Managing the Coordination of Care Across the Health Care Spectrum

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Burden of Chronic Illness in US

- About 125 million of the 276 million people living in the United States have some type of chronic illness (45%).
- Four chronic conditions affect nearly half of Americans with a chronic disease: asthma, depression and diabetes each affect about 15 million, while about 5 million have congestive heart failure.
- Chronic conditions account for 75% of the US healthcare dollar.

"The Silent Cost of Behavioral Health"

- Depression is the leading cause of disability in the U.S. and fourth leading cause worldwide
- Annual healthcare spending for an employer of a depressed employee is 56% greater than a non-depressed employee
- Depressed employees use 3x as many sick days per month than non-depressed employees, and are more often late or absent from work
- 40% of general hospital patients are being treated for problems associated with substance abuse (non maternity)
- A substance abuser is 5x more likely to file a workers' compensation claim, 3.6x more likely to be involved in workplace accident and is 1/3 less productive than a non-substance abusing employee

Depression:
Pervasive but Often Hidden Co-morbidity

- 25% - cancer patients
- 27% - diabetic patients
- 20% - cardiovascular patients
- 40% - 65% - heart attack patients
- 10% - 27% - stroke patients
- 10% - 15% - new mothers
- 33% co-occurrence of substance abuse

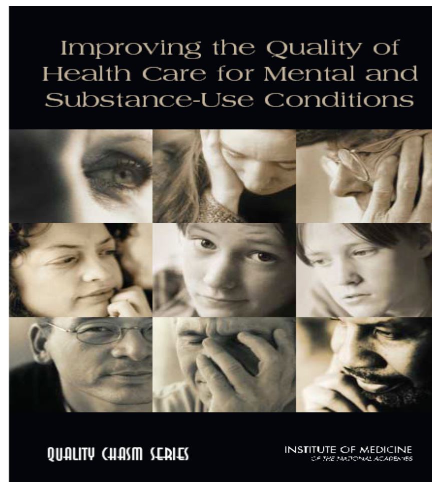
National Institute of Mental Health, July 1999

Depressed Patients with Medical Conditions Incur Higher Costs

Condition	Cost without Depression (PM/PM)	Cost with Depression (PM/PM)
Heart Failure	2.56	6.74
Asthma	3.73	10.56
Migraine	3.82	15.47
Diabetes	13.06	27.28
Ischemic Heart Disease	62.40	110.94

Sheehan et al, Managed Care 11:7-10, 2002

Improving the Quality of Health Care for Mental and Substance-Use (M/SU) Conditions – A Report in the Quality Chasm Series



Health care for general, mental, and substance-use problems and illnesses must be delivered with an understanding of the inherent interactions between the mind/brain and the rest of the body.

Problem 1: Patient-Centered Care
Problem 2: Weak measurement & improvement infrastructure
Problem 3: Poor linkages across systems of care
Problem 4: Lack of involvement in the National Health Information infrastructure
Problem 5: Insufficient Workforce Capacity
Problem 6: A Differently Structured Marketplace

Models of Care Management and Coordination Between Physical and Behavioral Health Care

- Consolidated Model (UC HealthPartners) Motivational - States of Change Model (Prochaska & DiClemente)
- Strengths Model (Rapp)
- Chronic Care Model (Wagner)
- Peer Support Model (DBSA and Others)

UC HealthPartners - Model for Behavioral Health, Primary Care, and Chronic Illness Management

High

Mental Health Status/Needs

Coordinated Primary and Mental Health Care

Intensive/Coordinated Care Management
- **Behavioral Care Management**
- **Integrated Care Management**
- **Bio/Psycho/Social Needs Assessment and Interventions**
- **Chronic Care Management**

Routine Primary Care

Medical Care Management
- Chronic Care Management
- Behavioral Health Screening/ Risk Assessment

Low

Physical Health Status/Needs

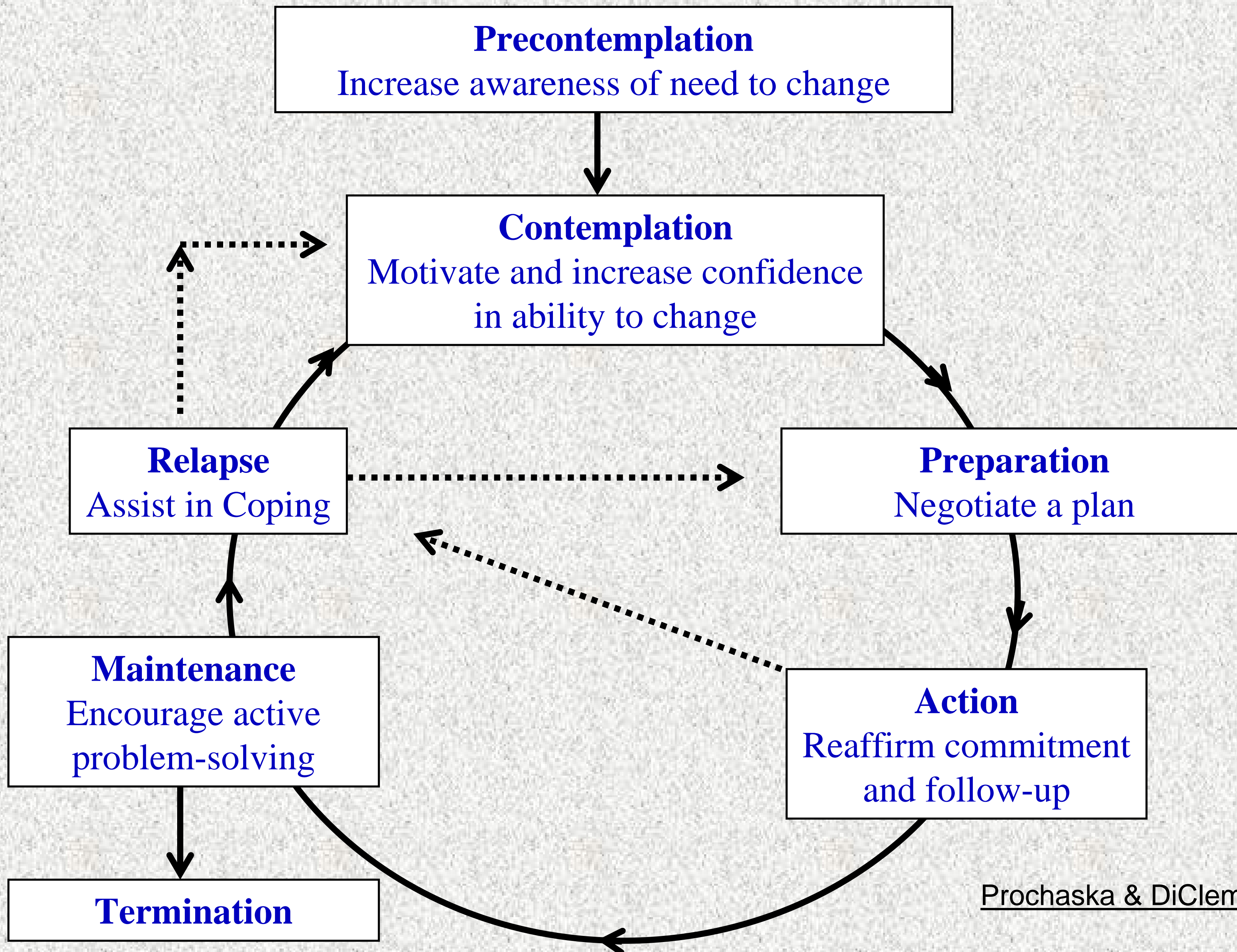
High

Prochaska & DiClemente
Motivational/Change Model

- **How Do People Change? Applies to both Patients and Providers!**
- **People change voluntarily only when:**
  - **They become *interested and concerned* about the need for change**

  They become *convinced* the change is in their best interest or will benefit them more than cost them
  - **They organize a *plan of action* that they are *committed* to implementing**
  - **They *take the actions* necessary to make the change and sustain the change**

Stages of Change Model



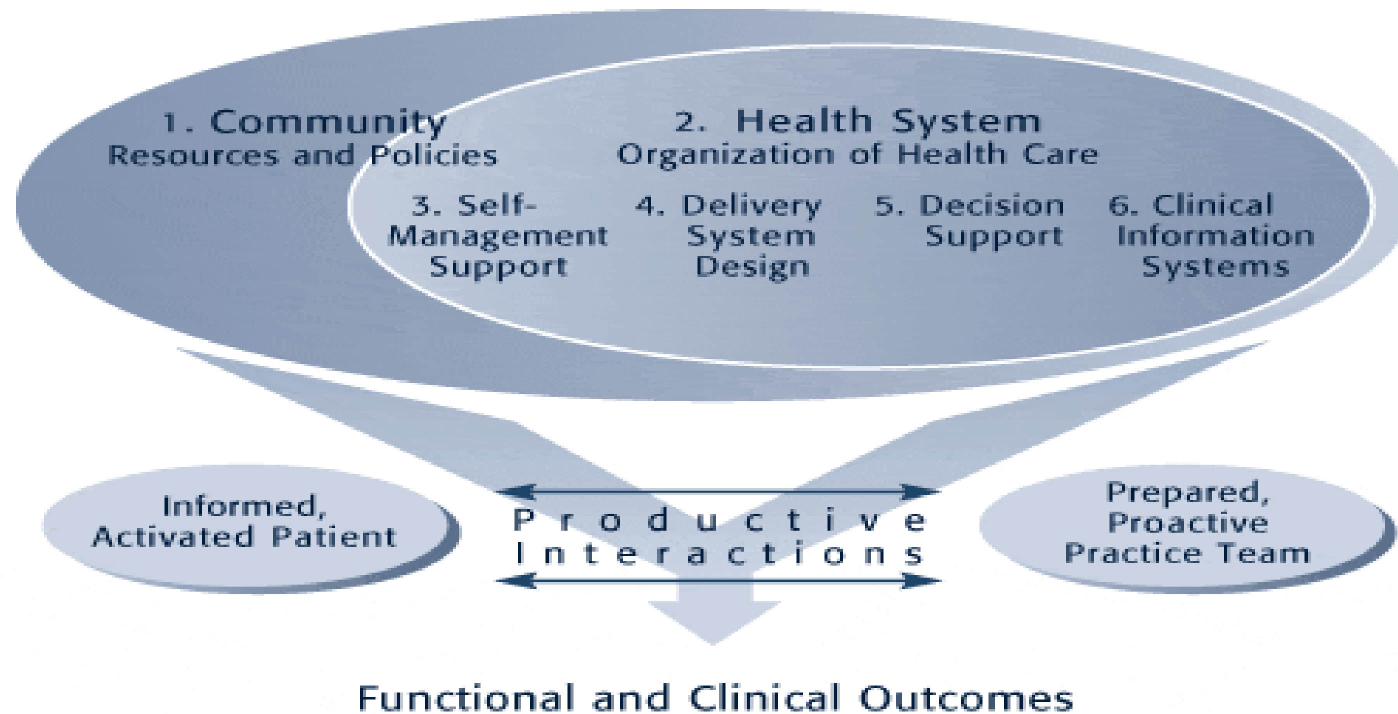
Prochaska & DiClemente

Strengths Model of Care Management (Rapp, 1985)

Principles for Intervention

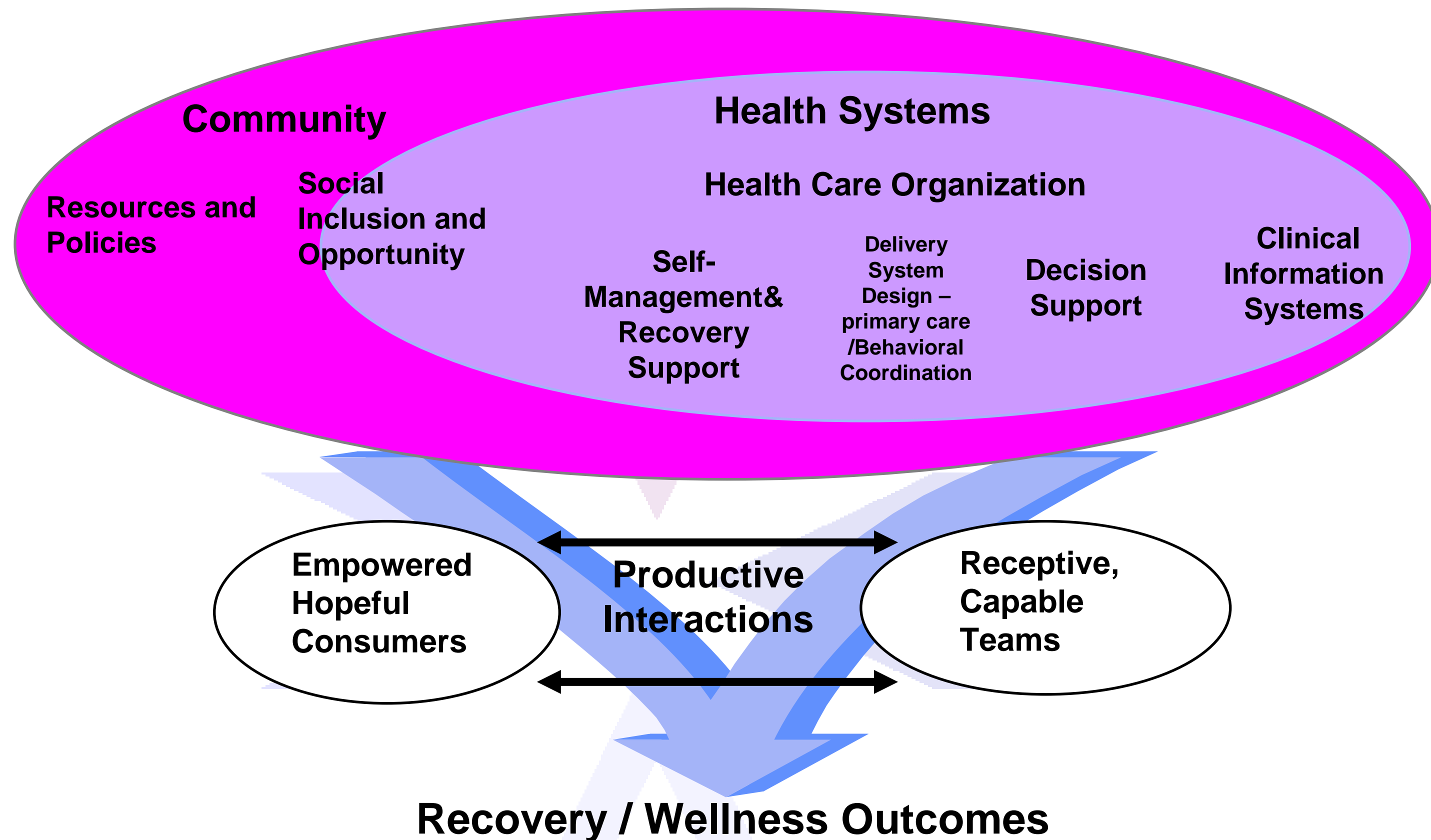
1. The focus is on individual strengths rather than pathology;
2. The case manager-client relationship is primary and essential;
3. Interventions are based on client self determination;
4. The community is viewed as an oasis of resources, not as an obstacle;
5. Aggressive outreach is the preferred mode of intervention;
6. People suffering from severe mental illness can continue to learn, change, and grow.

The Chronic Care Model



The Chronic Care Model emphasizes that patients and their families need to be seen as full members of the treatment team, and interventions should focus on improving self-efficacy in managing not only symptoms, but overall health and wellness.

(Wagner, 1998)



The Chronic Care Model for M/SU care focuses on the important aspects of recovery, social inclusion and opportunity, and empowered hopeful consumers (Daniels and Adams, 2007)

Motivational Interviewing
(Miller 1992)

5 techniques to improve the potential for change

1. Express Empathy
2. Develop Discrepancy
3. Avoid Argumentation
4. Roll with Resistance
5. Support Self-Efficacy

A fundamental assumption of motivational interviewing is "Motivation for change occurs when people perceive a discrepancy between where they are and where they want to be."

The Peer-Support Model
(DBSA)

Goals:

- cultivates peer's ability to make informed, independent choices
- helps their peer identify and build on their strengths
- assists peer in gaining information and support from the community to

Approach:

- Help others create individual service plans based on recovery goals and steps to achieve those goals
- Use recovery-oriented tools to help peers address challenges
- Assist others to build their own self-directed recovery tools
- Support peers in their decision-making
- Set up and sustain self-help groups
- Offer a sounding board and a shoulder to lean on

How to Manage Care?

- What do we mean by "Disease Management", "Chronic Care Management", etc…?
  - Timely, actionable clinical information
  - Evidence-based clinical decision support
  - Care coordination and/or management
  - Evidence-based self-management support / treatment adherence methods
  - May also include member risk stratification, wrap-around services, etc.

Opportunities for Improving and Managing Care – *Medication Compliance Example*

- Sample: 100 New Prescriptions written by the Doctor
  - **20% of Patients never fill the prescription**
- 80 Patients fill prescription
  - **30% of Patients fill them once but never refill**
- 56 Patients refill at least once
  - **30% quit filling before 6 months**
- 40 Patients still filling at 6 months
  - **50% of Patients Quit filling before 12 months**
- 20 patients filling at 1 year –
  - **What is the Care Management Opportunity??**