ORGANIZING THE MEDICAL STAFF FOR INTEGRATED HEALTHCARE: PHYSICIANS, MID-LEVEL PRACTITIONERS, AND NURSING STAFF

Here's the dirty lowdown...

There are some startling facts facing our future primary care settings:

- The average primary care physician has a caseload of over 2,300 patients
- The percent of physicians going into general or family medicine is *declining*. (In 2010 the rate of entry to primary care was 9%—the first year ever that low.)
- Demand for primary care services is *increasing*. (For example: the Elderly population was 13% in 2010 and is projected to be 30% by 2020—and the elderly receive most of their care from primary/general care practitioners.)
- A Survey of 422 general internists and family physicians 2001-2005
  - 78% of physicians felt they had little control over the work
  - 48% felt the work pace to be chaotic
  - 30% felt likely to leave the practice within 2 years
  - 27% of the physicians stated they were definitely burning out
- It is hard to do justice to a panel requiring BOTH preventive and chronic care:
  - A Primary care physician with an average panel of 2,500 patients will spend 7.4 hours per day doing recommended *preventive care* [Yarnallet al. *American Journal of Public Health* 2003;93:635]
  - A Primary care physician with an average panel of 2,500 patients will spend 10.6 hours per day doing recommended *chronic care* [Ostbye et al. *Annals of Family Medicine* 2005;3:209]

Primary care practices will continue to be at risk—so the need for new models is upon us.

One Part of a Solution: The Multidisciplinary Care Team

Care teams—typically led by physicians and including mid level practitioners such as nurse practitioners, physician assistants, registered nurses, social workers, nutritionists, pharmacists, and medical assistants—are hardly new. Team based care has been in the medical literature as a topic since the 1940s. What is different now is that the use of such teams has become a *necessity* not an interesting flourish: Teams are clearly correlated with better care coordination and service outcomes.

The work of Thomas Bodenheimer shows that increased coordination achieved by primary care teams leads to better clinical and financial performance and reduces clinicians' workload. Data from Kaiser Permanente demonstrates that "high-functioning care teams"—defined as those whose practice climate features high levels of collaboration and teamwork—performed 40–90 percent better than low-functioning teams in caring for

chronic diseases, including diabetes, hypertension, and asthma. In the United Kingdom, Stephen Campbell and colleagues note that care teams were the "only variable that was associated with high quality care across a range of aspects of care." (all from Schuetz, 2010). Bodenheimer, after surveying over 100 participants in primary care teams derived a list of factors deemed important for successful integrated care:

Key Elements of Successful Primary Care Teams
Building Teams in Primary Care: Lessons Learned

Successful Primary Care Teams have Defined Goals

There is an overall organizational mission statement

Examples :

- Improvement of patients' health
- Reduction in barriers to access to care
- Improvement in practice's financial performance
- Physician and staff satisfaction

There are specific, measurable operational objectives

Examples :

- At least 80 percent of diabetic patients in practice will have hemoglobin A1c lower than 8
- Ninety percent of requests will receive a non-urgent appointment within one week
- Practice will achieve a targeted level of revenue
- Each team member will achieve an explicitly identified goal for personal professional development

Successful Primary Care Teams have Defined Procedures

There are clear-cut Clinical procedures understood by all the Team Members

Examples :

- Procedures for providing prescription refills
- Procedures for informing patients of laboratory results

There are clear-cut Administrative procedures understood by all the Team Members

Examples :

- Procedures for making patient appointments
- Policies on how decisions are made in the practice

Successful Primary Care Teams have a Clear Division of Labor

There is a clear definition of tasks
There is a clear assignment of roles

Example:

• Determining which people on the team perform which tasks within the clinical and administrative systems of the practice

Successful Primary Care Teams Engage in Continuous Training

There are efforts to improve and solidify high performance

Examples

• Training for the functions that each team member regularly performs
• Sharing of new learning and skill sets with other members within the Team
• Cross-training to substitute for other roles (in cases of absences, vacations, or periodic heavy demands on one part of the team)

Successful Primary Care Teams Continuously Work on Communication

Teams develop reliable communication structures

Examples :

• Routine communication through paper and electronic information flow
• Minute-to-minute communication through brief verbal interactions among team members
• Team meetings with structured agendas

Teams develop reliable communication processes

Examples :

• Feedback Loops built into multiple systems/procedures
• Defined conflict resolution approaches used among team members
• Methods for mutual consultation

A Model for Developing a Multidisciplinary Team: The Centre for Strategic Management ABCDE Model

Systems Thinking Framework

The multidisciplinary team is built around the principles of Systems Thinking. One of the primary principles of this discipline is: " Focus on the outcomes – which must always be directed towards 'serving your clients'."

The practices of Systems Thinking can be effectively applied to the formation of teams, as well as the establishment of plans for the work of the primary health care team. Systems are made up of a set of components that work together for the overall objective of the whole. The Centre for Strategic Management (CSM) has developed and uses a simple five step "ABCDE" model to lead organizations through change in a "systematic" manner. The process involves starting with the desired future state, and

helping the organization to develop and implement a "road map" for achieving the desired change, an implementation plan to manage the change process, and a process to sustain high performance results.

The Centre's five step Systems Thinking ***ABCDE Model*** responds to the following:

A ***Where do we want to be?***
(i.e., our ends, outcomes, purposes, goals, holistic vision)

B ***How will we know when we get there?***
(i.e. success factors connected into a quantifiable feedback system)

C ***Where are we now?***
(i.e., today's issues, problems and opportunities impacting where we want to get to)

D ***How are we going to get there?***
(i.e., close the gap from C to A in a complete, and successful fashion)

E ***What will/may change in your environment in the future?***
(i.e., a constant watch on what's happening around us, to ensure our change strategies remain relevant and effective.)

Process for Team Chartering
Team Chartering is a process that will help team members to quickly establish clarity, from the outset, about their:

- Role, purpose and mandate,
- Team status within the Regional Health Authority,
- Reporting and responsibility relationships,
- Operating ground-rules,
- Plans for conducting regular meetings,
- Team membership, and
- Initial plans and initiatives in pursuit of their mandate.

This process helps to establish the team norms which are so vital to team effectiveness and productivity.

Management of Barriers blocking Multidisciplinary Teams
Creating a successful Multidisciplinary Team requires an awareness and a commitment to attend to those factors that prevent formation of successful Teams. This also requires an attitude within the Team (and in other organizational areas impacting the Team) that (a) good patient care is the core outcome sought; (b) good patient care requires successful multidisciplinary teams; (c) successful multidisciplinary teams require cohesion and collaboration; and (d) cohesion and collaboration requires removing any and all barriers to achieving good patient care. Some of the most

common barriers to forming a successful multidisciplinary acre team in a primary care setting are the following:

- Staff turnover disrupts collaboration among health care team members .
- Interpersonal differences can disrupt effective teamwork .
- Fee-for-service compensation; blended incentive systems promote shared care.
- A focus on funding rather than patient care.
- Differing terms and conditions of service.
- Separate and multiple lines of management.
- Differing and competing organizational priorities.
- Difference in status
- Different agendas of various professional groups.
- Different conceptual approaches (e.g., illness vs.. wellness paradigms).
- Difficulties in communication.
- Lack of awareness of each others' roles and responsibilities.
- Lack of attendance of meetings, etc.
- Lack of system support when developing teamwork.
- Lack of organizational systems and structures for supporting and maintaining teams.
- Lack of integration with reforms in other sectors of the health system.
- Micromanaging: focusing too much on procedural details and not enough on common vision

One model or method for all teams does not work. Each setting presents with unique challenges and strengths. Tolerance for pluralism (allowing for different ways of addressing various elements) is warranted. Systems thinking brings to many the important insight that it is not the elements themselves but rather the interrelationship among the elements that gets results.

Another Part of a Solution: Integrated Care Coordination

For an organization new to integrated care, is there a best entry point, and if so, what would it be? In other words, how can a practice bring together elements of BOTH primary and behavioral healthcare to form a more holistic approach to care? One method of practice change is to choose only one chronic condition or only one mental health condition to address within the practice. For example: how would adoption of a systematized depression care program impact a community health clinic? The lead investigator of the RESPECT-D trial suggested that incremental change, laying a foundation of either care improvement for chronic care management or collaborative care with behavioral medicine before attempting a program that utilizes lessons from both is the way to go (see Butler et. Al. 2008).

Whether generalist or specialist approaches to care coordination are used are used, what is clear from all the case studies is that the success of a program relies directly on successful relationship management. Program implementation, whether from an organic bottom-up or hierarchical top-down development approach, requires attention to relationships at all levels.

Tension is a natural consequence of change, as one case study participant noted. Programs new to organization staff, staff new to an organization with a functioning integrated care model, care models new to providers and staff trained under traditional care models, new ways of organizing delivery of services cobbled together from coalition of networked medical, mental health, and social services organizations, patients new to receiving services through care management, all are experiencing change. Every case study providing an integrated model of care noted that the right person in the right place—the right care manager, the right behavioral therapist, the right psychologist, the right clinic champion, the right organizational leader—was critical to success (Butler et. Al. 2008).

In Michigan, persons covered by Medicaid insurance have their general health and wellness managed by Medicaid Health Plans (MHPs) licensed and operating as Health Maintenance Organizations. They provide preventive, acute, and chronic medical care for the general Medicaid population enrolled with their Plans.

Adults with chronic mental illness, developmental disability, and substance use disorders or children with serious emotional disorders are covered by the Specialty Prepaid Inpatient Health Plans, which operate an integrated care system addressing all levels of mental health care required by its beneficiaries.

Each Health Plan (general and specialty) operates well within its own areas of expertise and resource. Each Health Plan type maintains joint clinical responsibility for the health and wellness of persons with serious mental illness. However, the issue of *shared or joint chronic care* for persons with serious mental illness with multiple medical comorbidities is more problematic:

- There is a lack of coordination between mental health and general health care providers
- There is a lack of financing for coordination of care across mental health and general health care providers
- Psychotropic medications may mask symptoms of medical illness and contribute to symptoms of medical illness—or foster a metabolic syndrome
- Lack of integrated treatment for co-occurring mental health and substance use disorders will exacerbate medical disorders while interfering with treatment regimen adherence
- Persons with serious mental illness may receive suboptimal care due to the unease of primary care providers with the needs of the SMI population
- Chronic care management may be attempted less frequently due to the decreased expectations of clients as partners in care

The *Michigan Association of Health Plans* has indeed recognized the frustrations of beneficiaries trying to negotiate a less-than-seamless service delivery system: “For a current Medicaid beneficiary, there is a maze of service delivery access points, each with their different requirements and each having separate state oversight…Where there is shared responsibility, too often it is the beneficiary who is disadvantaged while providers and contractors argue over where responsibility resides.”

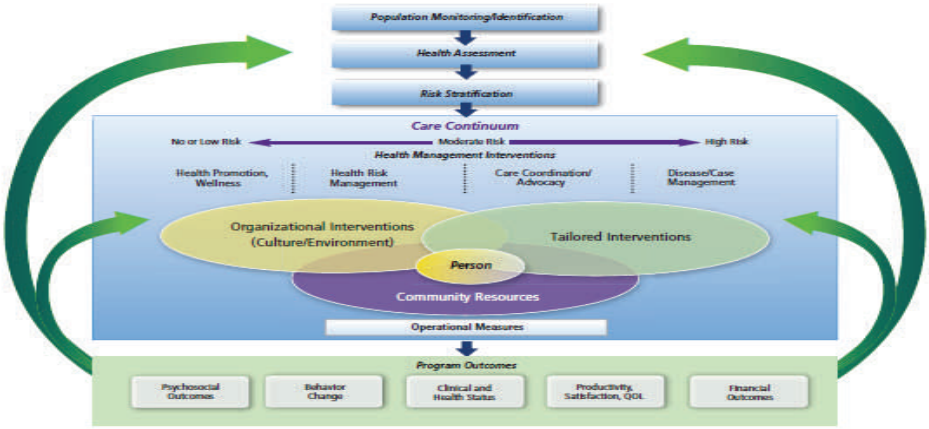
But the Health Plans have also identified the solution: coordinated *Disease Management* (DM). Also known as *Chronic Care Management* or *Population Management*, DM is a planned method of intervention to address a disease state condition through evidence-based interventions to bring about improved beneficiary health status.

Key components of the chronic care/population health improvement model include:

- Population identification strategies and processes;
- Comprehensive needs assessments that assess physical, psychological, economic, and environmental needs;
- Proactive health promotion programs that increase awareness of the health risks associated with certain personal behaviors and lifestyles;
- Patient-centric health management goals and education which may include primary prevention, behavior modification programs, and support for concordance between the patient and the primary care provider;
- Self-management interventions aimed at influencing the targeted population to make behavioral changes;
- Routine reporting and feedback loops which may include communications with patient, physicians, health plan and ancillary providers;
  Evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall population health.

The Disease Management Association of America has renamed itself the Care Continuum Alliance. It has described the elements of the clinical continuum—and the general recommended treatment approaches—based on risk. It identifies the chronic care continuum as a dynamic matrix that should operate in an integrated, responsive and planful manner.

As integrated care coordination develops, it would increasingly incorporate the elements of disease management into its collaborative approaches. It would jointly develop a continuum of treatment/population management to address the risks of health conditions with high negative outcomes (such as diabetes). The dynamic continuum called for in the chronic care model is described in the graph immediately below as developed by the Care Continuum Alliance.



Integrated care coordination would include responsibility by all members of the interdisciplinary team for monitoring and contributing to the elements below, at a minimum:

- Individual Care Coordination from a Holistic Perspective
- Intersystem Care Coordination
- Ancillary Care Coordination
  - Pharmacy
  - Nutrition
  - Peer Supports
- Multidisciplinary Case Consultation and Treatment Planning
- Education of Patients/beneficiaries regarding care
- Facilitating knowledge and support for caretakers, family members, etc.
- Active and continual Transition Care Planning irrespective of the system or level of care to which the beneficiary returns

Increasingly Integrated Care Coordination will become the central property of all successful healthcare systems who have positive and continuing improvements in patient healthcare outcomes.

Another Part of a Solution: Primary Behavioral Healthcare

Several states as well as all of the British countries have been incorporating behavioral health professionals into primary care settings. The scientific literature emerging has demonstrated that the use of interdisciplinary teams is an effective way of bringing about improvements in both the access to and the quality of primary health care.

Placing behavioral health professionals inside a primary care practice requires accommodations on all sides. The manner of addressing patient issues related to habits and emotions are not the usual stuff of primary care.

The practice needs to explore how they will accommodate the new services and the skill sets of the behavioral health personnel. There will be built in changes in the routine roles of Team members when behavioral health is integrated into a primary care practice. Some of the most important and obvious include:

> Much work will occur to make care coordination between the physician and behavioral health professional efficient. Time is of the essence. Quick, simple on site introductions are best. The term "hallway handoff" has come to define that model most in use. When the physician sees that person will most benefit from the behavioral health professionals efforts the physician quickly recommends the care and offers to introduce the participants. The Physician takes the patient to the BH professional (to free up the exam room) and the BH professional does a brief visit explaining role, likely brief course of care (and attending to any stigma related issues). The session must be brief due to the inability to bill separately for the activity (as most insurers allow only one billable OP event per day). The physician sets the cultural tone for accepting a new set of services in a practice. Their attention, verbal support and reliance on the behavioral health specialists make a huge difference in establishing the parameters and "room" in the practice for integration.

> Nursing staff will need to work out care coordination issues. Nurses now do most of the "counseling" in a practice. Their role must be respected, but the boundaries must be clear. A two edged sword lies with the nursing staff; they cannot assume medical awareness of the behavioral health staff. They must educate the behavioral staff in how to utilize the traditional primary healthcare.

Wikipedia has nicely brought together the definitional elements of primary behavioral healthcare under the term **Primary Care Behavioral Health Consultation (PCBH)**. PCBH is an

> approach to population-based mental health clinical care that is simultaneously co-located, collaborative, and integrated within the primary care clinic. The goal of PCBH is to improve and promote overall health within the general population. This approach is important because approximately half of all patients in primary care present with psychiatric comorbidities, and 60% of psychiatric illness is treated in primary care...Many patients present with mental health care needs whose symptomology may overlap with medical disorders and which may exacerbate, complicate, or masquerade as physical symptoms. Behavioral Health Consultants (BHCs) work side-by-side with all members of the clinical care team (including primary care providers (PCPs) and nursing staff) to enhance preventive and clinical care for mental health problems that have traditionally been treated solely by physicians. The role of the BHC is to facilitate systemic change within primary care that facilitates a multidisciplinary approach both from a treatment and reimbursement standpoint. BHCs typically collaborate with physicians to develop treatment plans, monitor patient progress, and flexibly provide care to meet patients' changing needs.

One of the premier examples of primary behavioral healthcare may be found at Cherokee Health Systems in Knoxville, Tennessee. [Their website may be found at http://www.cherokeehealth.com/]

Cherokee was a Community Mental Health Center that has reorganized itself as a Federally Qualified Health Center (FQHC) in order to provide integrated and holistic healthcare to a range of vulnerable populations. Cherokee has described its *Blended Behavioral Health and Primary Care Clinical Model* as incorporating the following elements:

- Embedded Behavioral Health Consultant on the Primary Care Team [i.e., housed, available, and operating within primary care time limits and responsiveness)
- Real time behavioral and psychiatric consultation available to PCP [i.e., "curb-side" consultation]
- Focused behavioral intervention in primary care [i.e., short-term immediate goals]
- Behavioral medicine scope of practice [i.e., focused on the behavioral components of common health issues such as adherence to diabetic self-management procedures]
- Encourage patient responsibility for healthful living [i.e., continuing focus on acquisition of self-management skills by patients]

- A behaviorally enhanced Healthcare Home

In an era of diminishing public resources, the emphasis on moving towards "carve-in" models and away from "carve-out" models of behavioral health benefits will continue for the foreseeable future. As a result, it can be expected that several models may come more to the fore:

- Carve-In Model similar to Cherokee Health Systems
- Expansion of the directly employed behavioral health practitioners within FQHCs, but operating more as an internal referral rather than as a member of the primary care practitioner
- Increase of co-location models by CMH but with greater resourcing, including Psychiatry, mental health nurse practitioners/physician assistants, and peer support specialists.

The primary issue is that public healthcare will become more integrated, holistic, and clinically effective due to processes correlated with improved health status—a result that will satisfy both patients and practitioners. These are three of the most important solutions on the way.

Resources:

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