Secondary Driver 1.3: Risk-stratified Care Management

Risk stratification is a critical starting point of effective population health. It provides a powerful framework for strategically allocating practice resources toward patients who need them most. Risk-stratified care management allows practices to assess the needs of the entire empaneled patient population, stratify that patient population into risk levels, then proactively develop, and match resources to meet those needs.

Change Concepts for risk-stratified care management

- Assign risk status
- Longitudinal care management
- Episodic care management
- Integrated behavioral health
- Medication management
- Self-management support

Risk Stratification and Care Management

- **Risk Stratification** is a process that uses established criteria to evaluate each empaneled patient to an assign risk level based on his or her current health. This process often requires the use of data from registries and payers as well as provider evaluation. Using established protocols and based on this information, care teams assigned patients to a risk level.
- **Care Management** includes coordination, oversight and education activities conducted by health care professionals to help patients with chronic diseases and health conditions such as diabetes, high blood pressure, chronic pain and depression to live with it successfully. The work involves motivating and supporting patients to develop skills to enhance their quality of life. Care management can be **longitudinal** (ongoing, relationship-based for patients of high or rising risk) or **episodic** (short-term, goal-directed for patients not otherwise identified as high risk).

The phases of the work in CPC

- Before CPC practices began risk stratification, they empaneled their patients (see **Driver 1: Comprehensive Primary Care Functions**, "Change Concept: Empanel all patients to a care team or provider" on page 4).
- Once empanelment was complete, practices identified a risk-stratification methodology appropriate for their patient populations.
- Once practices stratified the patient population into levels, they documented it in the practice EHR.
- Over time, practices honed their risk-stratification methods, using multiple sources of data to refine the process.
- With an initial focus on patients at the highest level of risk, practices developed their care management strategies. They continually fine-tuned these processes to meet the patients' needs.
- Practices initially integrated at least one advanced primary care strategy for patients in the highest risk cohorts: integrated behavioral health, medication management or self-management support. As their expertise with these strategies grew, many practices then directed these strategies toward patients experiencing rising risk.

Change Concept: Assign and adjust risk status for each patient

Having a tool to stratify patients according to risk is essential to the management of any population health initiative. Assigning risk status is particularly important because comorbidities significantly increase health care costs.[1] To provide targeted care management, practices must first identify a risk level for all patients with a standard methodology. Once the practice has assigned a risk level to all patients, care teams can focus their attention and resources on those high-risk patients who are most likely to benefit from care management.

Other benefits included the following:

- Reallocating staff to support higher need panels (supporting sustainability of panel without reducing panel size)
- Designing workflows to have different team members support sub populations, optimizing the team
- The ability to track patients between tiers
- The ability to produce data to negotiate incentives with payers

Implementation tips for assigning risk

- Identify a risk methodology.
- Determine how the risk stratification affects panel balancing (see empanelment).
- Develop a plan to assign risk to both existing and new patients.
- Test the plan with one team's patient panel and in new patient visits.
- Assess if the methodology accurately stratifies panel and assigns appropriate level of risk.
- Scale across all panels and for all new patient visits.
- Determine how your practice will reassess risk levels and rebalance panels.

Risk-stratification Tools

Several different methods are available for stratifying a population by risk:

- **Adjusted Clinical Groups (ACG):** Often used to forecast utilization rates, the ACG measures morbidity. Johns Hopkins University developed the ACG using populations from commercial managed care plans. Thus, its case-mix risk-adjustment methods more closely resemble the general patient population rather than those from Medicare.
- **American Academy of Family Physicians (AAFP) methodology:** This risk-stratification tool incorporates current health status, social determinants and utilization to evaluate patients' risk in a six-level framework.
- **Charlson Comorbidity Measure:** Charlson predicts the one-year mortality for patients based on their diseases and comorbid conditions. Conditions and diseases are weighted (1 to 6) based on the risk for dying from each condition. The sum score is the patient's risk for death.
- **Chronic Comorbidity Count (CCC):** Using data from the Agency for Healthcare Research and Quality (AHRQ), this tool groups selected comorbid conditions into six categories. A patient's risk score is the sum of scores from those categories.
- **Elder Risk Assessment (ERA):** An index score is assigned to adults over 60 based on age, gender, marital status, number of hospital days over the prior two years, and selected comorbid medical illness.
- **Minnesota Tiering (MN):** This tool calculates a patient's complexity by tallying the number of major chronic condition categories the patient has.

[1] Purdy S (2010). Avoiding Hospital Admissions, What does the research evidence say? London: The King's Fund

More information is available in the Risk Stratification Implementation Guide. CPC practices described their approaches, which varied in complexity, ranging from a simple checklist to an elaborate grid with scaled values for risk factors. Some of their tools easily integrated into their EHRs.

The key consideration in selecting a risk stratification approach is to find one that best fits the practice's patient population, works with the practice EHR, and can fit into the practice workflow.

Change tactics CPC practices have used:

- Use a consistent method to assign and adjust global risk status for all empaneled patients
- Monitor the risk-stratification method and refine as necessary to improve accuracy of risk status identification

CPC resources related to risk stratification

Risk Stratification Implementation Guide (2014). This 23-page guide captures how CPC practices tested and implemented a range of risk-stratification methodologies. Sample tools are included. https://downloads.cms.gov/files/cmmi/cpci-combined-implementationguide.pdf#page=35

CPC Practice Spotlight 2: SAMA Healthcare (2013). SAMA Healthcare describes its risk stratification tool in the EHR. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=6

CPC Practice Spotlight 6: TriHealth (2014). Using a standardized process, this practice established a four-level care management needs assessment as a means to identify patient risk level. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=14

Change Tactic: Use a consistent method to assign and adjust risk status for all empaneled patients

Using a consistent method to assign and adjust risk status is the first step to planning and implementing a care management strategy. To effectively accomplish this, clarify the type of risk being assessed, the targeted patient populations and health outcomes desired. This allows the teams to be clear about what they are tracking, the frequency and the goals for the interventions used. Reliability of the method and processes will be pivotal in ensuring patients receive the right amount of resources, with the right team member at the right time.

Essential components

- **The method aligns with practice resources and population needs.** The selected tool allows the care team to stratify each patient by using an established set of rules. The tool may have various risk levels, ranging from a three-tier model (low-medium-high) to one with five or more levels. The key is to implement a tool that enables the practice to stratify patients in a way that the practice can appropriately apply its resources. Most importantly, it must be easy to use.
- **Develop a defined workflow.** To mine data on the patient population in a way that informs the risk stratification process, each patient must be empaneled to a primary care provider or care team in the practice (see **Secondary Driver 1.1: Access and Continuity,** "Empanel all patients to a care team or provider," page 4). Once the team has its panel of patients, the EHR should provide the patient information needed to assign a risk level to each patient. Multiple criteria may be used to assist with risk stratification and obtain a patient list, but these are some of the basics:
  - Patient name
  - Age
  - Chronic diseases
  - Medication profile (look for polypharmacy)

  After obtaining the initial patient list and data, care teams should add any pertinent considerations based on their knowledge of each patient to the patient information section in the EHR. To capture a complete picture of the patient for risk stratification, all care team members should contribute their considerations as input. Those considerations could include social, emotional and environmental factors as well as family dynamics and cognitive ability. The assigned risk level should correspond to the patient's care management needs. Typically, practices prioritize patients in the highest risk levels for care management.

- **Document risk levels.** The team should decide where to document patients' risk levels so the entire team can easily access them, including the front office personnel. Risk levels should influence how the practice carries out standard protocols. Appointment availability may have a different urgency for a low-risk patient than a high-risk patient. If patients in the high-risk stratification call with an issue, the provider may ask the care team to rapidly triage the patient. Medication refill is another area that may have a different management process for the high-risk patient. When all practice teams can access a patient's risk level, they can make better, timelier decisions regarding the patient's care.
- **Review and update patient information.** Practices must update the information and re-stratify patients when their conditions change. For high-risk patients, care managers play a key role in updating patient records and collaborating with other team members on assigning risk for that population. Every hospitalization, emergency department visit and every instance of patient and practice contact (including care management calls) should result in patients' risk levels being re-evaluated. An additional annual risk stratification review of the entire patient population helps practices stay current on patients' care needs.

Considerations for your practice

- Choose a risk stratification method that will divide the population into levels that define the required amount of care management.
- Set schedules for reassessment tailored to the patient populations. Providers should reassess seniors approximately on a quarterly or semi-annual basis, whereas a yearly assessment is sufficient for younger patients.
- When transitioning patients between levels of care, consider these factors: psychosocial evaluations, stages of disease assessment of functional status and clinical input from the care team.
- Solicit your teams' input and feedback to evaluate the risk stratification tool's relevance, reliability and ease of use.

Change Tactic: Monitor the risk-stratification method and refine as necessary to improve accuracy of risk status identification

The practice must regularly monitor its risk stratification method for effectiveness. Risk stratification directly affects which patients need care management services. Further, it guides all of the practice team members in their actions for patient care. Practices should modify their risk-stratification methods to ensure they meet both practice and patient needs.

Essential components

- Assess the risk-stratification method. Continually assess the efficacy of your chosen risk stratification tool. Your clinical quality and utilization data can aid this evaluation, in addition to care management resources.
- Monitor regularly how patients are stratified, checking for appropriate assignments in each risk level.
- Modify to improve the method's effectiveness as needed. If your practice's care management resources are strained, or if your practice identifies adverse trends in utilization and outcomes data, your risk-stratification method may need to be further refined.

CPC resources related to risk stratification

CPC Practice Spotlight 22: Heeding the Signs: Know When It's Time to Modify Your Risk Stratification Methodology (2014). This example shows how a practice changed its three-tier risk stratification methodology after noting some trends that the team found troubling. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=44

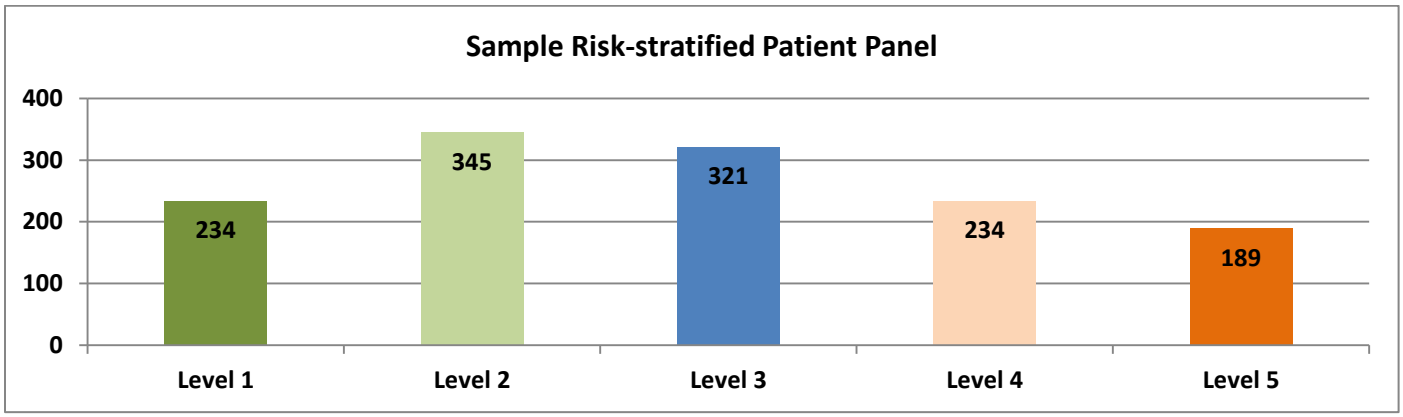
Considerations for your practice

- Engage care managers, providers and other team members when evaluating your current method's effectiveness. Their input about how to refine the method will ensure the entire practice team's needs are considered.
- Expect to see shifts in patient risk scores as your practice refines its work in other comprehensive primary care capacities, such as timely follow-ups to hospitalizations and ED visits, self-management support and active care management for high-risk patients.

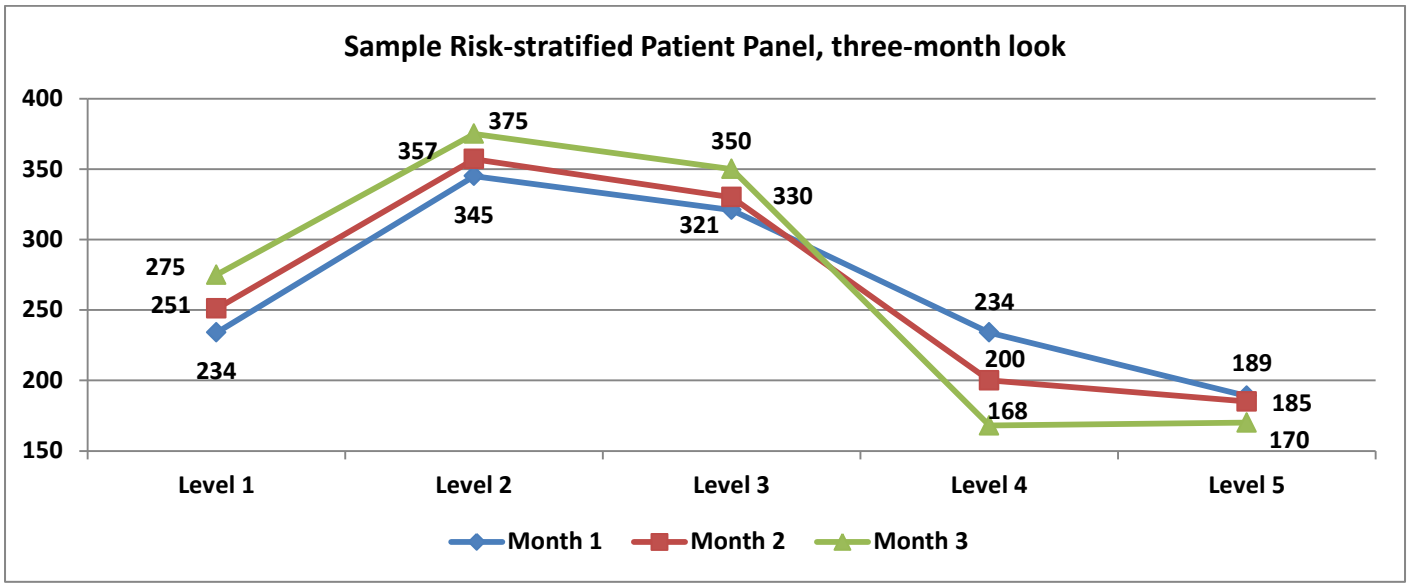
Measuring Success for Change Concept: Assign and adjust risk status for each patient

Risk stratification is fundamental to population health and care management. Continually monitoring this data will be key in balancing providers' and/or care teams' patient panels. That balance is critical to ensuring reasonable management of workloads.

See below for a sample patient panel. Level 1 is the lowest risk strata; level 5 is the highest.



Displaying the data in this or a similar format can help practices assign and adjust resources as necessary. To monitor how patients are moving between levels, run the data monthly. The run chart below illustrates a sample patient panel over a three-month period.



In this example, the practice's population of lower risk patients (levels 1 and 2) are increasing over time as patients from rising and higher risk categories move into lower risk strata. This insight should prompt decisions about shifting patients among providers and care teams or adjusting personnel hours as needed to manage level of acuity. Monitoring this data over time will help the practice better manage its overall resource and staffing needs.

Risk stratifying the patient population allows measurement of how many empaneled patients are risk stratified as well as how many are receiving care management. The table below shows how practices can identify the outcome of their risk stratification methodology. In this example, the total empaneled, risk stratified patient number is 1,000, and of those how many are receiving care management.

Level of patient risk *(start with highest risk in first row and list in descending order)*	**Total number of patients in each tier**	**Total number of patients in each tier under care management**	**% of patients under care management**
5	20	19	95%
4	32	30	94%
3	146	4	6%
2	213	6	3%
1	589	0	0%
Total	**1,000**	**59**	**5.9%**

In this example, roughly 6 percent of the total empaneled population receives care management (59 patients receiving care management divided by 1,000 total empaneled patients). This data allow the practice to designate appropriate resources for this care management. In addition, the data can show the need to refine the practice's methodology should trends indicate the tool is either too sensitive (too many patients in the highest tiers) or not sensitive enough (more in the lowest tiers).

Other areas to measure include the following:

- Percentage of patient panel per tier, monitor this regularly to understand and respond to movement between tiers (for example, the highest risk level shows a downward trend).
- Utilization measures (hospitalization, ambulatory care sensitive hospitalizations, re-admissions, emergency department (ED) visits and total cost of care)
- Quality measures for each tier

Change Concept: Provide longitudinal care management to patients at high risk for adverse health outcome or harm

Patients with high-risk conditions often struggle with multiple conditions including medical, behavioral health and socioeconomic issues. Longitudinal care management (ongoing, relationship-based for patients of high or rising risk) describes how a specially trained person (often from the nursing or social work disciplines) or a multidisciplinary team coordinates closely with primary care over time to provide care management for the patient. Patient populations and acuity levels will determine the care manager-to-patient ratios. A ratio often seen in care management is one care manager per 200 patients with episodic needs, or one care manager per 50 to 60 highest risk patients.

The basic functions of this approach are as follows:

1. Performing comprehensive health assessments to identify "root causes" that affect overall functioning. In addition to the medical evaluation, other factors are assessed, including mental health, substance abuse issues and social services needs.
2. Creating and developing an ongoing plan of care by working closely with patients, families and their caregivers. In addition, specialty, behavioral health and social service can be included for continuity. (See **Secondary Driver 1.2: Planned Care and Population Health**, "Engage patients, family and caregivers in developing a plan of care," page 19.)
3. Same-day access with flexible communication and follow-up (phone, email, etc.) allowing the care manager to quickly respond to changes in patients' conditions, thereby avoiding unnecessary services, particularly emergency department visits or hospitalizations. (See **Secondary Driver 1.1: Access and Continuity**, "Same-day or next-day access," page 4.)

Implementation tips for longitudinal care management

- Based on risk stratification, identify a subpopulation that will receive longitudinal care management.
- Review for a high frequency diagnosis in the sub population (chronic pain, high-risk diabetes, anxiety, etc.).
- Determine scope and activities of longitudinal care management and ratios.
- Determine skill set of team members needed to support sub population (e.g., BH or RN, etc.).
- Develop an assessment process and transition/plan of care/referral process.
- Develop mechanism to receive same day ER and hospitalization alerts.
- Identify/hire and train a team member to deliver the services.
- Test with five patients and slowly add more while adjusting process.
- Scale and spread to other panels.

Change tactics CPC practices have used:

- Use on-site practice-based or shared care managers to proactively monitor and coordinate care for the highest risk cohort of patients
- Use a plan of care as a tool to support patients that are at high risk for adverse health outcome or harm

CPC resources related to care management

Care Management: A Review of CPC Practice Approaches (2014). This guide provides additional information on care management, including CPC practice implementation case studies. https://downloads.cms.gov/files/cmmi/cpci-combined-implementationguide.pdf#page=2

Change Tactic: Use care managers to proactively monitor and coordinate care for the highest risk cohort of patients

A successful care management approach proactively monitors and coordinates care for the highest risk patients. CPC practices have implemented effective longitudinal care management in at least two models:

- Embedded care managers are located onsite and work with one or more care teams. This promotes close coordination and communication with the team and provides capacity to respond rapidly to patient needs.
- Care managers are centrally located but assigned across multiple sites. This simplifies the distribution of care manager resources across multiple sites. However, it may diminish response time and make communication and coordination more challenging.

Essential components

- **Contact patients regularly**. In the beginning, face-to-face contact offers opportunities to define goals, plan care, engage in shared decision making and build a trusting relationship. As time goes on, many care management activities can take place by phone, email or home visits. Care managers may also visit patients in skilled nursing facilities or hospitals to support transitional care.
- **Timely information on hospital and emergency department admissions**. Work with hospital partners to ensure same-day notifications of emergency department or hospital admissions. This coordination allows care managers timely access to discharge plans. This also allows the care manager to discuss appropriate use of the ED proactively and work with the patient to prevent avoidable visits.
- **Coordinate care transitions and close follow-up.** Review daily admissions, ED census and specialist visits with relevant parties to ensure providers transfer the important, non-clinical information to the downstream provider. This allows timely facilitation of care, as well as opportunities to educate and monitor patients to ensure the practice arranges follow-up care.
- **Link to community resources and social support.** Because high-risk patients also frequently have social needs, care managers must regularly assess for these needs and access to up-to-date information on community resources such as food access, housing, utility assistance and transportation.
- **Coordinate closely between the care manager and provider.** When care managers are part of the team or in the same room, coordination and communication happen regularly and continue throughout the day. When they are offsite or even in another room, dedicated time must be regularly scheduled for a case review meeting (virtually, telephone or in person). Email and telephone consults should be ongoing.
- **Support patient self-management support and activation, including medication education.** Before educating the patient on *anything,* always demonstrate empathy, listen to the patient and validate the patient's feelings and concerns. Incorporate basic problem-solving strategies and prioritization into every meeting. This will help break down complex problems into small, actionable steps. Success with these small steps will build the patient's confidence in self-management.

Online (external) resources for longitudinal care management

Improving Care for Complex Patients: The Role of the RN Care Manager (2012). An internal look at the needs of the practice population to guide the decision on the skill level of care manager that would best serve the patient and the practice. http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Supplement-Evidence-Based-Care.pdf

Chronic Care Management Services (2015). https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

- **Document activities in the medical record.** These include the nature and substance of the contact, assessment of current status, changes to the care pathway or overall care plan, unresolved questions and next scheduled follow-up contact. Billing for chronic care management demands timely and detailed documentation. This is particularly important for practices billing for chronic care management.

Considerations for your practice

- Develop a dashboard with measures such as admission rates, readmission rates, ED visit rates, and follow up dates for care managers to track.
- Schedule regular meetings to build relationships with others providers with whom you often share patients. This could include discharge planners, SNFs, nurse directors and specialist clinic staff.
- Use the "SBAR" format (Situation, Background, Assessment, and Recommendation) to keep case review sessions focused and on track.
- Provide support for your personnel when burnout and compassion fatigue appear.
- Implement a weekly huddle to discuss evolving internal processes. Gather feedback on what is going well and what is not going well in the early implementation stages.
- Train teams on effective facilitation and communication skills.

CPC resources related to longitudinal care management

CPC Practice Spotlight 16: Lower A1c Among Patients with Diabetes Through Standardized Team Approach (2014). One CPC practice in Oklahoma developed a standard approach to care management of patients with diabetes that demonstrated promising results. In taking a proactive approach to the care management of this population, this practice saw a notable improvement on this clinical quality measure. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=38

CPC Practice Spotlight 65: Social Worker Contributes to Collaborative, Team-based Care Management (2016). An Oklahoma practice added a part-time social worker to expand its care management expertise. Learn how this practice identified the need, created the position and recruited a person with the right skillset for the team. https://innovation.cms.gov/Files/x/cpcipsl2014-2016.pdf#page=26

CPC Practice Spotlight 72: Small Practice Leverages Team-based Care and Care Management (2016). Learn about an Ohio solo practitioner's care management strategy that led to reduced hospital admissions and ED visits. https://innovation.cms.gov/Files/x/cpcipsl2014-2016.pdf#page=30

CPC On Demand Video: Longitudinal and Episodic Care Management (2017). This video describes how one practice differentiates between patients who need long term care management and those who need shorter term or episodic care management during transitions of care. https://www.youtube.com/watch?v=99bbAZn_0Uo&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh&index=3

Change Tactic: Use a plan of care as a tool to support patients who are at high risk for adverse health outcome or harm

Creating care plans that are tailored to an at-risk patient's particular needs has shown a significant decrease on overall health care cost and improved health outcomes.[2] A plan of care supports coordination, contingency planning for excerbations of illness and treatment barriers, promotes preventive care and ensures the delivery of more timely care. It can prevent unnecessary ED visits and admissions for patients who are most at risk. It essentially ensures that everyone who works with the patient, including family members and caregivers, is clear about the conditions being treated, how they will be treated, when they are being treated and by whom. Additional discussion regarding the plan of care is found in **Secondary Driver 1.2: Planned Care and Population Health,** "Engage patients, family and caregivers in developing a plan of care," page 19.)

Essential components

- A care manager or care management team engages high-risk patients. This team often includes nurses, behavioral health clinicians, physicians, physician assistants, care managers and others who work with the patient to create a plan customized for the individual's goals. The plan could include more frequent clinic visits or increased contact with a consistent team.
- Document the care plan in the practice EHR. Flag the plan prominently to ensure it is visible to all team members.
- Ensure the patient receives needed follow-up care by having the care team facilitate referrals to specialists.

Considerations for your practice

- Understand that high-risk patients are also frequently high users of ED and hospital services. Build partnerships with local hospitals and develop a mechanism to share access to a plan of care that ensures continuity and consistency while reducing redundency in tests, labs and services.
- Be aware that when family members, caregivers and multiple providers are involved in providing care, it may be useful to have a "care conference." This meeting's purpose is to engage everyone in developing and implementing the plan of care. This also allows for clear communication (for example, direct contact to a care manager or caregiver) and to put contingency plans in place.
- Know that theraputic interventions may vary widely and may involve a variety of actions from behavioral health in-patient treatment to in home care.

Online (external) resources for longitudinal care management

Care Management: Implications for Medical Practice, Health Policy, and Health Services Research (2015). http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/caremanagement/index.html

CPC resources related to longitudinal care management

CPC Practice Spotlight 49: Patient-Centered Care Plan Curbs Patient's Hospital Use, Savings to Top $150,000 (2015). An example of use of the plan of care to improve the patient's overall health, reduce expenditures and emergency department utilization. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=13

CPC On Demand Video: Patient-centered Plan of Care (2017). A practice describes their tactics for care management and risk stratification, which helped them reach their goals. https://www.youtube.com/watch?v=LK2ILb9SgQs&index=20&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

Online (external) resources: provider story

FP Credits CPC Initiative With Practice Turnaround, AAFP (2016). An Ohio family practice physician describes how having a care manager in his CPC practice improved care for his patients. http://www.aafp.org/news/macra-ready/20161116cpcplus.html

[2] Individual care plans can reduce hospital admission rate for patients who frequently attend the emergency department; Emergency Medicine Journal June 1, 2010, Vol. 28, Issue 8

Case management of patients who frequently present to a Scottish emergency department; Emergency Medicine Journal 2009, Vol. 26, Issue 2

Measuring Success for Change Concept: Provide longitudinal care management to patients at high risk for adverse health outcome or harm

Process measures

- Number of patients in each risk tier who are under care management
  - Movement between tiers
  - Level of resource needed for each tier
  - Ratio between number of case managers and patients
- Percentage of patients in high-risk tiers with care plans
- Length of time patient receives longitudinal care management
- Track specified timeframe for follow-up (example: call within 3 days of discharge)
- Other quality measures

Outcome measures

- Track ED, admissions and readmissions
- Track total cost of care
- Track patient satisfaction

CPC resources related to longitudinal care management

CPC On Demand Video: Targeted Care Management (2017). Features DTC Family Health and Walk-in (Colorado) sharing data to show the how care management improved care for high-risk patients. https://www.youtube.com/watch?v=wtIvLQOez-g&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh&index=7

Change Concept: Provide episodic care management, including management across transitions and referrals

Unlike the select group of high-risk patients who need more intensive, longitudinal (ongoing) care management, other patients may benefit at times from targeted, episodic care management (short-term, goal-directed for patients not otherwise identified as high risk). This group of patients includes individuals who are otherwise clinically stable but experiencing a transition of care setting, receive a new major diagnosis or experiencing a short-term exacerbation of a chronic condition.

Episodic care management includes coordination, transitions of care, support to manage symptoms and reconciliation of patients' medications. Below are examples of the several ways to identify patients for episodic care management:

- Recent or frequent hospital admissions or ED visits
- Provider diagnoses patient with a new major illness or exacerbation of a chronic condition
  - Includes initiation or stabilization on a high-risk medication (e.g., warfarin)
- Individuals experiencing a transition in their care setting (between hospital, SNF, home care, assisted living)
- Additional indicators may be life events like the death of a spouse or financial issues, or psychosocial concerns, and addressing these matters may avoid future health-related issues

Change tactics CPC practices have used:

- Manage care intensively through new diagnoses, injuries, exacerbations of illness
- Routine and timely follow-up to hospitalizations, ED visits and stays in other institutional settings

Implementation tips for episodic care management

- Review transition of care and prevalence of chronic disease data from the last year.
- Determine probable staff ratio.
- Determine if reorganizing the existing staff will accomplish the work or if new staff need to be hired.
- Develop assessment process and transition/plan of care/referral process.
- Develop mechanism to receive same day ER and hospitalization alerts.
- Identify/hire and train a team member to deliver the services.
- Test with five patients and slowly add while adjusting process.
- Scale and spread across the practice.

Online (external) resources for episodic care management

Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs (2011). The authors discuss care coordination and management of patients with the highest need for this strategy.
http://www.ihi.org/resources/Pages/IHIWhitePapers/IHICareCoordinationModelWhitePaper.aspx

Change Tactic: Manage care intensively in new diagnoses, injuries, exacerbations of illness, routine and timely follow-up to hospitalizations, ED visits and stays in other institutional settings

There are several goals for managing a patient through episodic conditions. One goal is to assist with a new diagnosis, an exacerbation of a current chronic illness or acute injury and mitigate adverse effects on the patient's health. An additional primary function of episodic care management is ensuring routine and timely care management, and clinical monitoring following the patient's discharge from several settings:

- An inpatient hospital
- Observation status in a hospital
- Skilled nursing facility
- Community mental health center

Episodic care management seamlessly facilitates the transition to home, nursing home or assisted living. It also supports patients with a recent ED visit.

CPC resources related to episodic care management

CPC Practice Spotlight 42: Critical Elements in Care Management: Process/Data, Protocols and Reinforcement/Response (2015). A solo practitioner established his process with data capture that drove the care management and care coordination processes in the practice using established protocols. The result was consistency in care management as well as total population management. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=7

CPC On Demand Video: How to Enhance Transitions of Care (2017). In this video, you will explore the tools you can use to help in your effort to reduce unnecessary emergency room visits and hospital readmission rates. https://www.youtube.com/watch?v=LK2ILb9SgQs&index=20&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

Essential components

- **Recommended follow-up with patients who had visited the ED within 48 hours of notification and all hospital discharges within 72 hours (or two business days) of discharge**. Typically a phone call initiates the outreach. If that is not succesful, outreach attempts should continue through the patient portal or a letter mailed to the home. Scheduling a follow-up visit should depend on the diagnosis and other factors such as medication changes, ongoing medical concerns and social issues.
- **Identify patients with new diagnoses, injuries and exacerbations of illness.** Referral from the provider is more common with patients with new diagnoses or exacerbations of a current illness. Once identified, patients who would benefit from short-term care management should have their needs addressed in a timely fashion to avoid development of complications or problems.
- **Ensures clinical monitoring and interventions by using team members.** The nurse may work with the patient on transitions of care, clinical monitoring (wound care, etc.), abnormal lab follow-up and education. The dietitian or pharmacist may provide education for patients with diet and medication elements to their care. Behavioral Health Specialists are engaged to help with social, financial or psychosocial factors. A care coordinator may help with durable medical equipment, referrals and communication with home health. These coordinated activities are all part of episodic care management.
- **Creates an accurate list of medications through medication reconciliation**. This prevents adverse drug events that may occur during transitions in care or triggered by medication changes made during a referral to a specialist or outside facility, ED visit or hospitalization. See page 27 for more information on medication management.

Considerations for your practice

- Ensure the entire team can track actions to completion.
- Set time frames and deadlines for actions in EHR (e.g., 48 hours for hospital follow-ups).
- Review patients receiving episodic care in huddles.
- Some patients may benefit from a short-term plan of care.
- Referral from the provider is more common with patients with new diagnoses or exacerbations of a current illness. Once identified, patients who would benefit from short-term care management should have their needs addressed in a timely fashion to avoid development of complications or problems.

Measuring Success for Change Concept: Provide episodic care management, including management across transitions and referrals

Process measures

- Percentage of all empaneled patients receiving episodic care management
- Percentage of all empaneled patients receiving episodic care with care plans
- Ratio of care manager to patients (Then you must determine if this is the appropriate workload per case manager.)
- Length of time receiving episodic care management (This will reveal if longitudinal care management is a better option.)
- Track specified timeframe for follow up (for example, call within two days of discharge). (Are you following up with the patient and providing the resources they need in a timely manner?)
- Track type of activity needed (This may help with determining what type of preventative care focuses your practice may need to focus more prevention education services on.)
- Other quality measures

Outcome measures

- Track ED, admissions and readmissions
- Track total cost of care
- Track patient satisfaction

Change Concept: Offer integrated behavioral health services to support patients with behavioral health needs, dementia and poorly controlled chronic conditions

AHRQ, in its 2011 "Lexicon for Behavioral Health and Primary Care Integration defines **Integrated Behavioral Health** as **"**a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide care for a defined population. This care may address mental health, substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms and ineffective patterns of health care utilization."[3] CPC practices broadened this scope to include individuals with dementia and their caregivers.

Successful integration of behavioral health services in the primary care setting involves transformation of the entire team's approach to care. The movement toward integrating behavioral health into primary care brings care for the mind and body back together thereby reducing stigma and ensures behavioral care is just a routine part of overall *health* care. Through treating the "whole person," patients improve functioning and improve outcomes for both medical and behavioral conditions.

There are a number of approaches to integration, and finding one best suited to the practice considers the needs of the population, the functionality of the existing practice and funding resources. AHRQ describes three levels of integration:

- **Coordinated —** Separate sites, separate systems with periodic communication usually by phone or email and view each other as resources
- **Co-located —** Share the same sites and have some systems in common such as scheduling or charting. There are regular face-to-face interactions among primary care and behavioral health providers, and coordinated treatment plans for difficult patients
- **Integrated —** Share the same work space, systems and are integrated into the day-to-day operations, and are fully part of the team, mirroring the pace and rhythm of primary care

Implementation tips for behavioral health integration

- Establish leadership to support and guide BHI integration.
- Assess the needs of the population (high frequency BH diagnosis).
- Build a team that will test changes and will be early adopters.
- Determine model for BH (coordinated, co-located or integrated).
- Develop goals for BHI implementation and measures.
- Identify scope of practice for BH work (what will be managed in clinic and what will be referred out).
- Define reliable operations and process (seating arrangement, handoffs, check in, tracking, etc.).
- Develop documentation and billing procedures (EHR notes and forms).
- Develop data-driven systematic monitoring and tracking.
- Develop a communication plan and training for staff on how to access BH services.

[3] Lexicon for Behavioral Health and Primary Care Integration (2011). http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf

Change tactics CPC practices have used:

- Use evidence-based screening and case finding strategies to identify individuals at risk and in need of services
- Use evidence-based treatment protocols and treatment to goal where appropriate
- Conduct regular case reviews for at-risk or unstable patients and those who are not responding to treatment
- Ensure regular communication and coordinated workflows between primary care and behavioral health providers
- Use a registry or EHR registry functionality to support active care management and outreach to patients in treatment
- Integrate both behavioral health and medical treatment into care plans

CPC resources related to behavioral health screening

CPC Practice Spotlight 7: Oregon Medical Group (2014). This group used the services of a knowledgeable psychologist to develop their BHI program. Article describes steps taken, including selecting the appropriate BHS professional, and the screening used to identify patients. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=17

CPC On Demand Video: Using Data to Identify Patients with Behavioral Health Needs (2017). In this video, a practice talks about how it used data to identify the behavioral health needs of their patient population. https://www.youtube.com/watch?v=G6s7AuHyIQs&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh&index=8

Change Tactic: Use evidence-based screening and case-finding strategies to identify individuals at risk and in need of services

Screening tools are one method for identifying individuals with behavioral health needs. Other methods include looking at clinical indicators or utilization data to identify the patients who may need assistance with motivational techniques or social support to improve their outcomes or reach their goals. In these cases, it is helpful to conduct case reviews for those patients at-risk or unstable, as well as patients who are not responding to treatment or not meeting their goals.

Essential components

- **Reliable methods to identify patients in need of behavioral health services**
  - Screening tools for conditions such as depression, substance abuse, dementia or domestic violence
  - Clinical indicators, such as an A1c greater than 8, opioid prescriptions for chronic pain, positive pregnancy tests or numerous STD visits
  - Health risk assessment
  - Self-referral by patient
  - Referral by a team member or provider for any mental health condition, substance abuse, unmanaged chronic condition or social service need
- **Use of evidence-based screening tools**
  - AUDIT-C and DAST (substance abuse)
  - Mini Mental Status Examination or the Mini Cog (dementia)
  - PHQ-2 or PHQ-9 (depression)
  - Adult ADHD self-report tool (ADHD)

Considerations for your practice

- Train entire care team on the purpose and utility of identification and screening
- Train clinical personnel on the role of the BH specialist and when and how to access services
- Consider having a medical assistant complete initial screening as part of check in
- Develop a handoff protocol when a patient is in need of BH and social services
- Determine how screener results will be documented and tracked
- Determine if any of the screening activities can be reimbursed

Online (external) resources for behavioral health screening tools

PHQ-2. This questionnaire serves as an initial screening test for major depressive episodes. https://integrationacademy.ahrq.gov/sites/default/files/PHQ-2_0.pdf

PHQ-9. A multipurpose questionnaire for screening, diagnosing, monitoring and measuring the severity of depression. https://integrationacademy.ahrq.gov/sites/default/files/PHQ-9_0.pdf

SBIRT (Screening Brief Intervention and Referral to Treatment) – A Primary Care Tool to Assess for Substance Use Disorder (2016). This tool identifies patients who are moderate or high-risk users with the goal of early intervention to prevent health problems related to Substance Use Disorder. http://ejournal.tnmed.org/cgi/viewcontent.cgi?article=1039&context=home

DIAMOND for Depression (2016). ICSI's DIAMOND (Depression Improvement Across Minnesota, Offering a New Direction) program united a physician, care manager and consulting psychiatrist to provide a team-based model for caring for patients with depression in the primary care clinic. https://www.icsi.org/about_icsi/legacy_work/diamond_for_depression/

DIAMOND Study Findings (2014). Study results of the model, implemented in almost 100 clinics. https://www.icsi.org/_asset/nn70fc/ICSI-DIAMOND-Study-Finding-6-4-14.pdf

Screening Tools, SAMHSA-HRSA Center for Integrated Health Solutions (2016). This site offers multiple screening tools for behavioral health concerns that primary care practices may use. http://www.integration.samhsa.gov/clinical-practice/screening-tools

Change Tactic: Use evidence-based treatment protocols and treatment to goal where appropriate

Although about half of the people experiencing depressive symptoms seek help, only 20 percent receive adequate treatment in primary care.[4] One reason for this is that psychotherapy methods are often long term and time consuming (50-minute sessions). While few primary cares have tested these modalities in their fast-paced, time-limited settings, adapted methodologies have begun to emerge. The key is to identify the evidence-based protocol(s) that apply to your population, and then use small tests of change to try various approaches until one works in your practice.

Essential components

- **Evidence-based behavioral interventions for primary care**
  While many behavioral interventions exist, only a few have proven to work in primary care including Problem Solving Therapy-Primary Care, Cognitive Behavioral Therapy, Interpersonal Counseling and Behavioral Activation.
- **Treatment protocols that fit the culture and pace of primary care**
  The core features of any protocol must include the following:
  - A warm handoff with an explanation of the role and purpose
  - Intervention that lasts no more than 20 to 30 minutes
  - Empathetic and non-judgmental engagement
  - A structured approach that includes a targeted assessment, problem conceptualization, intervention and plan for follow-up
  - Be able to adapt to patient and team needs
  - Research evidence-based protocols
- **Treating to improve function**
  Behavioral Health treatment in primary care comprises small, concrete steps meant to build confidence that supports patients in meeting their health goals. Include creating an action plan that addresses any obstacles, triggers and skills needed to meet goals.

Considerations for your practice

- When hiring for behavioral health clinicians, make sure that they are a "good fit" for primary care.
- Be willing to adopt and test evidence-based interventions and protocols customized to the clinic and population.
- Look online for training resources to help train new behavioral health clinicians to work in a fast-paced primary care setting.
- Even after training, a new behavioral health clinician may need ongoing supervision and additional training.
- Non-behavioral health clinicians who work in primary care, such as nurses and care managers, can learn these treatment protocols.

Online (external) resources for BHI evidence-based protocols

A Guide to Evidence-Based Practices, SAMHSA-HRSA (2016).
http://www.samhsa.gov/ebp-web-guide

SAMHSA National Registry of Evidence-based Programs and Practices (2016). Additional information of various tools available for download.
http://www.samhsa.gov/nrepp

Recognition and management of dementia, AHRQ National Guidelines Clearinghouse (2012). This provides tools to screen for dementia.
http://www.guideline.gov/summaries/summary/43921

Tips and Strategies for Billing for Mental Health Services in a Primary Care Setting (2017). The Suicide Prevention Resource Center has valuable information to assist with documentation in the EHR and reimbursement strategies.
http://www.sprc.org/sites/default/files/tipsandstrategiesforbilling.pdf

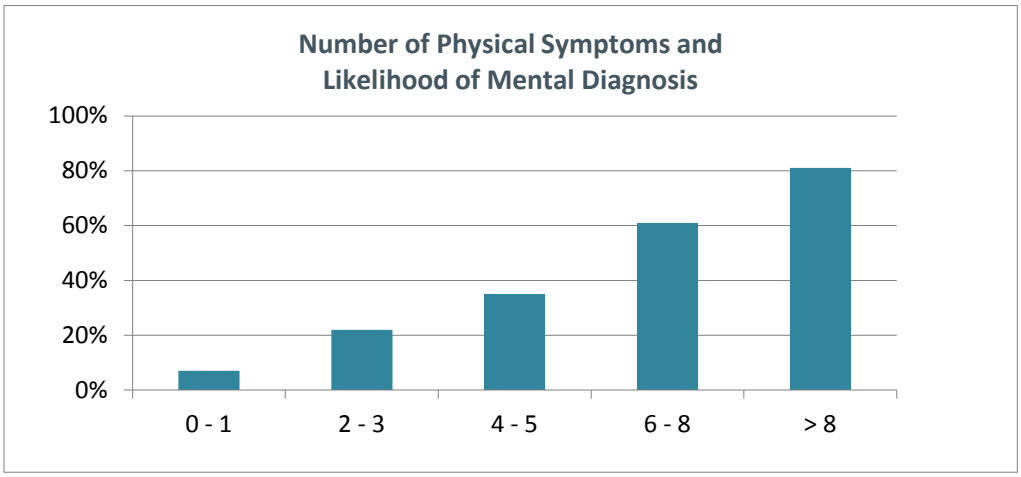
CPC resources related to behavioral health integration

CPC Practice Spotlight 57: Shared Decision Making Can Be Part of Behavioral Health (2015). A New Jersey practice used a shared decision aid to assist the patient and practice team to decide if using medication to treat depression was the most appropriate option per the patient's needs and preferences.
https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=20

[4] Kessler RC, Berglund P, Demler O, et al. The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). JAMA. 2003;289(23):3095-3105.

Change Tactic: Conduct regular case reviews for at-risk or unstable patients and those who are not responding to treatment

As the number of physical symptoms increases, so does the likelihood of a mental health diagnosis. The majority of high-risk patients have an average of eight diagnoses, indicating a strong probability of a comorbid mental health disorder (see graph below).Practices should consider assessing all high-risk patients for an underlying behavioral health diagnosis. Conducting regular case reviews allows teams to combine information from various team members and providers working with the patient, and monitor progress while problem solving concerns. Including the BH specialist offers another perspective and intervention to support patients that are not responding to treatment.



Spitzer, Williams, et al. (1994). "Utility of a New Procedure for Diagnosing Mental Disorders in Primary Care: The PRIME-MD 1000 Study." JAMA 272(22): 1749-1756.

Essential components

- Entire team is involved in case review (provider, care manager, BH specialist, etc.).
- Occur at a regularly scheduled interval (e.g., one time per week for one hour).
- Have an organized process for case review.
  - Identify the number of patients who can be reviewed
  - Identify who will facilitate review
  - Have charts available
- Identify patients who could benefit from a BH consultation or intervention.
- Document recommendations for case review. This may include a medication change, BH assessment, referral to an external specialist or modification in treatment schedule.
- Follow-up on progress in subsequent case reviews.

Considerations for your practice

- If BH specialist is offsite, include consultation by phone or virtually.
- Interval of meeting will depend on clinic resources and risk level of the practice population.
- Designate one person to follow-up on identified actions.
- The BH specialist may provide education to the team on topics such as opioid abuse, depression, anxiety or somatic symptom disorder and the effect on disease management.

Change Tactic: Ensure regular communication and coordinated workflows between primary care and behavioral health providers

Collaboration cannot happen without ongoing communication. This is key for any behavioral health specialist working in primary care. Both the behavioral health specialist and the medical provider hold valuable information that will affect care and the ultimate outcome of care. Both informal day-to-day communication and specific workflows designed to create seamless coordination and hand-offs are essential to providing timely and responsive care.

Having daily face-to-face communication to discuss the "referral question," assessment information and the follow-up from intervention allows care to be flexible and relevant, meeting patients' primary needs. Behavioral health specialists often sit with the team to facilitate this kind of communication. While sitting together, teams discover new ways to work together to leverage each other's expertise to meet patient needs.

Using one integrated EHR for behavioral health and primary care improved collaboration and made integrated service planning more effective than those that used two separate EHRs.

Essential components

- Daily face-to-face communication about shared patients
- BH involvement in huddles and case review
- Email, messaging and texting functionality to contact BH specialist
- Shared documentation
- A defined warm handoff process for how patients will get from the medical provider to the BH specialist

Considerations for your practice

- How workflows and handoffs between providers are developed vary by which approach is chosen:
  - **Coordinated** – Formal referral process and phone and email consultation
  - **Co-located** – Formal or informal referral process and regular communication about shared patients
  - **Integrated** – Informal, immediate referral process and communication happens consistently at the system, team and individual levels
- Consider where the BH specialist will sit and see patients (in the exam room?)

Change Tactic: Use a registry or EHR registry functionality to support active care management and outreach to patients in treatment

Health information technology (health IT) can aid the team in proactively identifying and tracking members in need of BH services. First, the registry function can track all screener (PHQ, AUDIT, MMSE, etc.) results, reminders and visit history. Second, a team may define "triggers" that might indicate BH needs such as an A1c greater than 9, frequent ED visits or a patient being prescribed regular benzodiazepines or using opioids. Third, if a patient is high risk and using a plan of care, the registry function can help track goals and how each member of the team is supporting the patient. In addition, these tools prompt the team to reach out to patients who are no longer engaged in treatment but still may need support. All of these methods provide the tools needed to provide comprehensive care management.

Essential components

- ***Use health IT for behavioral health care management.***
  - For each screener chosen, track date of screening, result, intervention and plan for follow-up (include referral to community resources here as well).
  - Track how many patients on the panel have a plan of care and the date it was last updated.
  - Track number of contacts with patient.
  - Set aside time as a team to review plans of care and registries such as frequent ED lists, depression, diabetes or other lists that may be useful to your population management.
  - Registries should be able to drill down to the care for each patient as well as provide data for the entire panel and clinic. For example, a care manager should be able to see when the last PHQ screening was done for the patient, the percentage of the panel that has been screened and the total number screened in the practice.

- ***Use health IT for outreach.***
  - Using health IT, teams can see when a patient might be overdue for a particular screening or if an action item from the plan of care was not complete. Care managers can either use outreach or catch the patient when they are in the clinic again.
  - When a patient has missed follow-up appointments or contacts, the team can reach out to the patient to understand what the issues are and work to resolve them.
  - Being able to track conditions and plans also allows teams to identify patients proactively that may benefit from a new service or resource such as a self-management support group or a diabetic cooking class.
  - Teams can also use a secure patient portal to send messages, provide educational materials and provide reminders.

Considerations for your practice

- Determine what should be high values registry lists for the patient population.
- Use discrete data fields in the EHR to ensure that reports include key information.
- Train teams how and when to use registries and involve them in the development.
- Ask patients for their preferences for outreach (phone, portal, etc.).
- Ensure entire team has access to registries.

Change Tactic:
Integrate behavioral health with medical documentation into plans of care

There is a common misconception that medical providers may not share patient's behavioral health records. The reality is that HIPAA makes exceptions for treatment and coordination among providers.

*The HIPAA Privacy Rule, in 45 CFR 164.508, contains special confidentiality regulations for psychotherapy notes. It states, "a covered entity must obtain an authorization for any use or disclosure of psychotherapy notes…**There are exceptions however, that include treatment, payment, or health care operations.** § 164.506h*[5]

Online (external) resources for shared plan of care

The Academy: Integrating Behavioral Health and Primary Care-The Playbook (2016). Provides a good description of its developed Shared Care Plan. http://integrationacademy.ahrq.gov/playbook/develop-shared-care-plan

Three characteristics define treatment:

- PHI shared between the physician and other health care providers providing treatment
- Coordination of treatment among providers
- Prior authorization decisions

These **exceptions** form the basis for a collaborative documentation between behavioral health and medicine. Without it, treatment would continue in isolation.

It is still important to review state regulations regarding shared information as they supersede HIPAA when the practice implements shared records.

Essential components

- Use a basic SOAP (Subjective, Objective, Assessment/Problem List, and Plan) template that incorporates BH-specific elements including diagnosis, assessments and symptoms and billing/CPT codes.
- Develop a method to identify/file the BH notes so that they are easily searchable.
- Create an easy-to-update "plan of care" template that all team members can add to and easily update.
- Create a written informed consent document stating that the practice uses a team approach and that team members share information among themselves. All patients should share and sign this document.
- Disclose the behavioral health specialist's role and background at the first encounter.

Considerations for your practice

- Behavioral health personnel may need training brief documentation in an EHR.
- When a plan of care addresses a primary BH diagnosis, the BH specialist may take the lead in management.
- Personnel may need training and education on this topic, as much of the resistance around shared documentation is institutional but does not have legal grounds.

[5] Health Information Privacy. U.S Department of Health & Human Services. https://www.hhs.gov/hipaa/index.html/

Measuring Success for Change Concept: Offer integrated behavioral health services to support patients with behavioral health needs, dementia and poorly controlled chronic conditions

Measuring this work will aid the practice in determining the effectiveness if their behavioral health integration process and support in continued improvement efforts.

Potential process measures

- Number of patients screened for behavioral health issues
- Number of patients identified for behavioral health services
- Number of referrals to behavioral health provider within the primary care practice
- Number of referrals to external agencies for behavioral health services
- Number of telephonic vs. face-to-face appointments vs. curbside consultations with providers
- Penetration rate – percent of patients in a panel seen by a BH specialist
- Number of times a patient returns for a BH visit per year

Online (external) resources: clinical outcome measures

The Academy: Integrating Behavioral Health and Primary Care-The Playbook (2016). Tools: Clinical Outcome Measures. http://www.integrationacademy.ahrq.gov/node/3134

Potential outcome measures

- Tracking results of screening clinical outcome measures such as the PHQ-9 and GAD-7 (see resources in call out box on the right)
- BH and medical provider satisfaction
- Access to BH services
- Visit efficiency rating by provider
- Duration of provider time in visits
- Tracking CQMs of chronically ill patients undergoing BH treatment
- Change in ED and hospital admissions

CPC resources related to behavioral health integration

CPC Practice Spotlight 55: Measuring the Effectiveness of Behavioral Health Management (2015). Colorado's Boulder Community Health included BH services in its five CPC practices. To evaluate the effectiveness of the practice's BH services, the team of social workers tracked the PHQ-9 scores of patients with moderate and severe depression following treatment. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=18

Change Concept: Manage medications to maximize efficiency, effectiveness and safety

Using medications for prevention or for treatment of chronic conditions has become especially common in medical practice. However, the potential for medication-related harm increases in those receiving multiple medications, care from multiple providers or settings, and in elderly individuals with multiple comorbidities. Many medications require scheduled monitoring for safe use. Medication management as an advanced primary care strategy involves engaging the skills of the clinical pharmacist as a member of the care team. The skills to provide comprehensive medication management for patients enhance the quality and safety of primary care.

Protocol-guided medication management can improve outcomes in many chronic conditions. The integration of a pharmacist on the primary care team has been instrumental in the reduction of medication-related adverse events. Medication management is an advanced primary care strategy that a portion of CPC practices focused their efforts on as they provided care management for high-risk patients.[6]

Comprehensive medication management can include several techniques:

- Medication reconciliation
- Coordination of medications across transitions of care settings and providers
- Medication review and assessment aimed at providing the safest and most cost-effective medication regimen possible to meet the patient's health goals
- Development of a medication action plan and integration of that plan into a global plan of care
- Medication monitoring
- Support for medication adherence and self-management
- Collaborative drug therapy management (when within the state's scope of practice)

Implementation tips for medication management

- Establish leadership to support and guide medication management.
- Identify a condition that that pharmacist may begin to manage.
- Build a team that will test changes and will be early adopters.
- Develop goals for medication management implementation and measures.
- Identify any opportunities to develop standing orders for med management.
- Develop a collaborative agreement with a physician (if applicable).
- Develop PharmD specific documentation and billing procedures (EHR notes and forms).
- Develop a communication plan and training for staff on how to access medication management.

Change tactics CPC practices have used:

- Integrate the pharmacist into the care team
- Reconcile, coordinate medications and provide medication management across transitions of care settings and providers
- Conduct periodic, structured medication reviews
- Provide medication self-management support and medication action plans
- Provide collaborative drug therapy management for selected conditions or medications

[6] Cipolle, R., Strand, L., Morley, P. Pharmaceutical Care Practice—The Clinician's Guide, 2004–2nd edition. McGraw-Hill; Cipolle RJ, Strand LM, Morley PC. Pharmaceutical Care Practice: The Patient-centered Approach to Medication Management. McGraw Hill, 2012 is the 3rd revised edition (in press).

Change Tactic: Integrate a pharmacist into the care team

Using medications for prevention or for treatment of chronic conditions is exceedingly common in medical practice. However, the potential for medication-related harm increases in those receiving multiple medications, care from multiple providers or settings, and in aged individuals with multiple comorbidities. Many medications require scheduled monitoring for safe use. Medication management as an advanced primary care strategy involves engaging the skills of the clinical pharmacist as a member of the health care team. The skills to provide comprehensive medication management for patients enhance the quality and safety of primary care. While optimal implementation of this concept would involve the full-time availability of a clinical pharmacist trained in Medication Therapy Management, clearly this would present a significant challenge to most primary care practices.

CPC resources related to medication management

CPC Practice Spotlight 8: OU Physicians and Associates in Family Medicine (2014). Two CPC practices describe the benefits when they included medication management as a part of their primary care services. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=20

Practices can accomplish many aspects of the change tactic by considering local pharmacists as specialty consultants. The processes of identifying needed services, co-management goals, communication expectations and regular performance feedback discussions can allow a small practice, seemingly without the resources to be successful at this Change Concept, to be successful. As in all specialty consultation relationships, the selection of your collaborating pharmacists, based on their abilities and interests in supporting this effort, is a foundation to success.

Essential components

- Be involved in patient care, either directly or through chart review and recommendations.
- Document care in the EHR.
- Participate in the identification of high-risk patients who would benefit from medication management.
- Manage formulary issues when cost is a problem.
- Develop drug administration protocols.
- Develop and enforce policies and procedures.
- Ensure compliance with regulations and accreditation bodies.
- Participate in care team meetings.

Online (external) resources related to medication management

The State of Provider Status: An Update for Pharmacy Students (2016). Although legislation at the federal level is still pending, progress is being made in many states to classify pharmacists as health care providers. http://www.pharmacytimes.com/publications/career/2016/pharmacycareers_february2016/the-state-of-provider-status-an-update-for-pharmacy-students

Considerations for your practice

- Pharmacist may need specific training to work on a primary care team.
- Determine where the pharmacist will sit in relation to the team.
- Determine the patient handoff between the physician and the pharmacist.
- Primary care team will need specific training and guidelines in how and when to use the pharmacist.
- Clinical workflows may need to be adapted to meet the pace of primary care.

Change Tactic: Reconcile and coordinate medications and provide medication management across transitions of care settings and providers

Pharmacists concentrate their efforts on medication reconciliation, safe medication management, and patient education to support smooth transitions of care. The goal of medication reconciliation is to obtain and maintain accurate and complete medication information for a patient and use this information across the continuum of care to ensure safe and effective medication use. [7]

Medication Therapy Management (MTM) extends beyond the basic tasks of medication reconciliation. Comprehensive medication management begins with pharmacists using a standardized approach to MTM service delivery. Beginning with a medication therapy review, then formulating a personal medication record and medication-related action plan, pharmacists can work with other members of the health care team to evaluate medication therapy, resolve identified problems and refer the patient to an appropriate health care professional. Proper documentation, including leveraging health IT solutions, will allow the pharmacist to safely transition the patient to another health care professional or setting.

Essential components

- Identify prospective patients who require direct pharmacist intervention due to a transition on care.
- Delineate handoffs and collaboration between care coordination and pharmacists.
- Document consistent medication histories and medication reconciliation.
- Use health IT solutions that allow the entire team to see the plan and documentation.
- Ensure the EHR has order set capability (see inset for information on order sets).
- Ensure easy sharing of plans between practices and provider.

Considerations for your practice

- Determine how to notify a pharmacist about a transition to care.
- Develop a standardized template for the EHR.
- Consider adding the pharmacist to case reviews and morning huddles.
- Review federal guidelines for medication therapy management.

Online (external) resources

Medication management

Integrating Comprehensive Medication Management to Optimize Patient Outcomes, PCPCC Resource Guide, Second Edition (2012). This includes information that would inform practices as they develop their strategy. https://pcpcc.org/sites/default/files/media/medmanagement.pdf

Order sets

Clinical Decision Support Starter Kit (2017). Order sets can make the ordering process more efficient and standardize a level of care across the practice. This starter kit describes how to use of order sets as a part of clinical decision support. https://www.healthit.gov/providers-professionals/implementation-resources/clinical-decision-support-starter-kit

[7] Improving Care Transitions: Optimizing Medication Reconciliation 2012 American Pharmacists Association and American Society of Health-System Pharmacists. https://www.pharmacist.com/sites/default/files/files/2012_improving_care_transitions.pdf

Change Tactic: Conduct periodic, structured medication reviews

Pharmacists have become increasingly involved in structured, intermittent medication reviews. Medication reviews can vary based on if they are pre-planned or happen in a visit. They may include one or more medications. The purpose of the review may also vary often depending on the patient's complexity. The 2008 National Prescribing Centre (NPC) "A Guide to Medication Review" identified three types of medication review.[8]

- Review of prescriptions including anomalies, changed items, cost effectiveness
- Review consistency in medication taking behavior
- Review clinical effectiveness

Coordinated with the primary care team, Pharmacists complete the review, often at the time of a patient's scheduled follow-up visit. The frequency will vary and is dependent on clinical appropriateness for that individual patient.

Essential components

- Assess if the medication prescribed is appropriate and effective for the patient's needs.
- Assess if medication is a cost-effective choice.
- Ensure required monitoring or arrangements are in place. Determine drug interactions, side effects, and if over-the-counter and complementary medicines are used or if there are unmet needs.
- The entire team can access the review.

Considerations for your practice

- Build triggers to identify when a pharmacist review may be necessary. For example, a pharmacist may review meds at diabetes follow-up visits or regularly for high-risk patients using the risk stratification approach.
- Consider requiring the medical assistant to gather initial medication information for the pharmacist to review as part of the check in process.
- Include a med review as part of the chart review process.

CPC resources related to medication management

CPC Practice Spotlight 28: It Takes a Neighborhood to Increase Medication Safety for Patients (2014). An example where the practice closed the gaps in its medical neighborhood by collaborating with with two local pharmacies. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=51

Online (external) resources related to medication management

Medicare Medication Therapy Management (2016). Medicare has a standardized format for medication therapy management for those participating in Medicare Part D. It includes a cover letter, medication action plan and personal medication list. https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Memo-Contract-Year-2017-Medication-Therapy-Management-MTM-Program-Submission-v-040816.pdf

Medicare Part D Medication Therapy Management Program Standardized Format (2012). A written summary of a comprehensive medication review. https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/MTM-Program-Standardized-Format-English-and-Spanish-Instructions-Samples-.pdf

[8] A Guide to Medication Review 2008. National Prescribing Centre. A framework for medication review with practical advice.

Change Tactic: Provide medication self-management support and medication action plans

Medication self-management support and medication action plans are used to aid patients in understanding the proper use of the medication they are prescribed, potential problems they may encounter and when to contact their provider. The pharmacist, in particular, can provide education and training on the appropriate use of medications, the importance of medication follow through and the development of treatment goals.

Combined with the communication strategies of motivational interviewing and Teach-Back, the medication action plan is one tool that empowers and engages patients in the self-management of their medication regimens. The patients' understanding of their role in self-care with medications, combined with the knowledge of their plan, provides the blueprint for ongoing health improvement.

CPC resources related to medication management

CPC Practice Spotlight 21: Data-Driven Improvement Using Medication Management and Shared Decision Making with High-Risk Patients with Diabetes (2014). Cherokee Nation Health Services' Wilma P. Mankiller Health Center engaged the expertise of a pharmacist as it launched an intensive diabetes management education program for patients with an A1c greater than 9. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=43

Essential components

- Begin with a medication therapy review.
- Co-develop a medication action plan.
- Coach patients to be empowered to manage their own medications.
- Monitor and evaluate the patient's response to therapy, including safety and effectiveness.
- Communicate appropriate information to the physician or other health care professionals, including consultation on the selection of medications as well as suggestions to address identified medication problems.
- Update the patient's progress and recommended follow-up care.
- Ensure the entire team has access to the plan.

Considerations for your practice

- Significant events such as changes in the patient's medication therapy, health status or condition and/or needs or resources, a hospital admission or discharge, an emergency department visit, or an admission/discharge from a long-term care or assisted-living facility should trigger outreach and re-evaluation of the plan. Possible methods for follow up include telephone and virtual presence.

Change Tactic:
Provide collaborative drug therapy management for selected conditions or medications

Implementation of Collaborative Drug Therapy Management (CDTM) varies across the nation, based upon state laws controlling this activity. The CDC published a resource for pharmacists that practices may find helpful: "Collaborative Practice Agreements and Pharmacists' Patient Care Services." With CDTM, the pharmacist formally partners with a physician to provide optimal drug therapy management. This collaborative practice agreement (CPA) grants the pharmacist the ability to manage medications. According to a Centers for Disease Control (CDC) resource, a pharmacist CPA is "a formal agreement in which a licensed provider makes a diagnosis, supervises patient care, and refers patient to a pharmacist under a protocol that allows the pharmacist to perform specific patient care functions."[9]

Online (external) resources related to medication management

Collaborative Practice Agreements and Pharmacists' Patient Care Services: A Resource for Pharmacists (2013). This resource describes the patient care services provided by pharmacists. These include medication therapy management (MTM) and collaborative drug therapy management (CDTM).
http://www.cdc.gov/dhdsp/pubs/docs/Translational_Tools_Pharmacists.pdf

Essential components

- Select conditions and medications that have a protocol developed.
- Set up a formal partnership between the pharmacist and the physician to provide drug therapy management.
- Have a collaborative practice agreement in place.
- Note that under the agreement, the pharmacist has authority to monitor, modify or initiate drug therapy, as well as order laboratory testing and assess the patient response to therapy.
- Ensure the pharmacist and physician have joint access to documentation.

Considerations for your practice

- Note that although the scope of CDTM can vary by state, 47 states allowed pharmacists to practice collaboratively with physicians. (Check with your state for specific regulations.)
- Note that most practices use CPAs with diabetes, hypertension, dyslipidemia, heart failure and anticoagulation.
- Determine patients who may benefit from this approach:
  - Patients in high-risk cohorts as identified in the practice risk stratification methodology
  - Patients who have not achieved a therapeutic goal for a chronic condition
  - Patients in care transitions
  - Patients with multiple ED visits or hospitalizations
  - Patients with high-risk medications or complex medication regimens

[9] Centers for Disease Control and Prevention. Collaborative Practice Agreements and Pharmacists' Patient Care Services: A Resource for Pharmacists. Atlanta, GA: US Dept. of Health and Human Services, Centers for Disease Control and Prevention. http://www.cdc.gov/dhdsp/pubs/docs/Translational_Tools_Pharmacists.pdf

Measuring Success for Change Concept: Manage medications to maximize efficiency, effectiveness and safety

Both process and outcome measures will inform the practice of the benefit to the patient population.

Process measures

- Meaningful use medication reconciliation measure
- Percent of patients with a transition of care who had medication reconciliation
- Number of patients with medication review each month
- Number of patients seen in collaborative drug therapy management

Outcome measures

- Track clinical quality measures of lipid management in diabetes control, hypertension control and heart failure therapy
- Track ED and in patient hospitalizations

Change Concept: Provide intensive self-management support for patients with poorly controlled chronic conditions

Intensive **self-management support** (SMS) is an advanced primary care strategy for practices. The tools and techniques align with the competencies needed for longitudinal case management (see page 9).

For more self-management support information and resources, see ***Secondary Driver 1.2: Planned Care and Population Health****.*

Intensive self-management support involves a team-based approach with specific team members dedicated to working with specific patients. Medical, behavioral and psychosocial needs for patients with chronic illness and co-morbid conditions are coordinated. These highly individualized interventions include several basic characteristics:[10]

- Guides patients through the development of a shared action plan
- Peer support
- Provides intensive interventions for self-management
- Helps patients understand signs of exacerbations of illness
- Provides referrals or coordinates behavioral, psychosocial and community services

Peer support is a useful method to reinforce SMS. The Stanford Self-management Programs are an example of a program based on peer support. [11] These sessions are community-based, peer-led sessions that allow the patient the opportunity to both learn self-management skills and support others in their disease management.

Change tactics CPC practices have used:

- Develop a shared visit agenda with the patient
- Provide coaching between visits with follow-up on care plan and goals

Implementation tips for self-management support for patients with poor control

- Build a team that will test changes and will be early adopters.
- Develop goals for SMS support implementation and measures
- Define "poorly controlled."
- Identify patients that can benefit from intensive self-management support through registry data.
- Train the team in intensive self-management techniques and regularly shadow for competency.
- Develop a tracking method for the patient's self-management progress through a plan of care.
- Develop a list of up-to-date community resources to incorporate in the EHR.
- Test process on five patients before scaling and make adjustments as needed.
- Build in techniques and tools into processes for patients with poorly controlled conditions.

[10] http://www.aafp.org/afp/2005/1015/p1503.html

[11] **Stanford Small-Group Self-management Programs (in English and Spanish).** http://patienteducation.stanford.edu/programs/

Change Tactic: Develop a shared visit agenda with the patient

A nurse or MA can complete visit preparations or an agenda the day before or just prior to the appointment. This may include reviewing past documentation, preventive health screenings that are due, and labs that need review. This will help identify and address gaps in care.

Before the visit, patients can be given a questionnaire (electronically or on paper) to write down what they would like to get out of the visit in descending order of priority. The pre-visit questionnaire can also include questions traditionally asked during rooming, such as depression screens, pain assessment, smoking status and falls screening. Using the questionnaire, the MAs and nurses are able to obtain much of the information that they would need to obtain during the visit, giving them more focused time with patients. If a patient cannot fill out a questionnaire, this can be a collaborative conversation between the MA and the patient to co-develop the agenda based on their mutual information needs. Agendas developed with the patient not only organize the visit, but also engage the patient to be an active member of the care team.

Essential components

- Develop registries to identify gaps in care.
- Ensure notes and care plans are accessible for review.
- Create a questionnaire to help identify what is important to the patient and what may need further assessment.
- Train teams how to negotiate and prioritize a shared agenda with the patient.
  - Many patients with poorly controlled conditions have difficulty with prioritization and problem solving. Being a role model for prioritization and problem solving at every visit teaches the patient a valuable skill and is an intervention by itself.
- Refer to the agenda throughout the visit and check off items as they are resolved.
- Ensure all reasonable patient needs are satisfied at the end of the visit.

Considerations for your practice

- Understand that some high-risk patients may expect solutions that may be unsafe to provide, such as ongoing opioid requests or early refills. The team should be clear about what boundaries exist, and agree on what actions to allow and disallow.
- Note that patients may have more identified concerns than there is time to address in the visit. Negotiation on how to handle these concerns can occur upfront in the visit (for example, bring in another team member to address issues).
- Determine how an agenda developed electronically will merge with the visit notes so that the provider can easily see it.

Change Tactic: Provide coaching between visits with follow-up on care plan and goals

Primary care teams often fail to meet the between visit needs of patients with unmanaged chronic health conditions. A major part of building self-management is ensuring that patients understand, are part of developing a treatment plan, and participate in the management of their chronic conditions. To do this, teams must incorporate coaching and follow-up into the plan. Coaching between visits and adequate follow-up ensure that each patient is educated about their condition, knows how to manage their medication, and is aware of what lifestyle behaviors positively and negatively affect their condition. Implementation of health coaching techniques to improve self-management and reduce the risk for hospital readmissions is a cost effective strategy to address this issue.[12]

Health coaching involves five principal roles: [13]

- Providing self-management support
- Bridging the gap between clinician and patient
- Helping patients navigate the health care system
- Offering emotional support
- Serving as a continuity figure

Online (external) resources: self-management support

Partnering in Self-management Support: A Tool-kit for Clinicians (2009). http://www.improvingchroniccare.org/downloads/selfmanagement_support_toolkit_for_clinicians_2012_update.pdf

Patient Self-management Tools (2016). http://champsonline.org/tools-products/clinical-resources/patient-education-tools/patient-self-management-tools

Stanford Chronic Disease Self-management Program (2016). This is an example of a peer lead, evidence-based support resource. http://patienteducation.stanford.edu/programs/cdsmp.html

Essential components

- Designate a trained team member to provide coaching resources (may be an RN, BH or specified "health coach").
- Introduce this person to the patient and their role in the patient's care.
- The patient should help develop the plan for frequency and the method of follow-up coaching (in-person, over the phone etc.).
- The entire team should have access to the documentation and updates.

Considerations for your practice

- Interventions and approaches should be flexible to meet patient's unique needs.
- The entire team should have at least basic knowledge of the techniques used to reinforce the methods or tools used during visits.
- Provide an up-to-date community resource list.
- Develop a guideline to determine when the person providing the coaching needs to review the case with the team because improvement is not occurring or the patient is struggling to make the change.

[12] Holmes-Rovner M, Stommel M, Corser WD, et al. Does outpatient telephone coaching add to hospital quality improvement following hospitalization for acute coronary syndrome? J Gen Intern Med. 2008;23:1464–1470.
[13] http://www.aafp.org/fpm/2010/0900/p24.html

Measuring Success for Change Concept: Provide intensive self-management support for patients with poorly controlled chronic conditions

Understanding how self-management support affects the patient population will assist the practice in its refinement efforts. Both process and outcome measures provide the necessary insight.

Process measures

- Number of patients receiving intensive self-management
- Number of patients receiving training or skills for self-management of a target condition
- Number of patients receiving peer-training or in group visits
- Percentage of patients with a personalized goal documented for a target condition
- Percentage of patients with an action plan for a target condition
- Number of patients receiving intensive self-management support for a poorly controlled chronic condition

Outcome measures

- Quality metrics related to target conditions will yield important insight into how support for self-management affects outcomes.
- Utilization measures for patients in the high-risk tier or with target conditions will also provide insight as to their effect.
- Reduction in ED and hospitalizations

Resources for Secondary Driver 1.3: Risk-stratified Care Management

The Academy: Integrating Behavioral Health and Primary Care – The Playbook (2016). Provides a good description of its developed Shared Care Plan. http://integrationacademy.ahrq.gov/playbook/about-playbook

Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs (2011). The authors discuss care coordination and management of patients with the highest need for this strategy. http://www.ihi.org/resources/Pages/IHIWhitePapers/IHICareCoordinationModelWhitePaper.aspx

Care Management: A Review of CPC Practice Approaches (2014). Additional information on care management with CPC practice implementation case studies. https://downloads.cms.gov/files/cmmi/cpci-combined-implementationguide.pdf#page=2

Care Management: Implications for Medical Practice, Health Policy, and Health Services Research (2015). http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/caremanagement/index.html

Chronic Care Management Services (2015). https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

Clinical Decision Support Starter Kit (2017). Order sets are used to make the ordering process more efficient and to standardize a level of care across the practice. This starter kit describes the use of order sets as a part of clinical decision support. https://www.healthit.gov/providers-professionals/implementation-resources/clinical-decision-support-starter-kit

Collaborative Practice Agreements and Pharmacists' Patient Care Services: A Resource for Pharmacists (2013). http://www.cdc.gov/dhdsp/pubs/docs/Translational_Tools_Pharmacists.pdf

CPC On Demand Video: How to Enhance Transitions of Care (2017). In this video, you will explore the tools you can use to help in your effort to reduce unnecessary emergency room visits and hospital readmission rates. https://www.youtube.com/watch?v=LK2ILb9SgQs&index=20&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC On Demand Video: Longitudinal and Episodic Care Management (2017). This video describes how one practice differentiates between patients who need long term care management and those who need shorter term or episodic care management during transitions of care. https://www.youtube.com/watch?v=99bbAZn_0Uo&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh&index=3

CPC On Demand Video: Patient-centered Plan of Care (2017). A practice describes their tactics for care management and risk stratification, which helped them reach their goals. https://www.youtube.com/watch?v=LK2ILb9SgQs&index=20&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC On Demand Video: Targeted Care Management (2017). Features DTC Family Health and Walk-in (Colorado) sharing data to show the how care management improved care for high-risk patients. https://www.youtube.com/watch?v=wtIvLQOez-g&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh&index=7

CPC On Demand Video: Using Data to Identify Patients with Behavioral Health Needs (2017). In this video, a practice talks about how they used data to identify the behavioral health needs of their patient population. https://www.youtube.com/watch?v=G6s7AuHyIQs&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh&index=8

CPC On Demand Video: Using Risk Stratification to Drive Workflow (2017). This video describes one practice's experience using a risk-stratification methodology to determine the level of involvement for care management and to drive their care management and coordination workflows. https://www.youtube.com/watch?v=rOjMOJ0YnHI&t=3s

CPC Practice Spotlight 2: SAMA Healthcare (2013). SAMA Healthcare describes its risk stratification tool and how the practice EHR plays a role in accomplishing this task and keeping care teams informed. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=6

CPC Practice Spotlight 6: TriHealth (2014). Using a standardized process, this practice established a four-level care management needs assessment as a means of identification of risk level. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=14

CPC Practice Spotlight 7: Oregon Medical Group (2014). This group used the services of a knowledgeable psychologist to develop their BHI program. Article describes steps taken, including selecting the appropriate BHS professional, and the screening used to identify patients. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=17

CPC Practice Spotlight 8: OU Physicians and Associates in Family Medicine (2014). Two CPC practices describe how they included medication management as a part of their primary care services. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=20

CPC Practice Spotlight 16: Lower A1c Among Patients with Diabetes Through Standardized Team Approach (2014). One CPC practice in Oklahoma developed a standard approach to care management of patients with diabetes that demonstrated promising results. In taking a proactive approach to the care management of this population, this practice saw a notable improvement on this clinical quality measure. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=38

CPC Practice Spotlight 21: Data-Driven Improvement Using Medication Management and Shared Decision Making with High-Risk Patients with Diabetes (2014). This health center engaged the expertise of a pharmacist as it launched an intensive diabetes management education program for patients with an A1c greater than 9. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=43

CPC Practice Spotlight 22: Heeding the Signs: Know When It's Time to Modify Your Risk Stratification Methodology (2014). This example shows how a practice changed its three-tier risk stratification methodology after noting some trends that the team found troubling. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=44

CPC Practice Spotlight 28: It Takes a Neighborhood to Increase Medication Safety for Patients (2014). A CPC practice closed the gaps in its medical neighborhood by collaborating with two pharmacies. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=51

CPC Practice Spotlight 42: Critical Elements in Care Management: Process/Data, Protocols and Reinforcement/Response (2015). CPC Spotlight dives into the use of data for care management, as well as implementation of innovative methods of care. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=7

CPC Practice Spotlight 49: Patient-centered Care Plan Curbs Patient's Hospital Use, Savings to Top $150,000 (2015). This CPC practice in Kentucky modified a patient's care plan to meet her needs, resulting in a large reduction in high-cost utilization and ultimately expenditures. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=13

CPC Practice Spotlight 55: Measuring the Effectiveness of Behavioral Health Management (2015). Boulder Community Health in Boulder, Colo., included behavioral health services in its five CPC practices. To evaluate the effectiveness of the practice's behavioral health services, the team of social workers tracked the PHQ-9 scores among patients with moderate and severe depression following treatment. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=18

CPC Practice Spotlight 57: Shared Decision Making Can Be Part of Behavioral Health (2015). Vanguard Medical Group (Verona, N.J.) has an imbedded behavioral specialist. The use of a shared decision aid assists the patient and practice team to decide if use of medication for depression is the best option. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=20

CPC Practice Spotlight 65: Social Worker Contributes to Collaborative, Team-based Care Management (2016). Stillwater Medical Physicians Clinic (Okla.) finds that the addition of a social worker to their care management team positively affects the services provided to the patients. https://innovation.cms.gov/Files/x/cpcipsl2014-2016.pdf#page=26

CPC Practice Spotlight 72: Small Practice Leverages Team-based Care and Care Management (2016). Learn how this Ohio solo practitioner's care management strategy led to reduced hospital admissions and ED visits. https://innovation.cms.gov/Files/x/cpcipsl2014-2016.pdf#page=30

DIAMOND for Depression (2016). ICSI's DIAMOND (Depression Improvement Across Minnesota, Offering a New Direction) program united a physician, care manager and consulting psychiatrist to provide a team-based model for caring for patients with depression in the primary care clinic. https://www.icsi.org/about_icsi/legacy_work/diamond_for_depression/

DIAMOND Study Findings (2014). Study results of the model, implemented in almost 100 clinics. https://www.icsi.org/_asset/nn70fc/ICSI-DIAMOND-Study-Finding-6-4-14.pdf

Resources

FP Credits CPC Initiative With Practice Turnaround, AAFP (2016). http://www.aafp.org/news/macra-ready/20161116cpcplus.html

A Guide to Evidence-Based Practices. SAMHSA-HRSA (2016). http://www.samhsa.gov/ebp-web-guide

Improving Care for Complex Patients: The Role of the RN Care Manager (2012). http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Supplement-Evidence-Based-Care.pdf

Integrating Comprehensive Medication Management to Optimize Patient Outcomes, PCPCC Resource Guide, Second Edition (June 2012). https://pcpcc.org/sites/default/files/media/medmanagement.pdf.

Medicare Medication Therapy Management (2016). Medicare has a standardized format for medication therapy management for those participating in Medicare Part D. It includes a cover letter, medication action plan and personal medication list. https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Memo-Contract-Year-2017-Medication-Therapy-Management-MTM-Program-Submission-v-040816.pdf

Medicare Part D Medication Therapy Management Program Standardized Format (2012). A written summary of a comprehensive medication review. https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/MTM-Program-Standardized-Format-English-and-Spanish-Instructions-Samples-.pdf

Partnering in Self-management Support: A Tool-kit for Clinicians (2009). http://www.improvingchroniccare.org/downloads/selfmanagement_support_toolkit_for_clinicians_2012_update.pdf

Patient Self-management Tools (2016). http://champsonline.org/tools-products/clinical-resources/patient-education-tools/patient-self-management-tools

PHQ-2. This questionnaire is used as the initial screening test for major depressive episodes. https://integrationacademy.ahrq.gov/sites/default/files/PHQ-2_0.pdf .

PHQ-9. A multipurpose questionnaire for screening, diagnosing, monitoring and measuring the severity of depression. https://integrationacademy.ahrq.gov/sites/default/files/PHQ-9_0.pdf

Recognition and management of dementia. In: Evidence-based geriatric nursing protocols for best practice, AHRQ National Guidelines Clearinghouse (2012). This provides tools to screen for dementia. https://www.guideline.gov/summaries/summary/43921

Risk Stratification Implementation Guide (2014). This guide captures how CPC practices tested and implemented their risk-stratification methodologies. Includes sample tools. https://downloads.cms.gov/files/cmmi/cpci-combined-implementationguide.pdf#page=35

SAMHSA National Registry of Evidence-based Programs and Practices (2016). http://www.samhsa.gov/nrepp

SBIRT (Screening Brief Intervention and Referral to Treatment) - A Primary Care Tool to Assess for Substance Use Disorder (2016). Tool used to identify patient who are moderate or high risk users with the goal of early intervention to prevent health problems related to Substance Use Disorder. http://ejournal.tnmed.org/cgi/viewcontent.cgi?article=1039&context=home

Screening Tools, SAMHSA-HRSA Center for Integrated Health Solutions (2016). This site offers multiple screening tools for behavioral health concerns that may be used in the primary care setting. http://www.integration.samhsa.gov/clinical-practice/screening-tools

Stanford Chronic Disease Self-management Program (2016). This is an example of a peer lead, evidence-based support resource. http://patienteducation.stanford.edu/programs/cdsmp.html

Tips and Strategies for Billing for Mental Health Services in a Primary Care Setting (2017). http://www.sprc.org/sites/default/files/tipsandstrategiesforbilling.pdf