INTRODUCTION TO CARE PATHS

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Carepaths…

Sometimes know as:

- Vertical Integration
- Groups
- Standing Orders

Horizontal and Vertical Integration

- Horizontal Integration: Population management
- Vertical Integration: Targeted services to a sub-population in need

Horizontal & Vertical are complementary approaches to integration

Rationale for Carepaths

- Improve health outcomes of target population
- Decrease burden. High utilizing patients present a significant burden and cost to practices
  - Impact of high utilizers on PCPs
  - Impact of high utilizers on staff
- Increase satisfaction of PCPs and patients

- Improve cost-offset (defined as decrease in medical utilization as a result of behavioral interventions)
- Better address complex problem areas
- Provide increased access for patients to receive care
- Provide more PCP-BHC collaboration opportunities

Starting a Carepath

Questions to ask of your clinic

- What does the clinic need?
- What do the PCPs need most help with?
- What are the needs of the larger community?
- What are the most common/ prevalent diagnoses/problems at your clinic or in your community?

Once you have a target group, consider types/models of carepaths

What model would best fit the population?

- Traditional care-path
  - automatic referral
  - part of system
  - care path is part of routine care for that particular condition

- Program-style: Patient or PCP referral to ongoing class

- Individual vs. Group

Consider your resources

- Are the PCPs all on board with the plan?
- Is space available?
- Will systems support it?

Consider criteria for identifying patients

- All receiving “x” diagnosis
- All high utilizers
- All meeting a specific criteria eg. with a BMI over 30
- Any exclusionary criteria?

Review roles of team members

- PCP role
- BHC role
- Medical staff
- Support staff

Review flow procedures for all members of team

- How will patients be flagged?
- Who will make the initial contact? (i.e. contacting patients and offering a series of classes in lifestyle management, illness management, building strengths, etc.)
- What intro scripts will be used?

Review and plan content of your program

- Include highly condensed, evidenced-based interventions tailored to fit the pace and flow of primary care.
- Didactic, skill-based work; emphasize improving adherence, improving health, activation, skill acquisition and application (practical application)

- Class, not therapy
- Good program will have education, behavioral activation, goal-setting, self-monitoring, coping tools
- Potential carepath elements: classes (most common); BHC (1 on 1); follow-up phone calls; reading materials; handouts; self-monitoring; goal-setting; videos

Things to keep in mind

- Be flexible and persistent
- Monitor progress/tracking of patients
- Program evaluation
- Make changes based on feedback
- Market and communicate well

- Stick with empirical-base
- Use marketing at clinic and community
- Implement and master horizontal program first (BHC comfort, PCP comfort, good collaboration, establish high pt satisfaction)

Carepath Template

Population

All patients with diagnosis of _____ defined by _____

Goals & Objectives

Goal: Reduce/increase _____

Objectives:

- Increased awareness of _____
- Improved adherence to _____
- Pt starts _____
- Pt stops _____
- Pt continues _____

Roles

- PCP
  - Conducts exam, defines treatment goals, reviews/adjusts medications
  - Helps identify appropriate patients by _____ (eg. defining criteria, reviewing patient list, referring patients)
  - Presents specific topics

- BHC
  - Identifies appropriate patients
  - Defines content
  - Coordinates with PCP and other staff members
  - Markets carepath by _____

- Nurse Care Manager role
- Medical Assistant role
- Other staff member’s roles

Structure

- Contact1
  - Introduction to carepath
  - Define goals & objectives
  - Education about _____ (topic)
  - Set targets till next contact

- Contact 2 (define time frame)
  - Review goals and objectives
  - Discuss barriers and successes (e.g. medication adherence, exercise planning, diet change, family issues, side effect issues, MH issues, etc.)
  - Further patient education regarding disease if needed
  - Discuss progress and changes to patient's goals with PCP

- Plan for follow-up

References

- Robinson & Reiter. *Behavioral Consultation and Primary Care.*
- O'Donohue and colleagues. *Integrated Behavioral Healthcare*
- Susan McDaniel and colleagues. *Primary Care Psychology.*