Strategies for the Implementation of Disability-Competent Care
Integrating Behavioral Health Competency within Disability-Competent Care
May 20th, 2015 - Transcript

Scott: Ladies and gentlemen, thank you for standing by. Welcome to the Strategies for the Implementation of Disability-Competent Care conference call. At this time participants should be in listen only mode. Later there will be a question and answer session. If you require assistance on today's call, please press star and then zero. I would now like to turn the call over to Chris Duff. Go ahead, please.

Chris Duff: On behalf of the Lewin Group, I would like to welcome you to the third 2015 webinar round table session, this one on the integration of behavioral health competency within primary care. As Scott stated, my name is Chris Duff, and I'm a disability practice and policy consultant working with the Lewin Group. The Medicare and Medicaid coordination office at the Centers for Medicare and Medicaid Services have contracted with the Lewin Group to develop technical assistance and actionable tools to support providers in their efforts to deliver more integrated coordinated care to Medicare and Medicaid enrollees.

First, I'd like to introduce you to our platform for this presentation. If your slides are not advancing, please push F5 on your computer keyboard. Also, please note the icons on the bottom of the screen. The second icon from the right allows you to download the slides for this presentation. The Q&A window is open next to your slides. Please enter any questions you may have regarding the presentation, and we look forward to discussing them during the Q&A portion of this webinar.

The other Q&A feature to which you can submit questions and comments at any time we will be using instant polling to ask specific questions to help guide our presentation. To demonstrate the process, here is the first question. In what context do you interface with persons with disabilities? In a primary care setting, different health care setting, as a health plan staff member, or as a community-based coordinator, navigator, advocate? Then the other choice is other. If you could choose one of those and submit, we'll be reviewing the tabulation of the answers shortly.

This series consists of eight webinars running on Wednesdays at this time through June 24th. All of the webinars will be recorded and are available along with a PDF of the slides at the link on this slide--www.resourcesforintegratedcare.com. That is all one word.

In 2013, we published a comprehensive disability competent care software assessment tool describing disability competent care in three pillars. The first being individualized care coordination provided by an interdisciplinary care team. The second thing will be redesign primary care delivery, and third being flexible long term services and supports. This is our third webinar series focusing on specific components in disability-competent care. Resources from past webinar series and this one are available on the RIC website that I mentioned earlier.

Our previous webinar series were all more content laden with little time available for discussion and Q&A. For this series we are switching that around with only summary content being provided to allow for discussion, if the participants are interested. We would like to solicit your

opinion on this series, as well as past webinars and supplemental resources. Please take time to complete the survey at the end of this webinar and to send us your ideas for future topics and content. This is really very important, so that we remain sensitive and responsive to what your individual interests are.

Now, let's go back and review the results of the first polling question. I see the vast majority--a little bit over half of you--are health plan staff members. I'm guessing, as with previous webinars, that it is likely primarily care coordinators within health plans, but there could be other goals for representation from community-based support persons, whether they're coordinator, navigators, or advocates. Other is likely people from policy roles or government.

Today's webinar will be presented by Dr. Andy Jorgensen and Dr. Colleen O'Brien. Dr. Jorgensen is Medical Director for the Everett and Revere Center of the Cambridge Health Alliance and is board certified in both pediatrics and internal medicine. Dr. Jorgensen is a clinical instructor at Harvard Medical School and has been active as a teacher throughout his career. His particular interest includes integration of behavioral health into primary care, the development of the patient-centered medical home, as well as forging ties that lead to healthier communities.

I'm afraid we were not able to include a picture of Dr. O'Brien, but let me assure you she looks very professional and impressive. Dr. O'Brien is Associate Director of Primary Mental Health also at the Cambridge Health Alliance and brings 20 years experience in behavioral health care and quality improvement. She's responsible for advancing an integrated model at the 12 community health alliance primary care sites, introducing primary medicine health, and promoting new rules for therapists and case managers in primary care settings. Formally, she was Senior Clinical Consultant on a Robert Wood Johnson Foundation grant on the treatment of depression in Vermont primary care practices.

Today's webinar is going to be a bit more clinical focused than most of our webinars. We felt this was important to provide a good foundation for understanding and addressing primary and co-existing mental illness with a view in adults with disability. This has clearly been the number one issue that we hear from providers and plans alike, as they struggle with meeting the needs of their participants. After providing some data about the presence of mental illness and substance abuse issues in the dual eligible population, the speakers will proceed to present an overview of tools and approaches by identifying a triage in these issues within the primary care context. They will finish with a discussion of their multi-disciplinary team approach to address these needs.

To provide presenters additional context, I'd like to ask one additional polling question at this point. How competent do you feel in addressing mental illness and substance abuse issues? Choose highly competent, moderately, minimally competent, or not at all. The speakers will review that in a few minutes. At this point, I'd like to turn the presentation over to Dr. Jorgensen and his colleagues for their presentation.

Andy Jorgensen: Thank you, Chris. I'm very happy to be able to speak to everyone today about this very important topic. For those of you who are not familiar with Cambridge Health Alliance, we're an integrated safety net delivery system north of Boston. We have 12 health centers, most

of which are NCQA level three certified medical homes. We've been on our journey for integrating mental health in primary care for the last several years now, and so we're very excited to be able to share with you today some of our experience.

I'm going to start off today just by giving you a little bit of information about the scope. We're going to first review a little bit about the prevalence of behavioral health disorders in the dual eligible population. About 40% of dual eligible enrollees who are under age 65 have a mental health diagnosis. We know that there's a higher rate of substance abuse, higher comobidities of three or more chronic conditions, and we also know that Medicare-Medicaid spending is twice as high for individuals with serious mental illnesses. Because of this, we know that we need to focus on provided better care for these individuals.

We know that the cost burden of untreated mental health disorders is high. Health care utilization and costs are twice as high in diabetes and heart disease patients who also have depression. We also know that nationwide approximately 217 million days of work are lost every year related to mental illness and substance use disorders, this costing employers up to $17 billion a year. This data is old, and so I can imagine that these numbers have only increased. Effective depression treatment in primary care we know lowers total health cost spending. In the study that is quoted, we saw that it was about $3,300 per patient over 48 months. Before we can talk about what we're doing at Cambridge Health Alliance, Colleen is going to talk to you a little bit about different models care that have been used to address this population.

Colleen O'Brien: Thank you, Andy. In our pursuit of the medical home model, we've been moving away from traditional care, where the physician provides a relatively passive individual patient with episodic acute care at the time of illness, toward the model that emphasizes the health of defined populations, especially those living with chronic health conditions. This model offers person-centered team-based care that supports the individual in their self-management goals. It's based on the common sense premise that people are much more likely to follow through with their treatments if they have chosen the goals and less likely to follow through on treatments that are chosen for them.

This emphasis on self care resonates with the behavioral health system's movement towards a recovery and resilience orientation, advising approaches such as wellness management recovery program or Copeland's Wellness Recovery Action Plan. These models are for structured approaches to strengthen the individual's capacity to set goals for improved self management of specific conditions and to problem solve barriers using the resources of the community and personal support systems in addition to formal medical services. These approaches meet the needs of people living with serious mental illness, as well as other chronic health conditions, and they shift the burden for practitioners from symptom monitoring and medication compliance to promoting individuals and families in managing their long term condition. Next slide.

It's interesting to look at the population at Cambridge Health Alliance. When we looked at things by diagnosis listed in our electronic medical record, we were--some of us--shocked to find that primary care patients with psychiatric disorders were 17%, and of those 72% were only being seen by their primary care provider. Patients with addictions seen alone by their primary care provider alone were 68% of that population. Next slide.

These numbers were analyzed before we started screening the population for depression and substance abuse. When we went forward to do that, we used the PHQ-9 to screen for depressive disorders, the GAD-7 for anxiety disorders, and the AUDIT and DAST for alcohol and substance abuse. These draw heavily from models you may be familiar with--the INTACT model for depression care and the ESPRIT model for drug and alcohol addiction. Next slide.

The impact model really stresses systematic adjustments to treatments using evidence-based algorithms with provider consensus, so stepping up the care. It's very aggressive in terms of medication management and dosing, and it really banishes any thought that someone might just be depressed and they have to accept that as a condition, but really looking at those PHQ-9 scores and responding pretty quickly if there is no improvement. Next slide.

One of the things that my primary care colleagues found helpful is when we broke down the mental health and substance abuse population into different levels of treatment intensity. At step zero the primary care teams maintains the lead. That includes screening. That includes brief interventions for people who may have had screens indicating mild depression or the being of risky drinking or a need for psycho-education around unhealthy substance use, but hadn't yet progressed into a moderate severity condition. That support really required behavioral health integration in terms of training and being available to consult, but those folks were people that the primary care teams could be very comfortable managing, as were the folks in the step one. This might require more active psychiatric consultations or case reviews. We did those telephonically, in person, in trainings, and also in the electronic medical record.

In step two we asked that the patients be referred to an integrated mental health provider. In those cases the condition might have been more serious, some more risk--not an acutely suicidal patient, but someone who might be having passive thoughts of hurting themselves, and they haven't responded to earlier intervention. This might be also someone with a milder case, but someone who is isolated and without access to community-based supports.

Then step three and four become more severe. A step three patient might be someone with a serious mental illness but has been stabilized and can be managed during the stable periods within primary care as long as the primary care team is able to step them up during acute exacerbations. Stepping them up would be involving specialty care, the outpatient department. These are complex cases or again cases that have become more acute. Next slide, please.

Andy Jorgensen: I just want to highlight the fact that the step model of care was one of the most important developments as we integrated our behavioral health and our primary care system. If you think about the traditional model, a patient would come in. The provider might try to treat the depression with an SSRI or another single agent and, if not successful, would just refer the patient on. Our health system does not have the resources to be able to provide specialty care for all patients with mental health needs. The step model of care really helped to explain to the providers how to best utilize a very limited resource. That involved a lot of training for these providers, but it really has fundamentally changed our ability to provide mental health access for our patients with disability.

What about substance abuse? When you look at the data around substance abuse, it's very similar to what we see with other mental and behavioral health disorders. You can see on this chart that a patient with co-existing mental illness and drug and alcohol problems cost the health care system an incredibly elevated amount compared to a patient with no mental illness or drug problem. Taking diabetes specifically you can see that a diabetic patient might cost $10,000 per year. Whereas if you take that same diabetic patient and if that patient also had a comorbid mental illness and a drug or alcohol problem, the cost is three to four times as much. Next slide, please.

What did this tell us? This told us that we needed to really get to know our patients better, and we did that by developing improved screening. What we did was we employed initially what is referred to as the National Institute and Alcohol Abuse and Alcohol One Screener Questionnaire and for drug abuse, the National Institute on Drug Abuse One Item Screener for drug abuse. Patients who were positive for either of those were then screened further with the audit which is the Alcohol Use Disorder Identification Test or the DAST-10 which is the drug abuse screening test.

When we first started to do this, we were really afraid because of our population that lots and lots of patients would screen highly positive which would then require us to find resources for them that we maybe didn't have. Once you can re-stratify patients, patients with addiction we were able to refer to specialty addiction treatment, which is really only maybe 3-5% of the population. For at-risk patients--and this is where it is very important--we were able to educate the patients more about the risks of unhealthy alcohol or drug use, with the main purpose of trying to decrease their risk for consequences or progression of disease.

If you can ask your patients about their alcohol and drug use, you then have the opportunity to provide more education which then decreases the likelihood of needing referral for more advanced care. Then, of course, for patients not at risk, educating patients about risk and discussing and promoting healthy norms with them was very important. Next slide, please.

This slide just explains what I was referring to previously, trying to help explain a little bit more about the screening and assessment tools that we choose to use. Next slide.

This will explain to you a little bit in more detail what we actually did. This again was a great tool for the providers that we developed--both the behavioral health providers and the primary care providers--to really help them understand how to use these tools we were providing. You can see that for most patients they received just a brief screen which for most patients is just two questions at their annual physical or when they're new to the clinic. If those two screens are negative, we would reinforce the healthy behavior. If they are positive either for the NIAAA 1 or the NIDA 1 or both, they would receive one or the other or both additional assessment tools. That again led us to re-stratify the patient. Patients who were very high risk, that provided an opportunity to help assess the patient's willingness to change and then to refer to higher levels of care if necessary, and for patients with moderate risk, to help reinforce healthy behaviors.

I'm now going to have Colleen talk a little bit more about how we address the substance abuse needs of our patients by helping to assess risk and set goals for our patients.

Colleen O'Brien: Sorry. I was on mute. The process of change that we embrace when addressing substance abuse needs is the same process of change that we would consider for any change in behavior. We're talking now about how this relates to substance abuse, but I think it's important to stress that these same steps would be relevant for someone changing their behavior to better manage their depression or to better manage a chronic physical element. It's all about really beginning to have a self care plan and take responsibility for implementing and revising that plan.

In the pre-contemplation stage, the goals of the therapist or anyone else on the primary care team is to establish rapport, raise doubts about the discrepancy between the person's goals and their behavior, and increase the patient's awareness of risks related to their behavior.

In the contemplation stage, we want to use behavioral activation and motivational interviewing to elicit reasons for change and evaluate new consequences of remaining the same and really eliciting self-motivational statements from the patients that we can then go back and address their ambivalence about change in their words.

In the preparation stage, we want to help them by offering a menu of options for change or treatment in helping them think about which ones would be easier for them to begin with. It's important to really set very achievable goals initially and be quite realistic about steps to take to begin. In the action stage we would be again and again be looking at taking very small steps and being realistic.

In the maintenance stage we would help the patient identify and use strategies to prevent relapse. It's important to include relapse and discussion about relapse in the discussion of behavioral change, primarily because once folks who have committed to making a change relapse they often give up. We want them to see the relapse as a little experiment in what works and what didn't work and really not get caught up in a lot of self-defeating thinking, but look at that as an opportunity to explore what went wrong, what was the trigger, how could you better plan for that trigger. Next slide, please.

The team structure is taken from the AIMS center. The patient is a member of the team. The primary care provider is. The patient is dealing directly with a care manager as well as directly with the primary care team. There may or may not be a therapist or a psychiatrist involved, and there may or may not be referrals made to external community-based resources.

The new roles in this model are a care manager that's trained with very specific skills around coaching using MI techniques--motivational interviewing techniques--and engaging the psychiatric consultant in a collaborative way for trading and also very frequent case review. In an hour at a primary care center a psychiatric consultant could come in and see one patient and do one assessment, or they could sit down with a small team of care managers and look at a chronic illness care registry for depression or substance and address the needs of patients who were not improving. The care manager can integrate any feedback about behavioral changes that the treatment team could make to make some progress in the treatments.

Andy, do you want to talk about some of the challenges we face?

Andy Jorgensen: Sure. Thank you, Colleen, but before that lets take a look at the poll results just to get an idea of everyone's comfortability with mental health disorders. Let's see if I know how to do this thing here. We're going to push the poll results. The results here are very similar to the results at Cambridge Health Alliance when we started our integration of mental health and the primary care. Very people felt highly competent, especially on the primary care side, and 41.6% is what you had for moderately competent, 53.3% for minimally competent. I would say those are very, very similar results to what we experienced.

For mental health providers, many do not feel very comfortable with the substance abuse issues. That was one of the barriers we had to overcome was hoping to help our mental health colleagues feel comfortable dealing with significant population with substance abuse issues. What I want to review next are just what some of the challenges were that we faced as we were trying to do this at Cambridge Health Alliance.

Really one of the most important things was changing the idea that the mental health team would have one clinic and the primary care team would have another clinic, so really having the physical space and the time necessary for real team development. Having the mental health providers sit with the primary care providers in the same space was tremendously important to developing real teamwork.

Another significant issue is the fact that behavioral health and primary care providers come from very different cultures of care. One example of this is the idea that primary care providers are very much used to following patients for a lifetime and managing a population over time and being concerned about population quality metrics. Mental health providers--the goal of their care is really termination--to achieve a goal and to move on, to have very firm boundaries. Their treatment relationships are very process oriented, time dependent. A lot of the work is for the patient, whereas between primary care and the patient it's really focused on the entire team taking care of the patient and moving to a structure in which the behavioral health team members embrace a similar team approach required a lot of culture change.

Another challenge that we found is that--and it remains difficult to measure success. In fact, we had to create a lot of our own metrics to determine success--this is a process that is new in many different areas, and so a lot of the metrics that have been developed have not been validated. Benchmarks are still being established, and there is not a lot of data yet that really shows the impact on total medical expense other than some of the data that I showed you earlier.

Finally, another challenge is that community resources are often very transient and limited. You may develop a great relationship with a community partner and then their funding source is eliminated and they're gone, or a local mental health agency closes their doors. Having people that actually help connect the patients to these resources is equally limited. A lot of time is spent really thinking about what community resources and partners are available and trying to foster and encourage their development.

I have two summary slides, and I want to really in the next slide focus on some of the big lessons. These are really some key points. The number one thing is that it is very important to learn about the population you serve by screening all patients for mental health and substance abuse disorders. We had no idea when we started screening some of the concerns that some of our patients have. Mental health and substance abuse disorders are stigmatized. They're not things that patients are always willing to talk about. Using validated screening tools really helps to begin the conversation with the patient. Providers often underestimate the demands or the resources that are needed--the services that patients require.

Secondly, we found that the physical co-location of mental health and primary care providers is paramount and key to clinical integration. It's not just enough to share a medical record or share a population of patients, but physically having the providers sitting near each other to develop team and to be able to do warm handoffs and to really talk about patients is really important.

Then finally the allocation of the limited resources requires both developing partnerships with outside agencies, as well as training our frontline providers and staff to confidently provide screening and brief interventions. That's really what the step model of care is all about. It's looking at the resources that are available and really figuring out how to best utilize those resources that are available.

Finally, I'd like to summarize, and then we'll have time for a robust conversation. The first step is really to establish a primary care relationship with the participant and enabling an opportunity to identify and assess behavioral health and substance abuse needs. It's that relational way of providing care that is the first step. Once issues are identified, using a step model to guide the intervention and support is critical. This helps to deploy resources effectively, efficiently, and providing patients access to those resources.

It's important to recognize and reinforce the role of the lead communicator from the team of persons working with the individual. By that we mean really identify individual that helps coordinate the care of that individual. For a lot of patients that's your care manager. The care manager is a great way to make sure the patient is staying connected and a collaborative relationship is happening with all of the stakeholders involved in caring for the patient.

Finally, the key, as with all interventions, is to start with where the participant is and to attempt to move them towards helping with sustainable strategies of support. We talked a lot about walking along with our patients through their life and starting where they are and helping them get to the goal that they're willing to meet at this time. With that, I'm going to turn it back to Chris.

Chris Duff: Thank you, Dr. Jorgensen. I appreciate your presentation and you too, Dr. O'Brien. I'm eager to hear questions from the audience, but before those questions I'd like to ask one last polling question here. Are you interesting in hearing additional webinars on the topic of addressing mental illness and substance abuse issues, either as primary or co-existing conditions, perhaps with the use of more concrete, first-person stories? Please respond here as you can. We'll go over those in a minute.

At this point, Scott, could you give instructions and open the phone line?

Scott: Certainly. Ladies and gentlemen, if you wish to ask a question, please press star-zero. You will hear a tone and an operator will take your name and further instruct you. If an operator has already taken your name, please press star and then one. Again, star-zero for a question.

Chris Duff: Thank you. Before we get started, I want to go back to just--if you could put up slide 18--and I think Dr. O'Brien, in some ways, that slide really talks about what this webinar has been leading to which is the collaboration of the team structure. Could you talk a bit more about that, since so many of the people on the phone line are care coordinators. Now, many of them are based in the community--not within the clinic, but could you talk a bit about the role of the care coordinator in this model here and how that care coordinator may work with a community-based care coordinator?

Colleen O'Brien: In this model the care manager would have very, very specific training in behavioral activation and motivational interviewing. The coaching and the support that they're offering is really to help the patient develop a self management plan and be motivated to follow that. Attending an AA meeting might be one of the self management goals that's happening in the community or participating in another agency's programming. In that sense there would be coordination between the two agencies. The other important piece that this care manager does is tracking the progress of the population in a registry that's built into our electronic medical record so we can work more intensively with patients whose scores indicate that they're not improving.

Chris Duff: Great. Thank you very much. That does kind of go hand-in-hand with one of the questions we've gotten, which is what I experience is that many of our primary care providers--no, I'm sorry. I'm looking at a different question here. I commonly find that our members have both primary care practitioners and mental health providers, but they aren't in medical communication nor collaboration. They're obviously at Cambridge Health Alliance, so they're in different organizations. How do you guys handle an externally-based mental health provider, whether it's CD or a mental illness, and how do you coordinate that with the primary care that you're trying to provide in house?

Andy Jorgensen: That does remain a challenge. We've made some progress in that area through our complex and care managers in the sense that having someone who can get release of information between the mental health clinic and the primary care clinic at a rigor that allows conversations about mental health concerns for patients and also helping to activate the patient to also be part of the bridge that helps that communication happen. This is an issue that occurs all of the time for my patients who are seeing psychiatrists and therapists outside of Cambridge Health Alliance. As a primary care doctor, I may want to know--the patient may not know what dose of medication they're on or what their treatment plan is what goal activation techniques are being used by the mental health provider, and so it does remain a challenge and it's an important one that we need to figure out.

Colleen O'Brien: I think we're fortunate to have an outpatient department within our system. Even though we can get into our separate silos with that, we do have a shared medical record and shared documentation, and we've done a lot of work this year to separate highly sensitive

information that may remain confidential between the patient and the mental health provider from information that's helpful for the entire treatment team to understand. We get the patients to sign the release when they come into primary care that we will work together as a team. We're still working around some of that for addictions because the laws are different and we haven't tackled the addictions laws yet.

Chris Duff: Thank you. There is a question here from Mary Martin. Do you all have any particular strategies for working with individuals who have cognitive issues in the pre-contemplation stage?

Colleen O'Brien: I can take that. I think the pre-contemplation goal for the therapist with any patient is really just to help develop the awareness of the cost of the behavior and looking at how the patient views the stresses in their life--maybe using alcohol, for example, to relieve a certain stress. You could honor and respect their need to reduce that stress or to feel more comfortable in social situations.

Some of the training that we recently went through with the Mass Bureau of Substance Abuse training actually did a roadmap where you talked about all of the destinations where the alcohol or addiction where the patient was trying to get to and honoring those destinations, but then providing healthier roads to get there. That analysis would then inform subsequent sessions, so there might be specific skill-building modules that you would employ around social anxiety that would help shore someone up so they weren't as dependent on the addictive substance to get to that destination.

Chris Duff: Thank you. We've got a couple of questions that are all kind of around a similar issue and that's the issue of the participant or consumer or patient--whatever language you use--and the disability competency model with each participate, but about the primary care practitioner and the behavioral health competency practitioner talking with each other. Can you guys talk a bit about how often? I'm sure you pick up some concern about that. How do you address that concern and is that really--do you not hear it that often or do you hear it a lot and then what are your strategies for addressing that? Perhaps each of you could clarify. I think it probably first happens on the primary care side. Andy, would you take a first shot at this?

Andy Jorgensen: Yeah, so I'm going to first answer a side question that I'm reading here which will lead to the answer to the other question. One person asked how does the patient feel about the whole integration process itself? I would say that the patients are very excited about how they improve the access to care, and we've also noted more patients completing therapy and also reaching goals of care and also having improvements in their PHQ-9 scores for depression as well as their GAD-7 scores for anxiety. We know that patients are getting more care, they're getting better care, and they're getting some of the quality metrics we've developed that have improved. With that said--

Chris Duff: That's phenomenal.

Andy Jorgensen: --patients do have the opportunity when we refer them to their mental health provider to request that the information is not shared. I'll let Colleen address a little bit about

how those discussions happen with the patient, because obviously some of the issues that are causing the patient to not want to share the information with the primary care may also be the same issues that are the source of part of their depression and their anxiety. There can be a process by which maybe part of the patient's treatment goal is actually to feel comfortable sharing that information. It does get complicated, but as Colleen said, we've spent a lot of time really negotiating between the culture of mental health and the culture of primary care. It was a several-year process of actually figuring out what information could be share, what information could be opened in the electronic medical record, and figuring out how to get the proper consent from the patient.

Colleen O'Brien: Having participated in the discussions with the mental health providers that did not include primary care, it became obvious to me that the kinds of information they didn't want to share were not things that the primary care providers had time to read anyway. What the primary care providers really wanted to know was, was the patient making progress using these interventions or did something else need to be done. They really didn't want to get into the details of family dynamics or who traumatized who. It just really isn't relevant at the pace that they're working. I think part of it was really understanding that what we need to keep our primary care colleagues up to speed with was really just the status of the success of our interventions. People's anxiety came down when we could really tease out what was more process-oriented information that you would share with a clinical supervisor in behavior health and what was the treatment progress that you wanted to update on the care plan.

I think the other piece is I haven't had anyone raise issues about confidentiality in my work in primary care, and I think that's because my referrals are coming from the primary care provider. Some of the clinicians that I work with feel that one of the most exciting parts of the work is that the folks that they're seeing are not folks who would present for outpatient psychotherapy, but they're making that contact because they're already connected to a primary care provider that they know and trust and they're comfortable in that primary care setting. When we're integrated it's just a part of the team and introduced as someone that can help with questions related to depression or problem solving, the barrier is broken down right there, and I don't see a lot of concern. I've had more concern about people not wanting to share their immigration status than I have about confidentiality related to mental health.

Chris Duff: Those are great responses and actually quite helpful. I think especially what primary care is interested in isn't the nitty-gritty of may be being shared within the mental health relationship. That just makes a lot of sense. I should think that the resistance would go down once that's explained, so thank you for that very much.

We have a question here from Shannon Creole. Hello. There is a great deal of turnover in care managers. I think she's probably talking about within health plans. How do you deal with that in order to continue making rapport with the team structure both within? I think that probably refers to care managers within clinics as well as within health plans.

Andy Jorgensen: From my perspective, I'm thinking about we have two complex care managers who are--this is a little side from directly with just behavioral health patients--but most of our complex care patients are behavioral health patients. They're been in their role since their

creation two years ago, and I'd have to say the number one thing is they really feel as engaged parts of the team. The providers really feel and let them know all of the time how valuable they are, and we also make sure we share stories of success. We are celebrating the successes. We're working as a team. We're in constant communication. I think because of that they feel really invested. Working with complex patients can lead to burnout. Acknowledging that and having an open communication really helps.

Chris Duff: Thank you. Scott, are there any questions lined up on the phone line?

Scott: There is a question from the line of Victoria Haltom. Go ahead, ma'am.

Victoria Haltom: Yes. I was concerned about the care manager thing too--the number of people that they're responsible for--what is the ratio of patient per care manager?

Colleen O'Brien: I don't think that we have decided that yet. I don't know what it is for complex care manager.

Andy Jorgensen: I can say most complex care managers are covering maybe like 75 patients.

Colleen O'Brien: That sounds right.

Chris Duff: That's the kinds of numbers I hear across the country too--between 60 and 75.

Colleen O'Brien: Yeah, which is very challenging.

Chris Duff: That's still a lot.

Victoria Haltom: Yeah. That's what I was concerned about--was the breakdown in communication just for the sheer number of people they're responsible for.

Chris Duff: Go ahead, Colleen.

Colleen O'Brien: No. That was someone else.

Andy Jorgensen: I was just going to say the big difference with us is that these are embedded care managers now. We have worked with health plan care managers, and that's an entirely different challenging set of circumstances. I think what's worked best--and we have worked with health care managers--is for our care manager to be connected with a geographic population or with an health system instead of having a care manager in many different health systems trying to group their patients within health systems so that they have that ability to develop team-based relationships with the primary care and mental health providers.

Colleen O'Brien: I think the way that we have staffed it in our model for the behavioral and the mental health care manager is one for every 10,000 patients in the population.

Chris Duff: I think we're going to have a webinar towards the end of series that's going to talk a bit more about this, but the whole issue of how do you stratify allocation of staff and staff competencies to the unique complexity of individual populations who you serve. It's certainly something that is at this point more an art than a science. Of course, it makes a difference whether you're in a health science or a provider setting.

I'm going to ask one more polling question before I go to another question. That last polling question is--just if you could put it up--are you interested in additional webinars? Ninety-one percent of you said that you are interested in more. I think one thing we might want to do--and it might even be good to bring back these speakers if they would be so willing--would be to actually use a few individuals--we call them first person stories instead of case examples--just to kind of talk through and maybe get someone from a health plan involved just to talk about how does that communication go back and forth. The response here doesn't surprise me, because this is a major issue but especially those that we saw in earlier slides--those within primary care--this is a challenging issue but for those outside of primary care it's even more so. This slide I think speaks to that.

The last question I'm going to put forward is a question that we got from Carol Winter. That is--and I think it probably goes to Colleen--can you provide more examples of the personal center planning and the recovery model, and are there studies supporting it, and especially the recovery model?

Colleen O'Brien: It varies--a lot of research behind the two models that I mentioned. I think the differences between them is the emphasis on the recovery model is on really the development of peer supports and community-based supports, and the emphasis on the patient-centered model is that the patient is defining their goals for their care and that they want to prioritize their diabetes or their depression and working with their care team to set goals that they're invested in. That's how I would contrast them. I think that there's a lot of overlap and that they've been developed on parallel tracks with the recovery model coming more from the recovery community.

Chris Duff: That makes total sense to me and clearly the patient-centered model is a policy engine that's well out of the station. The government has made it very clear that that's where we're going, especially on the Medicaid side, but even on the Medicare side and follow-up programs that that's a given. There is some decent research. What I see is that the recovery model is still something to have. It allows providers on the more traditionally medical side more scratching their heads about and not quite sure how to do those linkages. I think from the consumer perspective, I see it coming out of the clubhouse model. I think that was started in New York. I might be wrong, but where it's really a peer support, as you said. The clubhouse model was a center where people can go to, to just hang out and be with each other that wasn't a typical adult day program.

They are more complementary and anything. I think a challenge then is how do you align people. How do you make sure that we are interfaced with the participant in a personal-centered manner so all of our planning is done in that manner? Then how do we incorporate as much a recovery model in our discussions and help the participate hook up with the community-based services and opportunities or support systems that are available for them?

At this point I think we are going to wrap it up here because we're at the end of our time. There are a few questions that we've received that we weren't able to answer and we'll make sure we get that to those individuals offline. Next week at this time we will explore approaches to creating a disability-competent care network. Again, that will be presented by previous presenters, June [Kales] and Dr. Adam Burroughs.

Everyone who has signed up for this webinar will receive notice about future webinars and tools or other resources we are able to provide. I would like to again thank the speakers for your presentation today, and we look forward to continuing to work with you. Please, please take time to go through the survey on the slide to give us some feedback now in this webinar, from other webinars, and what your needs are for the future. It's very important to us that we are beginning to think about where we go from here and we need your ideas. We would really appreciate your taking the time to do that.

At this point, thank you, Dr. Jorgensen and Dr. O'Brien. We appreciate your time and we may be calling upon you in the future.

Andy Jorgensen: Thank you.

Colleen O'Brien: Thank you.

Chris Duff: Thank you.

Scott: That does conclude your call for today. Thank you for using AT&T Executive Teleconference. You may now disconnect.