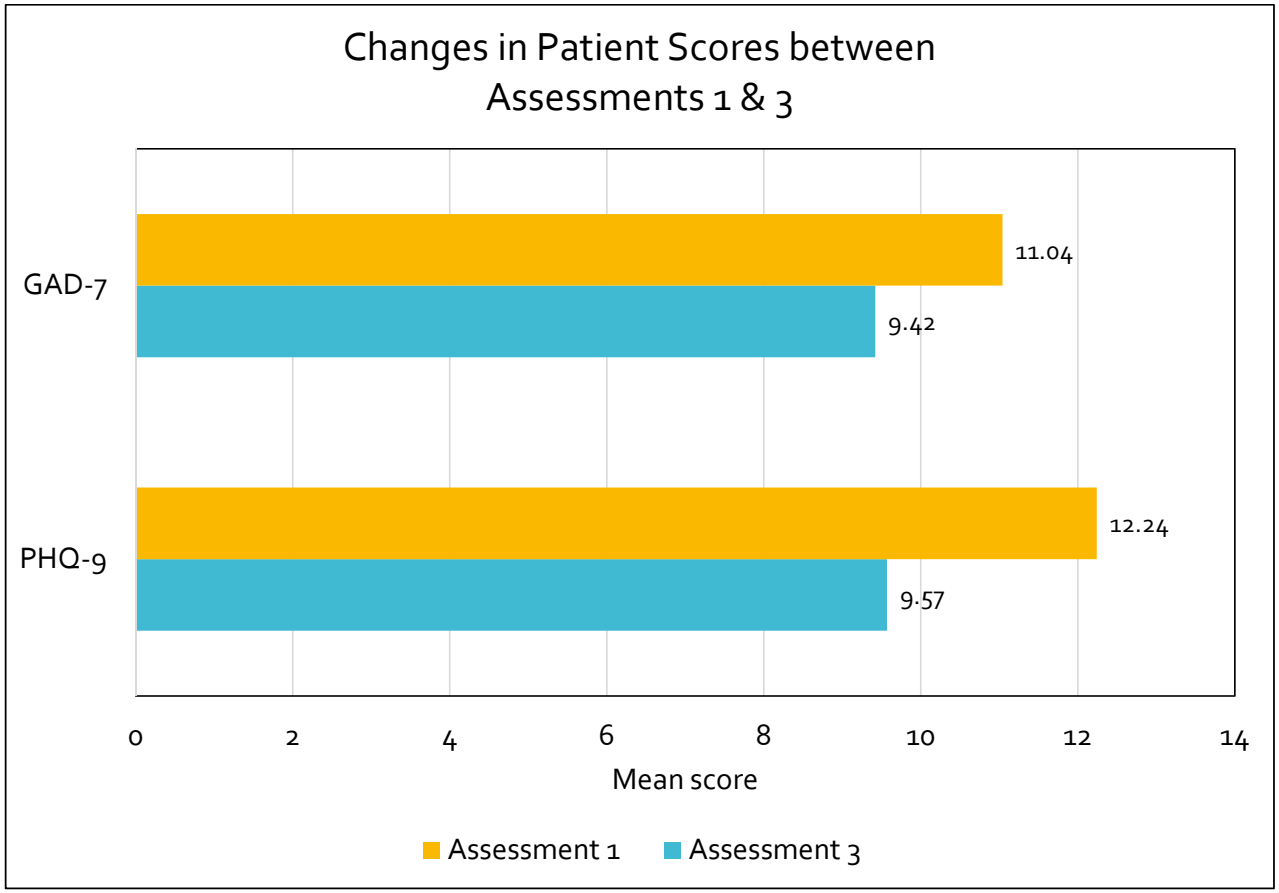
Psychological Distress

GAD-7: Anxiety, n=72
Statistically significant difference:
$t(71) = 2.295$, $p = .025$

PHQ-9: Depression, n=75
Statistically significant difference:
$t(74) = 4.013$, $p < .001$

Anxiety – Scores improved by an average of 1.63

Depression - Scores improved by an avg of 2.67 pts



Summary of Diabetes Self-Care Activities

Increase in number of days

- Followed a healthful eating plan (n=62)*
- Followed eating plan (n=61)*
- Ate 5+ servings of fruits/vegetables (n=62)
- Number of days ate high fat foods (n=61)
- Spaced carbohydrates evenly throughout the day (n=62)*
- Took recommended diabetes medication (n=60)*
- Took recommended insulin injection (n=40)

* indicates statistical significance at α =.05 level of significance

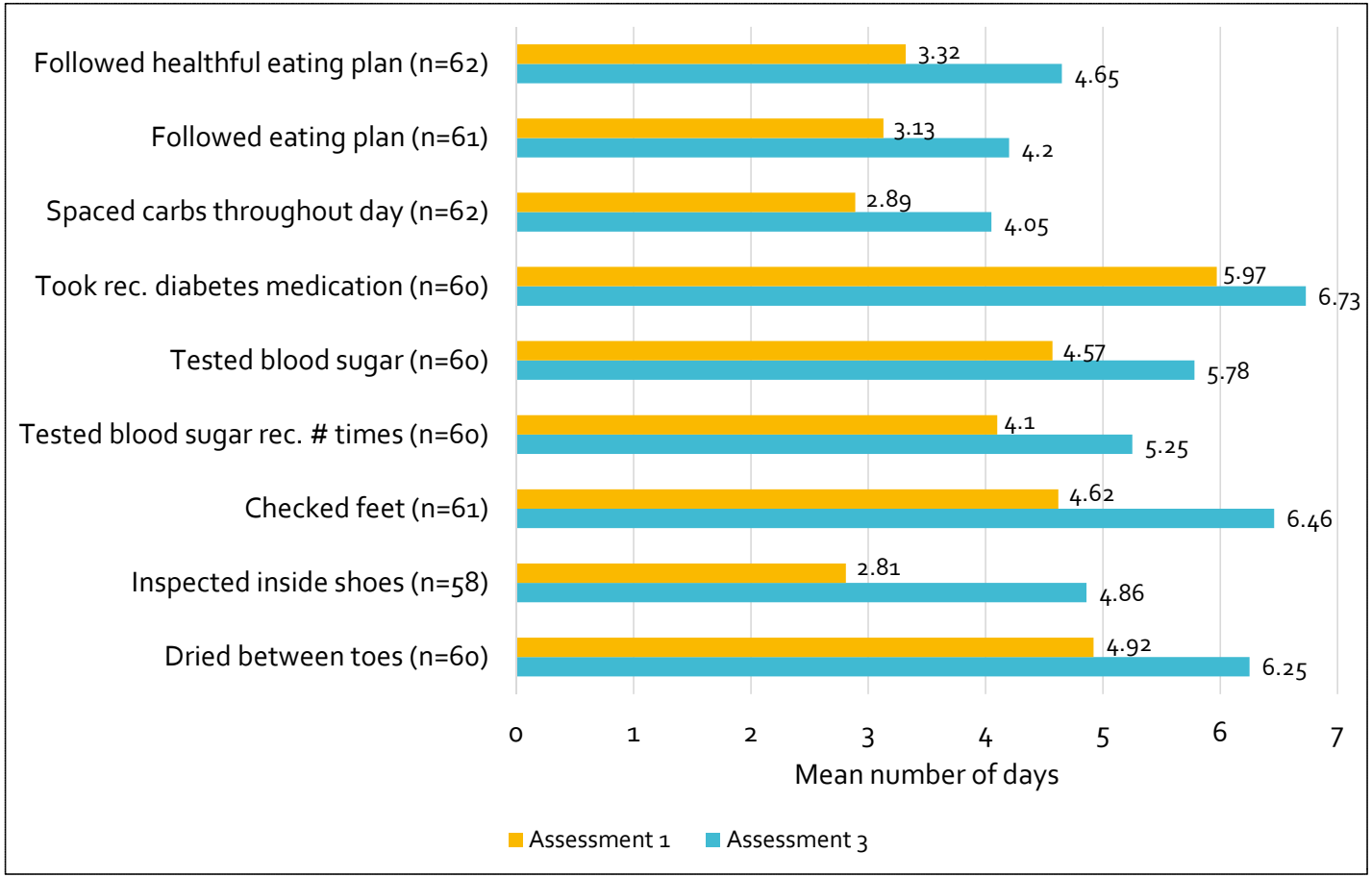
Summary of Diabetes Self-Care Activities

Increase in number of days

- Took recommended number of diabetes pills (n=56)
- Tested blood sugar (n=60)*
- Tested blood sugar recommended number of times (n=60)*
- Participated in at least 30 minutes of physical activity (n=62)*
- Checked feet (n=61)*
- Inspected inside shoes (n=58)*
- Washed feet (n=61)
- Dried between toes after washing (n=60)*

* indicates statistical significance at α =.05 level of significance

SDSCA Items with Significant Improvement between Assessments 1 & 3



Medical Outcomes between Assessments 1 & 3

Although not statistically significant between the two assessments overall, some improvements were revealed when the patients were divided into groups based on demographic and other characteristics

- A1C – non-sig. mean improvements of…
  - .14 among 42 Caucasian patients
  - .30 among 32 male patients aged 45-65
  - .15 among 44 patients with A1C $\geq$ 9.0 at baseline

Funding and Sustainability

- Developing a productivity standard that ensures sustainability using CPT Billable Mental Health Codes
- HBAI (?)
- Cost Benefit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QUESTIONS?