



INTRODUCTION TO CARE PATHS

Geeta Aatre-Prashar, Psy.D.

Saint Louis Behavioral Medicine Institute

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Carepaths...

Sometimes know as:

- Vertical Integration
 - Groups
 - Standing Orders
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Horizontal and Vertical Integration

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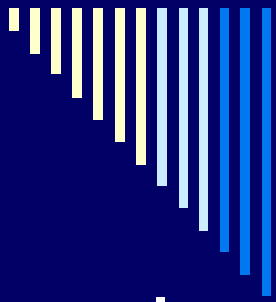


**Horizontal & Vertical are
complementary approaches to
integration**



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
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- 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
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Starting a Carepath

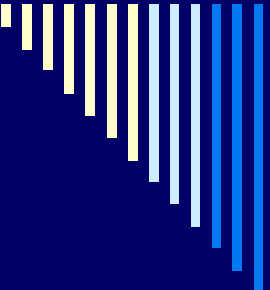


Questions to ask of your clinic

- 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?
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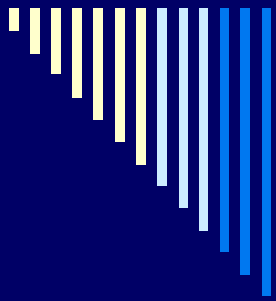


**Once you have a target group,
consider types/models of
carepaths**



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
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- 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?
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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?
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Review roles of team members

- PCP role
 - BHC role
 - Medical staff
 - Support staff
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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?
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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)
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- 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

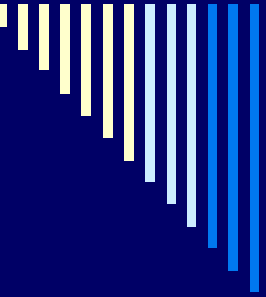


Things to keep in mind

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

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



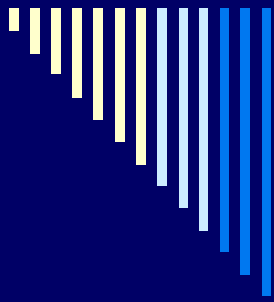
- Nurse Care Manager role
- Medical Assistant role
- Other staff member's roles



Structure

□ Contact1

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