

Multi-disciplinary Model for the Management of Multiple Chronic Health Conditions

Introduction

This is a team-based approach to the management of chronic health conditions. It is based on the Chronic Care Model and on the full integration of what have been called behavioral and physical health care. It is a cooperative effort of Cherry Street Health Services, Proaction Behavioral Health Alliance, and Touchstone innovare.

Rationale

- Despite improvements in the pharmaceutical care of chronic health conditions, successful management of those conditions remains elusive for many patients.
- The greatest apparent cause of failed management is often described as patient non-compliance. This has several components related to how patients behave.
 - Not taking medication as prescribed.
 - Not keeping all recommended appointments.
 - Continuing to do things that exacerbate or trigger the condition.
- Behavioral health care, which is used to describe the treatment of nearly all psychiatric disorders, is carved out of the rest of health care.
 - Behavioral health care has evolved separately from the rest of medicine and has developed distinct practices, language and staffing.
 - Chronic psychiatric and substance use conditions are not considered to be equivalent to other chronic health conditions by either party to the carve-out.
- There is evidence that those who have a chronic psychiatric condition may die up to 25 years earlier than a similar comparison group. Early death appears to be related to other co-occurring chronic health conditions.
- Numerous studies suggest that those who have a chronic health condition account for a disproportionate share of health care costs.

Reflections on the Current Conditions

- Chronic health conditions, whether considered to be physical or behavioral, tend to co-occur.
- Neither physical nor behavioral health care has been particularly effective in helping people to manage chronic health conditions.
 - Physical care tends to be procedure driven, resulting in episodic, acute care of chronic conditions.
 - Physical care processes rarely provide the time to help people to behave differently.
 - Behavioral care tends to view chronic psychiatric conditions as permanent disabilities, resulting in an emphasis on supportive social services.
 - Behavioral care tends to view chronic substance use addiction as an episodic condition to which it responds with acute care interventions.
 - Behavioral care processes are lengthy and inefficient in relation to the rest of health care.

Reflections on an Alternative

Disability due to a chronic health condition is neither inevitable nor immediate.

Whether physical or behavioral, chronic health conditions pose much the same challenges.

- They can't be cured and so must be managed in order to minimize their impact on a person's life.
- Management, and so health care that supports the management, must be life-long.
- There are relatively effective pharmaceutical interventions for many chronic conditions.
- Pharmaceutical interventions alone are insufficient because:
 - The person's ability and willingness determines whether they use medications to their maximum effectiveness.
 - The person's diet, exercise, environment, and relationships can exacerbate or trigger the condition; or they can ameliorate or hold off the condition.
- The type and intensity of health care that a person needs to successfully manage one or more chronic health conditions can vary considerably from person to person and from time to time.
- Continuous, coordinated and comprehensive care can be more effective than fragmented and episodic care.
- The person's, and the health care providers', expectations about their ability to manage the condition will influence their actual ability to manage the condition.

As the Chronic Care Model posits, effective management of chronic health conditions requires that prepared and proactive practice teams must meet informed and activated patients in optimal encounters.

A prepared and proactive practice team includes all of the disciplines needed for the majority of interventions, working from a unified treatment model, from one set of practices, and from a single treatment plan and record. All interventions are consistent with the others. The team must have the skills needed to address the multiple facets of a patient's life that can influence the success of the management of the condition. They must be capable of assisting their patients to become informed and activated.

Informed and activated patients have the hope, motivation, and knowledge necessary to manage their condition. They are not just the person with the condition, but are also those who are most likely to have an influence on the many factors that affect effective management. They do what will help and avoid doing what will not help effective management.

Proposed team

This is a team designed to serve 1100 – 1300 patients who have one or more chronic health conditions. This number is proposed because it represents enough patients to occupy a full-time primary care physician. The proposed care model is significantly different than the care currently provided by the three partners. In order to achieve and sustain such a significant change in practice, we believe that those who provide the care must be fully committed to the model and not distracted by also providing care as usual. Therefore, the demonstration must be at once, large enough to fully employ those providing the service, and small enough to be manageable.

It will be important to start with a subset of chronic health conditions that are relatively common, tend to co-occur, and for which effective interventions are fairly well known. The first team will focus on: bi-polar disorder, cardio-pulmonary illnesses, depression, diabetes, and schizophrenia.

Substance abuse and addiction disorders (including tobacco use) are expected to be a common co-occurring condition and will also be treated by the team. Trauma, past and present, is also expected to be a part of the lives of many of those served.

Those served by the demonstration team will all be patients of Cherry Street Health Services. A subset will also be current clients of ProAction and Touchstone innovare.

The team will include:

- One primary care physician
- One Physician's Assistant
- 0.5 FTE psychiatrist
- Two nurses
- One nutritionist
- One PT
- 10 Health Coaches*
- 1 – 2 case managers
- 2 peer support specialists/recovery coaches

* Every patient of the team has a Health Coach. The primary responsibility of the Coach is to assist each patient to become informed and activated. This person will use e.g. Motivational Interviewing, Cognitive Therapy and other techniques as they are demonstrated to be successful, to assist a person to be in action regarding their chronic health conditions whether or not that chronic health condition carries a psychiatric diagnosis. The Coach will also provide primary interventions when they are appropriate to the condition, e.g. Cognitive Therapy for depression or addiction. Consequently, a Health Coach will be licensed to provide outpatient therapy or counseling.

Primary and chronic care are both provided by the team primary care physician and PA as any health condition can affect the management of a chronic health condition.

The team implements the Chronic Care Model. It has a single electronic health record and works from one care plan. It coordinates with other specialty and laboratory providers. Over the course of time, the patient may have contact with many of the team members. The type and frequency of services will be as necessary to help a person manage their health. This will vary from person to person and from time to time. This will be seamless from the patients' perspective. He or she will not have to change programs or providers because of a change in health status.

All team members will assist their patients to become informed. There will be many ways to do this ranging from handouts, to classes, to web accessible information. Peer support groups, facilitated by people who have the health condition(s) themselves are an invaluable resource. Information will be consistent, persistent, and appropriate to the patient's culture and stage of activation.

The team does not provide either physical or behavioral health care as we know it. It provides health care as necessary for the effective management of chronic health conditions. There is an understanding that to be effective their patients must accept the reality of their condition,

understand how it may or may not affect their life, have hope and a belief that they are in control over their condition, and have the knowledge and skills to do just that. Therefore, the Health Coach. Team members believe that chronic health conditions can be managed well enough to have a minimal impact on a person's life. There is no presumption of disability and so interventions are those that will help a patient do, rather than to do for them.

Services are available as they are needed. The duration and frequency are determined by effectiveness not by convention. For example, Health Coaches do not routinely provide fifty-minute long bi-weekly sessions. The physical space and work-flow reinforces the attitude of the program. All of the providers are equally available. There are no barriers, hoops, or intrusive hierarchy. There is nothing that would reinforce a sense of stigma, shame, or hopelessness. There is nothing odd about either seeing a nutritionist about one's schizophrenia or seeing a health coach about one's diabetes.