Integrating Services and Supports for Primary Care and Behavioral Health

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Integration Goals

- To address access (both access to MH services for those in primary care/not SPMI, and access to primary care for those with SPMI);
- To create infrastructure within and across the primary care and mental health systems to support effective integration; and
- To engage consumers in the design of the integration initiatives.

The Care Model

Using Wagner’s Model as a Template

- Interaction between the patient and provider is key
  - IOM “Mutual Healing Relationship”
  - People with disabilities have special needs and skills
- Self Management is a component of Recovery
  - Understand “Stages of Change”
  - Must accept and plan for setbacks as well as successes
- Community Resource Connections
Robert Wood Johnson Support

Depression in Primary Care – Linking Clinical and Systems Supports
http://www.depressioninprimarycare.org/
- Incentive Demonstration Grant

Center for Health Care Strategies
http://www.chcs.org/
- Medicaid Managed Care Program Grant
- Best Clinical and Administrative Practices in Medicaid Managed Care (BCAP) for People with Disabilities or Chronic Conditions

The Vermont Community Depression Project (2002-2005)
- RWJF “Depression in Primary Care” Program (www.depressioninprimarycare.org)
- Administered by University of Pittsburgh Medical School
- Links Clinical and Economic strategies
- Focus on Chronic Care and Collaborative Improvement
- Connecting Safety Net providers for Primary and MH Care

Context
- Low Income Vermonters in Rural areas
- Primary Care Practices that serve Medicaid/uninsured populations
- Community Mental Health Centers

Windsor
Objectives

- Integrate primary care and community mental health systems to increase access to services
- Enhance capacity of primary care practices to provide care to patients with complex psychosocial needs

Design, Setting and Participants

- Co-Location of CMHC case managers (“Care Partners”) in Primary Care Practices
- 2 Federally Qualified Health Centers
- 2 Critical Access Hospitals

Interventions

- “Wellness Action Recovery Planning” self management strategy
- “How’s Your Health?” online health assessment and care planning tool
- Clinical Microsystem Improvement approach
- Web-based reporting system
**Main Outcome Measures**

- Changes in PHQ-9 scores
- Percentage of patients with documented self-management goals
- Followup after hospitalization
- Appropriateness of medication

**Progress To Date**

- Program began in July 2003; all sites had Care Partners on staff as of July 2004
- 2100 Vermonters served as of 1/1/06
- Over 90% have documented self-management goals
- Care Partners are still assisting practices in managing comorbidities, such as diabetes and cardiovascular disease

**Potential Significance**

- Care partner activities (self management support, community integration) obtained dedicated FFS reimbursement
- CMHC/Primary Care alliances can offer a wider continuum of care than carveout models
The Vermont Medical Home Project

- Funded by an RWJ Grant through the Center for Health Care Strategies, Inc. Medicaid Managed Care Program (2000-2005)
- Also included in CHCS Best Clinical and Administrative Practices for People with Disabilities and Chronic Conditions (2003)

Drivers

- Lessons learned from SSI Enrollment
  - “Nothing About Us Without Us”
- The Importance of a Medical Home for Everybody
- Primary Care Overload
  - “How do you build a Medical Home without any tools?”
- Vulnerable Populations
- People with Serious/Chronic Mental Illnesses

National Association of MH Medical Directors – Problem Statement

- Recent data from several states have found that people with serious mental illness served by our public mental health systems die, on average, at least 25 years earlier than the general population.
NASMHD - Contributing Causes

- Preventable Medical Conditions
  - Metabolic Disorders, Cardiovascular Disease, Diabetes Mellitus
  - High Prevalence of Modifiable Risk Factors (Obesity, Smoking)
  - Epidemics within Epidemics (e.g., Diabetes, Obesity)
  - Some Psychiatric Medications Contribute to Risk
  - Weight gains of 40-100 pounds
  - Established Monitoring and Treatment Guidelines to Lower Risk Are Underutilized in SMI Populations

Other Contributing Causes

SMI may be a health risk factor because of:

- **Patient factors**, e.g.: fearfulness, homelessness, victimization/trauma, resources, advocacy, unemployment, incarceration, social instability, IV drug use, etc.
- **System factors**: Funding, fragmentation
- **Provider factors**: Comfort level and attitude of healthcare providers, coordination between mental health and general health care, stigma

Cardiovascular Disease (CVD) Risk Factors

<table>
<thead>
<tr>
<th>Modifiable Risk Factors</th>
<th>Estimated Prevalence and Relative Risk (RR)</th>
<th>Schizophrenia</th>
<th>Bipolar Disorder</th>
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</thead>
<tbody>
<tr>
<td>Obesity</td>
<td>45-55%, 1.5-2X RR²</td>
<td>26%³</td>
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</tr>
<tr>
<td>Smoking</td>
<td>50-80%, 2-3X RR²</td>
<td>55%³</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>10-14%, 2X RR³</td>
<td>10%³</td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>≥18%⁴</td>
<td></td>
<td>15%³</td>
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<tr>
<td>Dyslipidemia</td>
<td>Up to 5X RR¹</td>
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The Project and the Partners

- Enhancing systems and supports for care of individuals with disabilities or chronic conditions
- For SPMI population - building connections between primary care and community mental health services
- Consumers, State agencies, primary and mental health clinicians worked together on design and implementation
Key Concepts
- Wellness Recovery Action Planning
  - www.mentalhealthrecovery.com
  - Wellness Tool Box
  - Maintenance, triggers, crisis and post-crisis planning
  - Connection with other chronic conditions such as diabetes
- Co-location of “Care Partner” Nurses in Community MH Centers

Where We Are Now
- Demonstrated that people with chronic mental illnesses are the highest cost population seen in Primary Care
- Shown that onsite nursing support can improve health status (HgbA1C, Cholesterol, BP)
- Wellness is not expensive
  - “Benchmarking Project”
  - Integrating Medical Care and Recovery

Care Changes in MH System
- Health care questions posed more often by case managers and other staff
- Greater attention to involvement of health care provider for all consumers.
- Persons in crisis more often viewed in context of how health issues may be impacting on them versus seeing them as psychiatric issues first
Comments from case managers

- “...for those with serious co-morbidity issues like diabetes, the addition of this critical coordination and oversight of medical services to help the client navigate through the myriad of issues and potentially conflicting information around their physical and mental health care, is essential.”
- “…it has provided something that case managers, lacking sufficient medical knowledge, cannot. I couldn’t articulate how much of a burden is lifted for a case manager when this happens”

Recommendations - Consumer Supports

- Shared decision making around medication
- Motivational interviewing re: health behaviors
- Peer supports for nutrition and exercise
- Empowerment of families to support and advocate for wellness
- Community connections to foster natural supports and combat stigma

Recommendations – Care System

Care Partner roles
- Nurses with ambulatory care and/or home health experience co-located in Community Mental Health programs.
- Consultation liaison between RN and CMHC Case Manager
- Physical health status' impact on psychiatric symptoms and vice versa
- Continuum of care – from total wraparound to information and referral
**Recommendations – Care System**

- Connection with co-occurring disorders
  - Integration of harm reduction and stages of change approaches to both addiction treatment and health promotion/disease management
  - Trauma sensitivity
    - Especially concerning physical exams, GYN care, etc
    - Awareness of effect of PTSD on behavior, addictions, etc.
- PC/CMHC connection
  - Primary Care Providers
    - Advanced practice nurses may serve as PCP’s and liaison with MH system
  - Connection with Federally Qualified Health Centers/Rural Health Centers

**Lessons Learned**

- Recovery is key – treatment is part of recovery rather than vice versa
- Integrate or Stagnate
  - BH-Primary Care and Primary Care-BH
  - Comorbid BH can double costs
  - Don’t overlook Trauma
- Long term ROI
  - Significant Costs but Significant Opportunities

**Resources**

SAMHSA/CMHS Building Bridges: Mental Health Consumers and Primary Health Care Representatives in Dialogue
- [http://download.ncadi.samhsa.gov/ken/pdf/SMA06-4040/Po](http://download.ncadi.samhsa.gov/ken/pdf/SMA06-4040/Po)licy_Makers_Booklet.pdf

NASMHPD Position Paper

NCCBH Integration Overview