# Integrating Primary and Behavioral Health Care

Lessons from the Field

# Lessons From Far Afield

- What does “integration” mean?
  - What we learned from the Missouri  Primary/ Behavioral Health Integration Initiative.
- Missouri’s Health Homes
  - How we’ve applied what we learned

# Missouri Primary/Behavioral Health Integration Initiative

- State Level Partners
  - Department of Mental Health
  - Primary Care Association
  - Coalition of Community Mental Health Centers
- Local Participants
  - Six CMHC/FQHC partners
  - One CMHC recently designated as an FQHC
  - Three year demonstration project
    - January, 2008 through June, 2011

# Integration Initiative Objective

- Improve access
  - To **primary care** for people with serious mental illness
  - To **behavioral health services** for people with previously unrecognized and/or untreated mental health problems
  - To **behavioral health supports** for people who require assistance in effectively managing their chronic disease or improving health status

# Integration Initiative Design

- FQHCs: Co-location
  - Open a primary care clinic on-site at the CMHC
- CMHC's: Embedding and Co-location
  - Embed a Behavioral Health Consultant (BHC) in FQHC primary care teams
  - Provide psychiatric services and consultation on-site at the FQHC

# Integration Initiative Lessons Learned

- Co-locating Primary Care Clinics
  - Most CMHCs do not have enough consumers to support an on-site primary care clinic
  - Many FQHC's already see a significant number of CMHC consumers
  - Many CMHC consumers already have some connection to a community PCP

**"Processes must be in place – beyond simple co-location – to ensure that effective communication and coordination between providers happens routinely."***

*"Behavioral Health Homes for People with Mental Health and Substance Abuse Conditions: The Core Clinical Features", Center for Integrated Solutions, SAMHSA-HRSA

# Integration Initiative Lessons Learned

- Embedding Behavioral Health Consultants
  - Highly valued by Primary Care teams
  - Changed how primary care teams saw the people they serve

# What Does 'Integration' Mean?

"A whole person approach to care looks at all the needs of the person and does not compartmentalize aspects of the person, his or her health, or his or her well-being…. [and uses} a person-centered planning approach to identifying needed services and supports, providing care and linkages to care that address all of the clinical and non-clinical care needs of an individual."

CMS Letter to State Medicaid Directors, Re: Health Homes for enrollees with Chronic Conditions, 11/16/2010

# Serving the Whole Person

- Is not possible through Co-location without Coordination or Collaboration.
- Is possible through Coordination or Collaboration without Co-location.
- Embedding is critical, but not sufficient

# Two Types of Health Homes: Why?

- Coordination/Collaboration is the key
- Trust between the safety net systems of care
- Lewin Group: Five percent (5%) of the Medicaid population accounts for 52% of the costs
  - **85%** have at least one **mental health diagnosis**
  - **30%** receiving **psychotropic medications**, but no behavioral health office visit
- Significant percentage of CMHC consumers have or are at risk for other chronic diseases
- CMHCs are already their "home"

# Missouri's Health Homes

| Primary Care Health Homes | CMHC Healthcare Homes |
| --- | --- |
| **Providers** | **Providers** |
| 18 FQHCs/5 Hospitals | 28 CMHCs |
| **Enrollment: 15,954** | **Enrollment: 18,998** |
| Adults: 15,226 | Adults: 16,611 |
| Children: 428 | Children: 2,387 |

# Target Populations

## Primary Care Health Homes

- Individuals  with Diabetes
  - At risk for cardiovascular disease and a BMI > 25
- Individuals who have two of the following
  - COPD/Asthma
  - Cardiovascular Disease
  - Developmental Disabilities
  - Use Tobacco
  - BMI>25

## CMHC Healthcare Homes

- Individuals with a serious mental illness
- Individuals with other behavioral health problems who also have
  - Diabetes
  - COPD/Asthma
  - Cardiovascular Disease
  - Developmental Disabilities
  - Use Tobacco
  - BMI>25

# Missouri's Health Homes

| Primary Care Health Homes | CMHC Healthcare Homes |
| --- | --- |
| Health Home Director | Health Home Director |
| Care Coordinator | Care Coordinator |
| Nurse Care Managers | Nurse Care Managers |
| Behavioral Health Consultant | Primary Care Physician Consultant |

CMHC Healthcare Homes

# Medicaid Rehab Option

- Community Psychiatric Rehab (CPR) Teams
  - Team Caseloads:  125
  - Master's Level BH Clinician:  1
  - BA Level Community Support Specialists (CSSs): 5
  - Psychiatrist (serves multiple teams)
  - Psycho-social rehabilitation staff (serve multiple teams)
- Embed Nurse Care Managers

HCH Team Members

# Nurse Care Managers

- **Champion healthy lifestyles and chronic disease management**
- **Review client records and patient history**
- **Participate in annual treatment planning**
- **Consult with CSS's** about identified health conditions of their clients
- **Coordinate** care **with external health care providers** (pharmacies, PCPs, FQHC's etc.)
- **Follow up on hospitalizations** and **reconcile medications**
- **Provide education to staff and consumers**

HCH Team Members

# Primary Care Physician Consultant

- **Helps educate** community support specialists, case managers, and clinical staff on the nature, course, and treatment of chronic diseases
- **Establishes priorities** for disease management and improving health status.
- **Participates in case consultation** with psychiatrist, QMHP, nurse care managers, and community support specialists
- **Develops collaborative relationships** with treating PCPs and Psychiatrists, as well as other healthcare professionals and facilities

# What is a Healthcare Home?

- Continuous Team-based Care
- Population Management
- Comprehensive Care Management
- Person Centered Empowerment
- Wellness and Healthy Lifestyles

# Continuous Team-based Care

- Each individual has a care team that
  - Is proactive
  - Provides continuous care across settings and life transitions
  - Understands the nature, course and treatment of relevant chronic diseases
  - Promotes and enables individuals to manage chronic disease, and to embrace wellness and adopt healthy lifestyles

# Population Management

- Care teams utilize care management data to
  - Establish priorities for disease management and improving the health status of a cohort, and
  - Identify individuals who may require immediate intervention or a case consultation
- Care teams use registries to proactively contact, educate, and track individuals by disease, self-management status, and service and support needs.

# Comprehensive Care Management

- Each individual has a comprehensive health assessment and treatment plan with health and wellness goals
- Each individual, and their care team, has an effective healthcare relationship with a PCP
- The care team is aware of ER visits and hospital admissions, and participates in discharge planning, and follows up to conduct a medication reconciliation.
- The care team monitors key indicators related to the management of the targeted chronic diseases and the improvement of health status.

# Person-centered Empowerment

- Individuals are empowered and supported in the self-management of their chronic diseases
- Individuals are encouraged and supported in embracing wellness and adopting healthy lifestyles
- Individualized treatment plans are developed collaboratively, include self-management and clinical management goals, address health and wellness as well as chronic disease issues, and are used to guide care
- Services and supports promote independence

# Wellness and Healthy Lifestyles

- The organization promotes and supports staff and consumers in choosing and pursuing healthy lifestyles
- Eight dimensions of wellness
  - Emotional, Financial, Social, Spiritual, Occupational, Physical, Intellectual and Environmental

"Wellness is a conscious, deliberate process that requires a person become aware of and make **choices** for a more satisfying **lifestyle**".

Swarbrick, M. (1997),"A Wellness Model for Clients", Mental Health Special Interest Section Quarterly, 20, 1-4.

## Care Management

# Tools and Reports

- Medication Adherence Reports
  - Enables CMHCs to identify all prescriptions that have been filled by consumers and determine Medication Possession Ratios
- Behavioral Pharmacy Management Reports
  - Includes a series of Quality Indicators™ to identify prescriptions that deviate from Best Practice Guidelines for Antipsychotics, Antidepressants, and Mood Stabilizers
    - Inappropriate polypharmacy
    - Doses that are higher or lower than recommended
    - Multiple prescribers of similar medications

Care Management

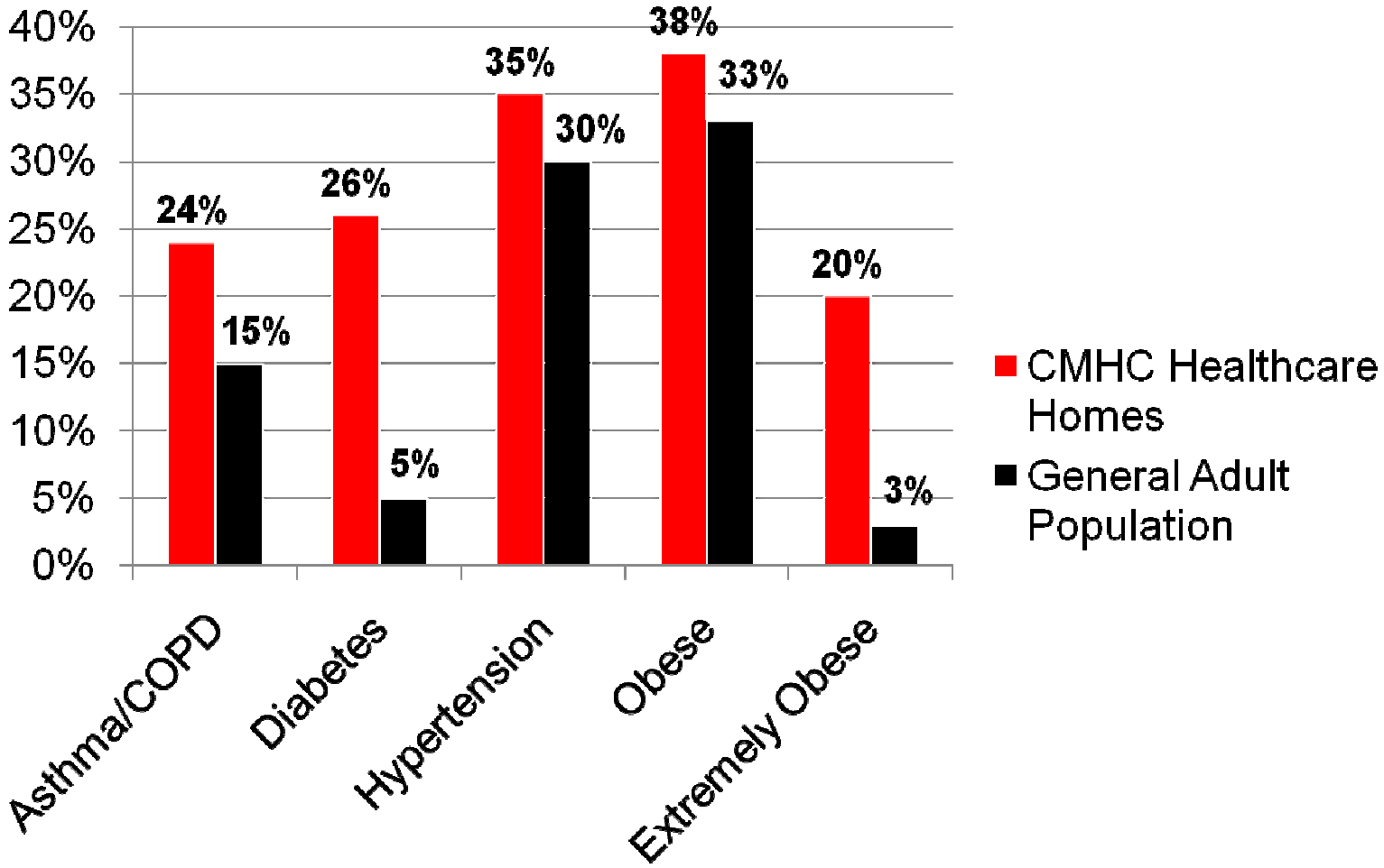
# Tools and Reports

- Disease Management Reports
  - Identifies individuals with specific diagnoses who are not meeting specific indicators
    - Asthma/COPD – have not been prescribed inhaled corticosteroids
    - Hypertension:  Blood Pressure>140/90
    - Diabetes:  BP>140/90; LDL > 100 mg/dl; A1c>8.0%
- Hospital Admissions E-mails Daily

# Staff Training Needs

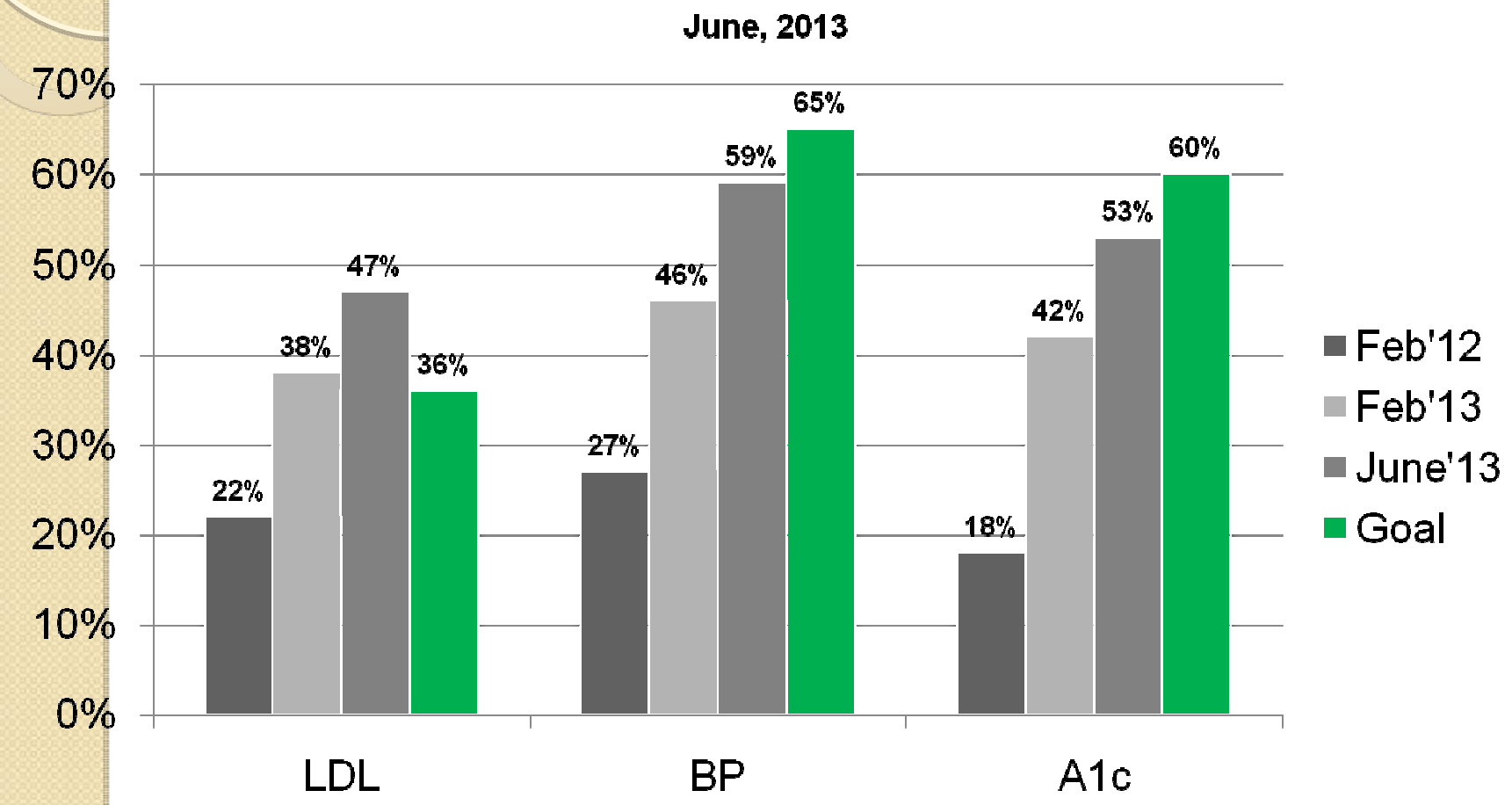
- Understanding
  - The nature, progress and treatment of the targeted chronic diseases
  - Wellness and healthy lifestyles
- Promoting and enabling individuals to
  - Manage the targeted chronic diseases
  - Embrace wellness and adopt healthy lifestyles
- Effective Use of Registries and Care Management Reports

# Prevalence of Chronic Disease and Obesity



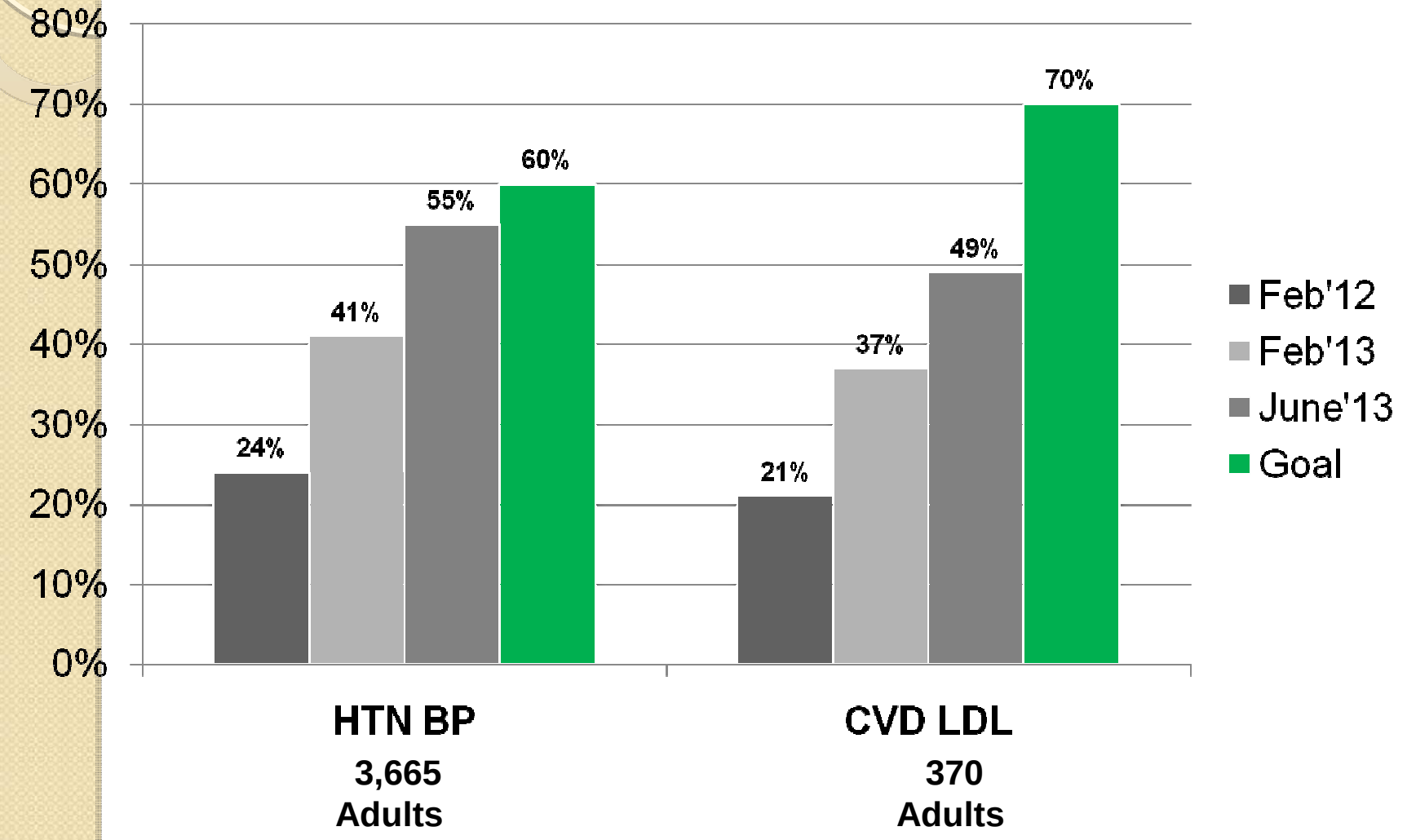
# Percent of HCH Adults with Diabetes whose LDL, Blood Pressure and A1c Levels are in Control

( 2822 Continuously Enrolled Adults)*

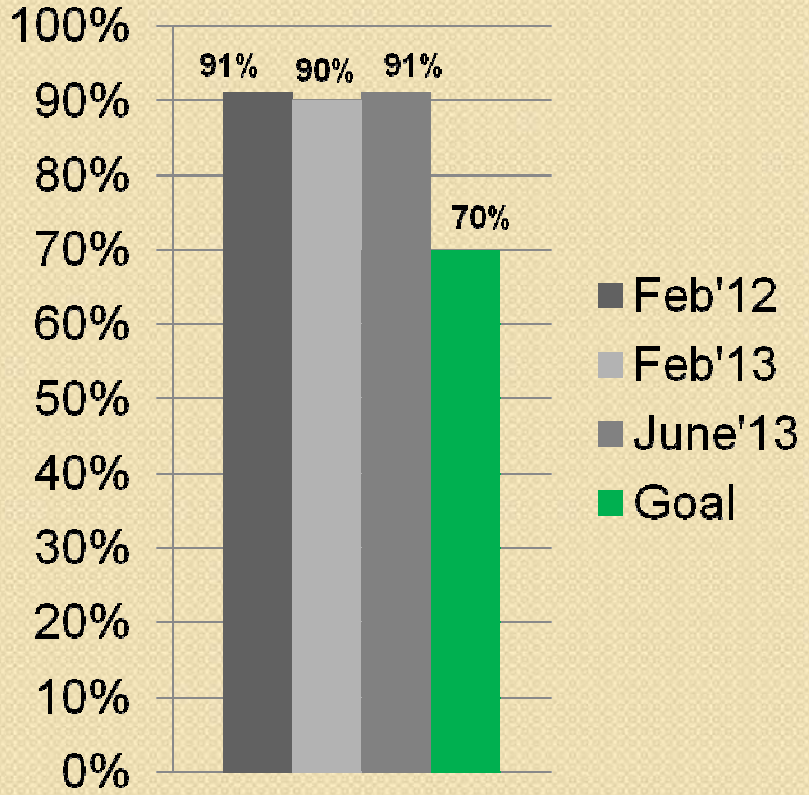



*29% of continuously enrolled adults

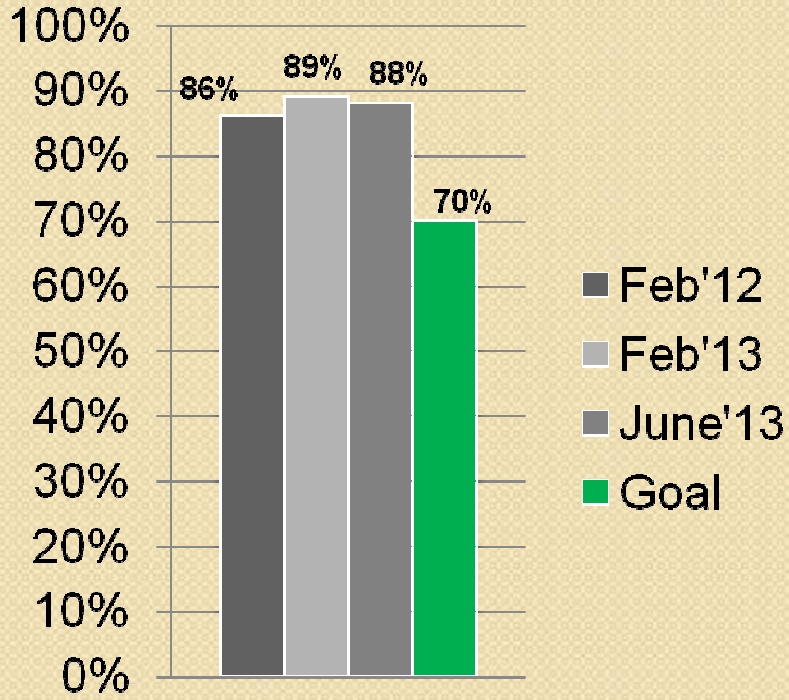
# Percent of Continuously Enrolled HCH Adults with Hypertension and Cardiovascular Disease whose Blood Pressure and LDL are in Control



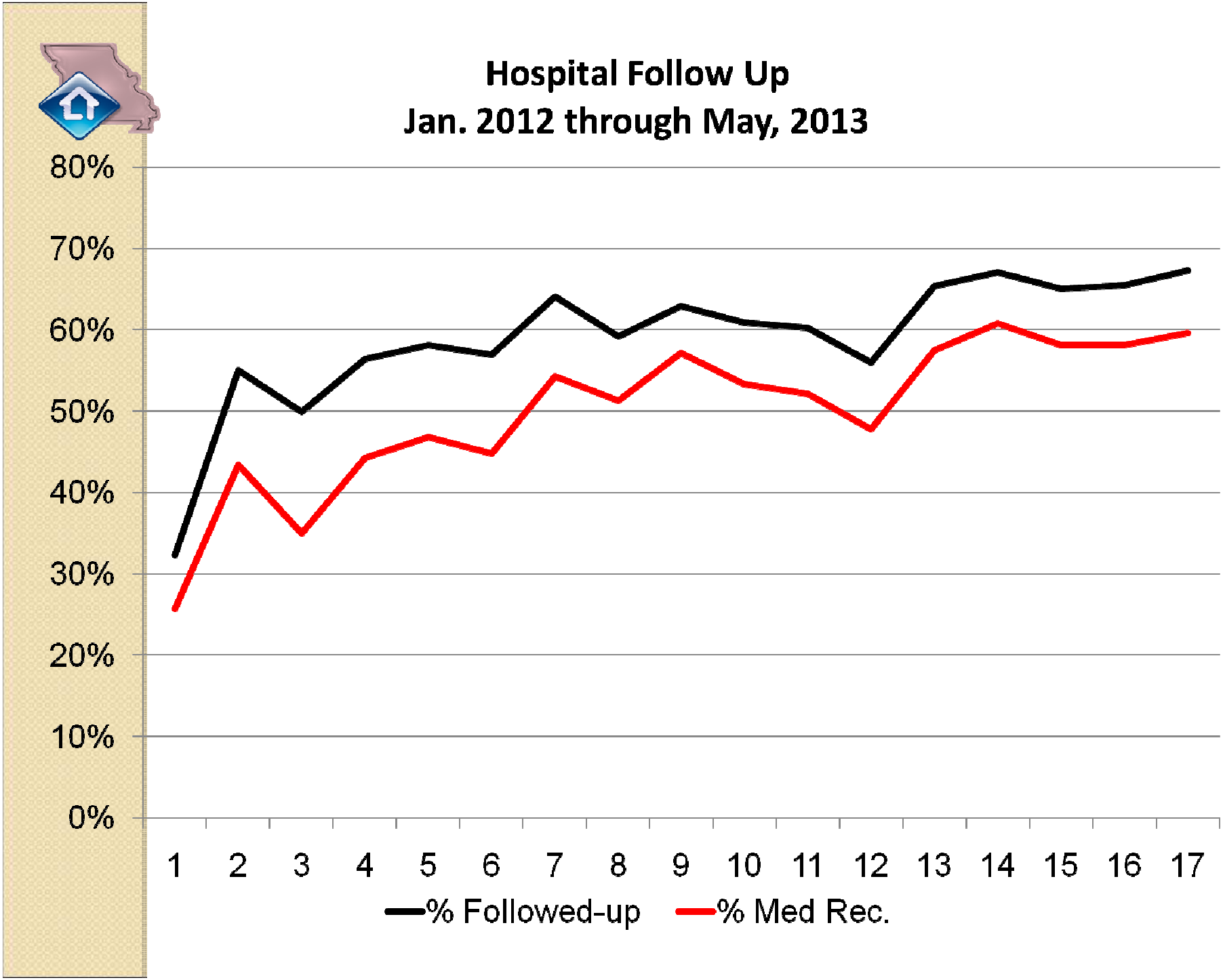
2427 Adults
Continuously Enrolled



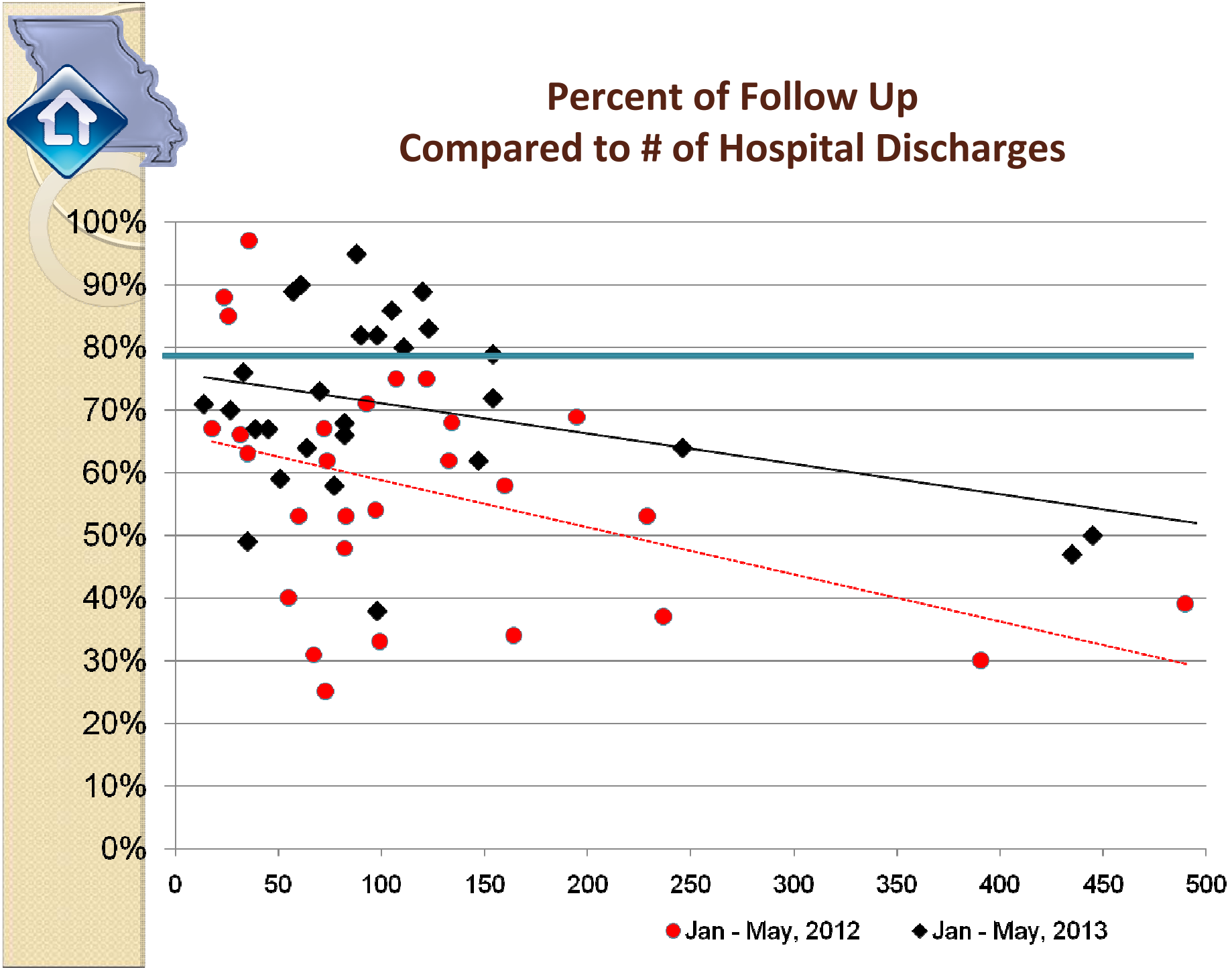

269 Children and Youth
Continuously Enrolled




# Percent of HCH Enrollees with Asthma Prescribed a Corticosteriod


Hospital Follow Up
Jan. 2012 through May, 2013
80%
70%
60%
50%
40%
30%
20%
10%
0%
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
% Followed-up
% Med Rec.

# Percent of Follow Up Compared to # of Hospital Discharges



CMHC Healthcare Home

# System Impact

- Hospitalization
  - 12.8% reduction in hospitalization/1000
  - 8.2% reduction in ER visits/1000
  - $48.81 PMPM savings = $2.9 million
- Total Medicaid Savings
  - Current consumers:  $32.98 PMPM = $2.4 million
  - Outreach:  $247.16 PMPM = $4.9 million

# Recovery

- Sense of Self
  - Independence
  - Belonging
  - Responsibility
- Sense of Power or Mastery
- Sense of Meaning
- Sense of Hope