

Behavioral Health is Essential To Health



Prevention Works



Treatment is Effective



People Recover



Outcomes of Integration of Primary Care and Behavioral Health Grant Program

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Center for Mental Health Services
Southeast Regional Meeting, Feb. 29, 2016



Integrated Care

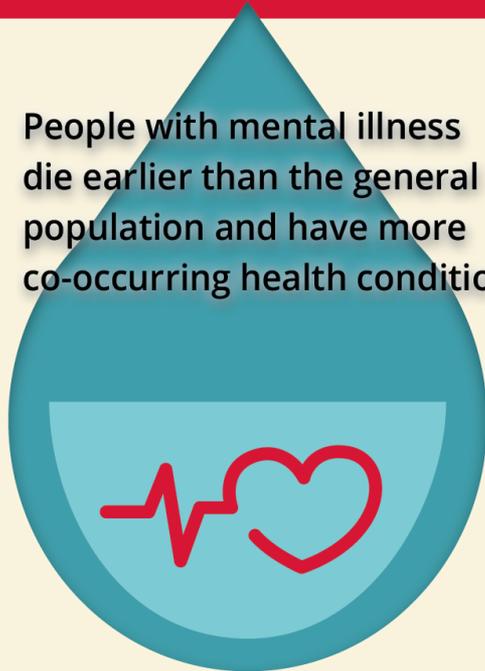
- What is integrated care?
 - *“Integrated care is the systematic coordination of general and behavioral health. Integrating mental health, substance abuse and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.”*

-SAMHSA-HRSA Center for Integrated Health Solutions,
www.integration.samhsa.gov

The Problem

The PROBLEM

People with mental illness die earlier than the general population and have more co-occurring health conditions.



68%

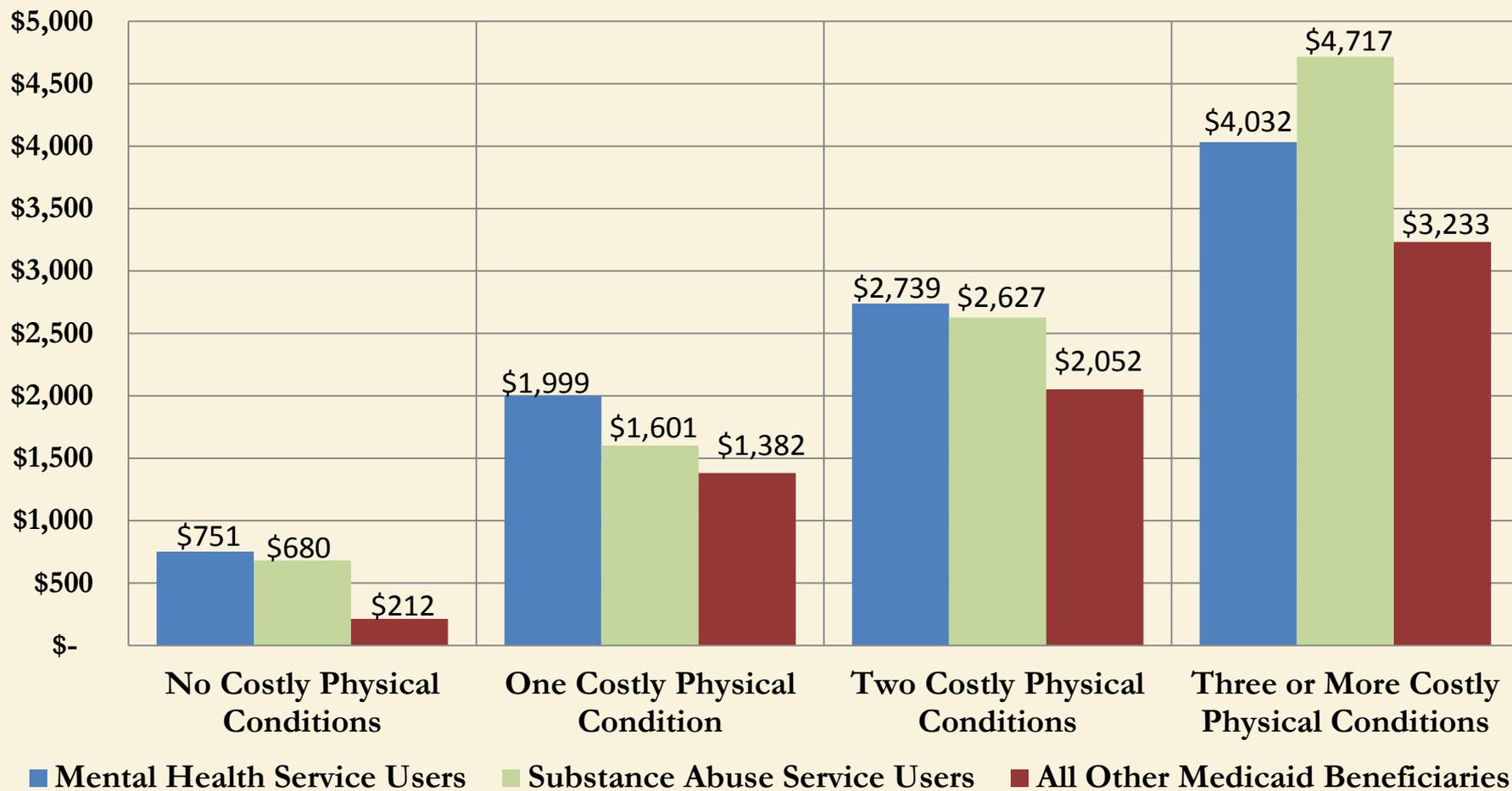
of adults with a mental illness have one or more chronic physical conditions

more than

1 in 5

adults with mental illness have a co-occurring substance use disorder

The Cost of Having Multiple Chronic Conditions



SAMHSA. (2010). *Mental health and substance abuse services in Medicaid, 2003: Charts and state tables*. HHS Publication No. (SMA) 10-4608.

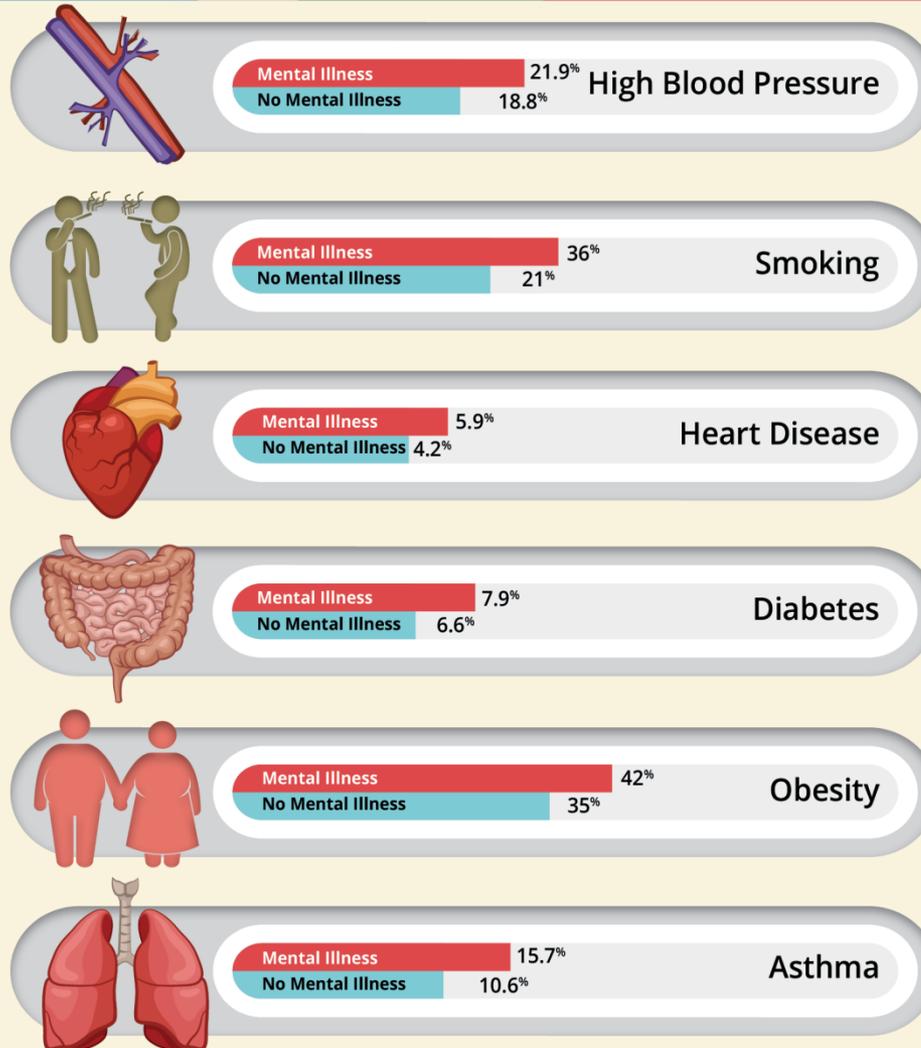
Medicaid Population: Data

MEDICAID BENEFICIARIES WITH DISABILITIES:

- 45% have 3+ chronic conditions
- 50% have a psychiatric illness
- 35% have a chronic mental health/substance use disorder (MH/SUD)
 - 60% of those with MH/SUD also have other chronic physical conditions & report fair or poor health
- Healthcare spending is 60-70% higher for beneficiaries with MH/SUD and chronic physical conditions;
- 4-5 x more likely to be hospitalized for the top 5 most common chronic conditions (asthma/COPD, congestive heart failure, coronary heart disease, diabetes & hypertension)

Co-Occurrence Between Mental Illness & Chronic Health Conditions

Co-occurrence between mental illness and other chronic health conditions:



Overview of SAMHSA's PBHCI Grant

- **Goal:** Improve the physical health status of adults with serious mental illnesses who have or are at risk for co-occurring primary care conditions and chronic diseases.
- **Objective:**
 - Improve health of adults with serious mental illness
 - Enhance consumer's experience of care (quality, access, and reliability)
 - Reduce/control per capita cost of care.
- **Program Components**
 - Coordinated MH and primary care, specialty care, and substance abuse services;
 - Wellness programs;
 - Health Home;
 - Health Information Technology

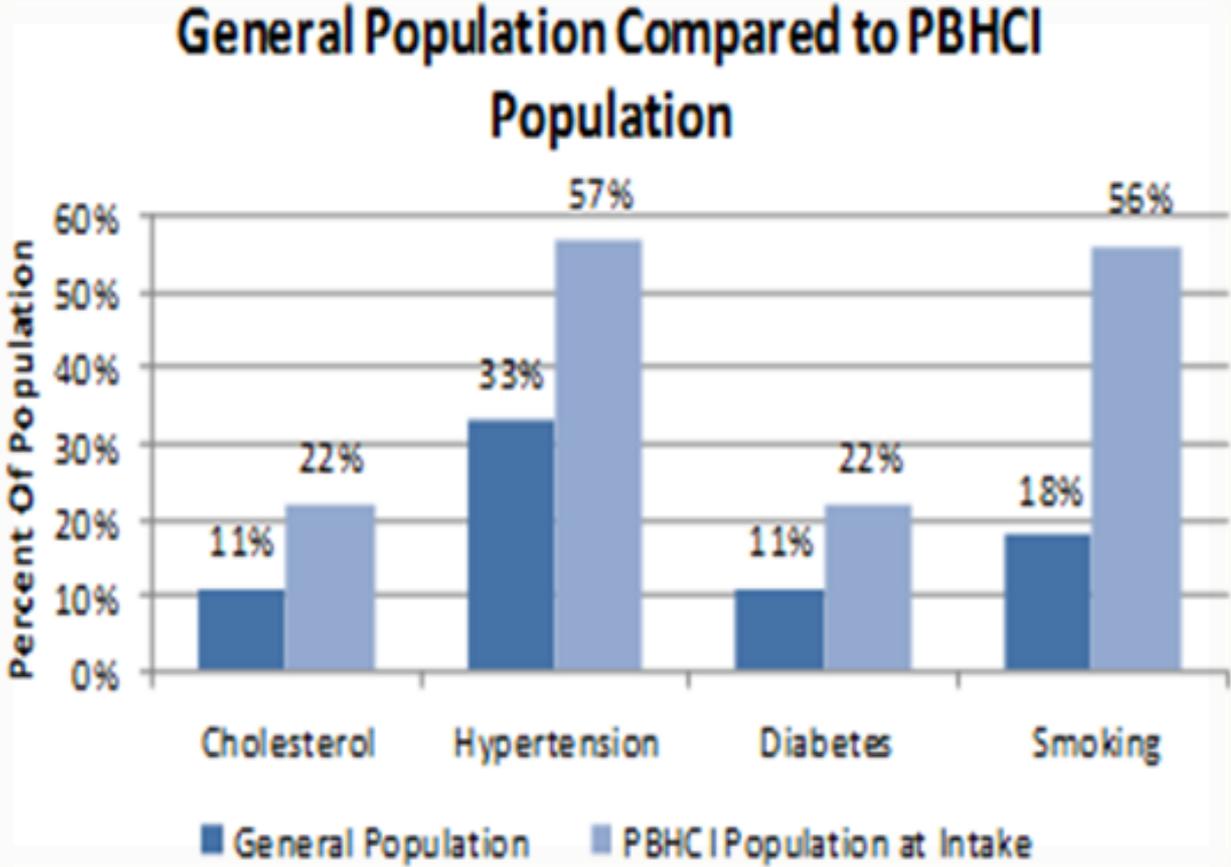
PBHCI Data Collection

PBHCI grantees collect the following health indicators:

- a. Blood pressure—semiyearly**
- b. Body Mass Index (BMI)—semiyearly**
- c. Waist circumference— semiyearly**
- d. Breath CO (carbon monoxide)— semiyearly**
- e. Plasma Glucose (fasting) and/or HgbA1c—annually**
- f. Lipid profile (HDL, LDL, triglycerides)—annually**

Measuring blood pressure, cholesterol and BMI are indicators for the risk of cardiovascular disease. Plasma glucose, Hemoglobin A1c and the lipid profile are predictors of diabetes. The risk of having respiratory disease is also determined by Breath CO.

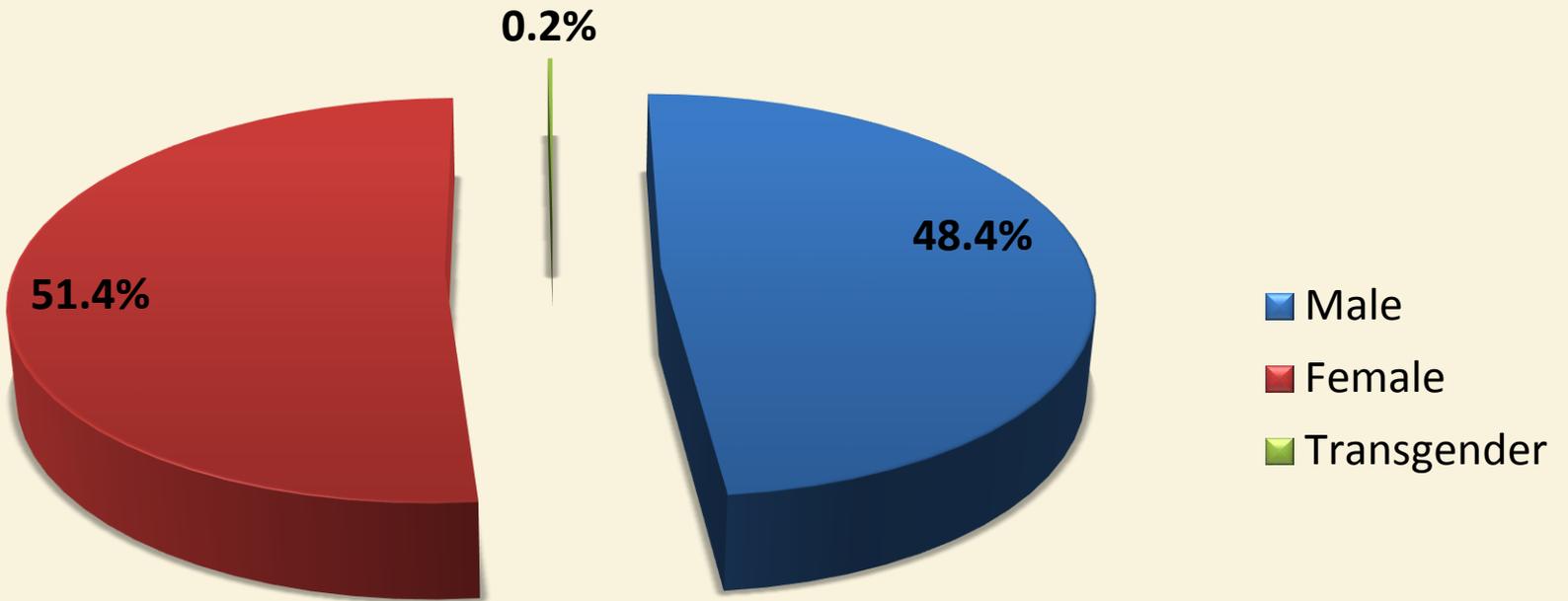
PBHCI Data 2015



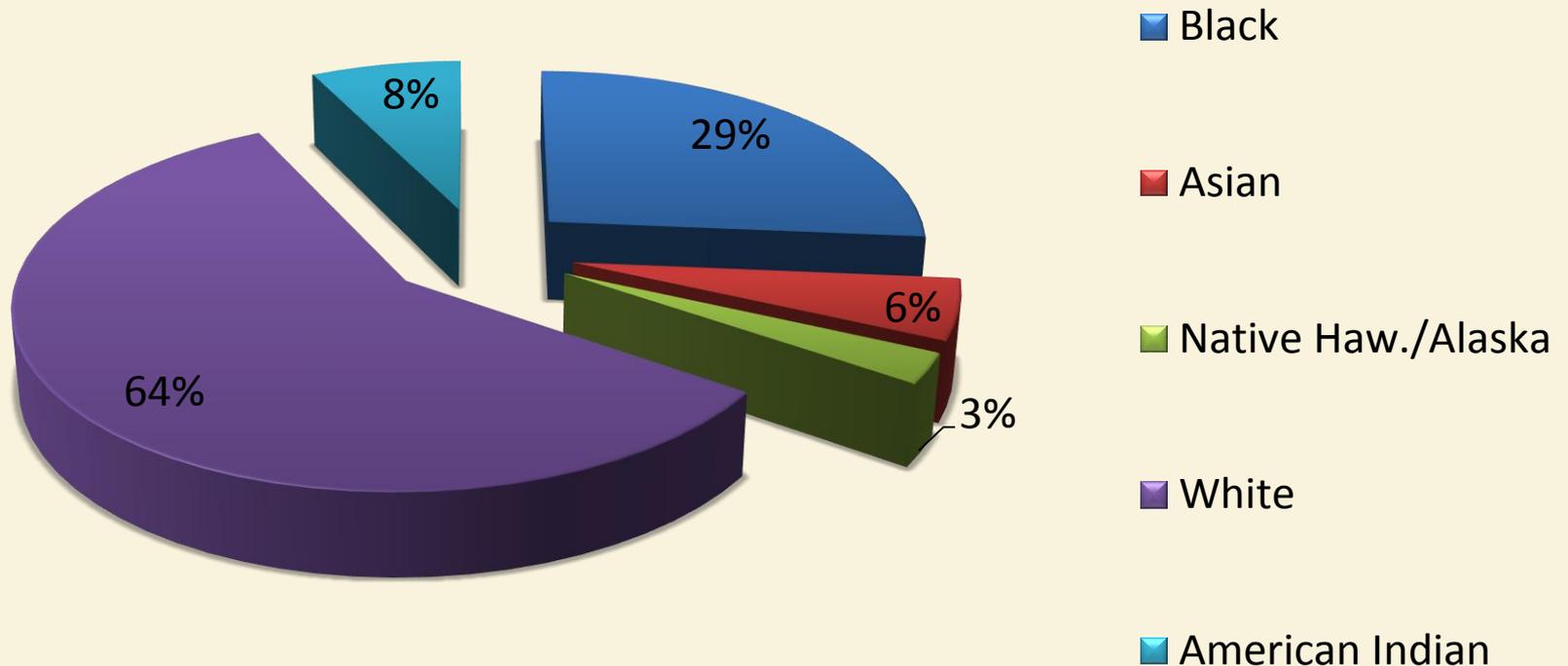
DATA

- This data reflects all cohorts. Out of over 52,000 individual people in the data set, 15,516 had three data points of NOMS (intake, 6-months, and 12-months)

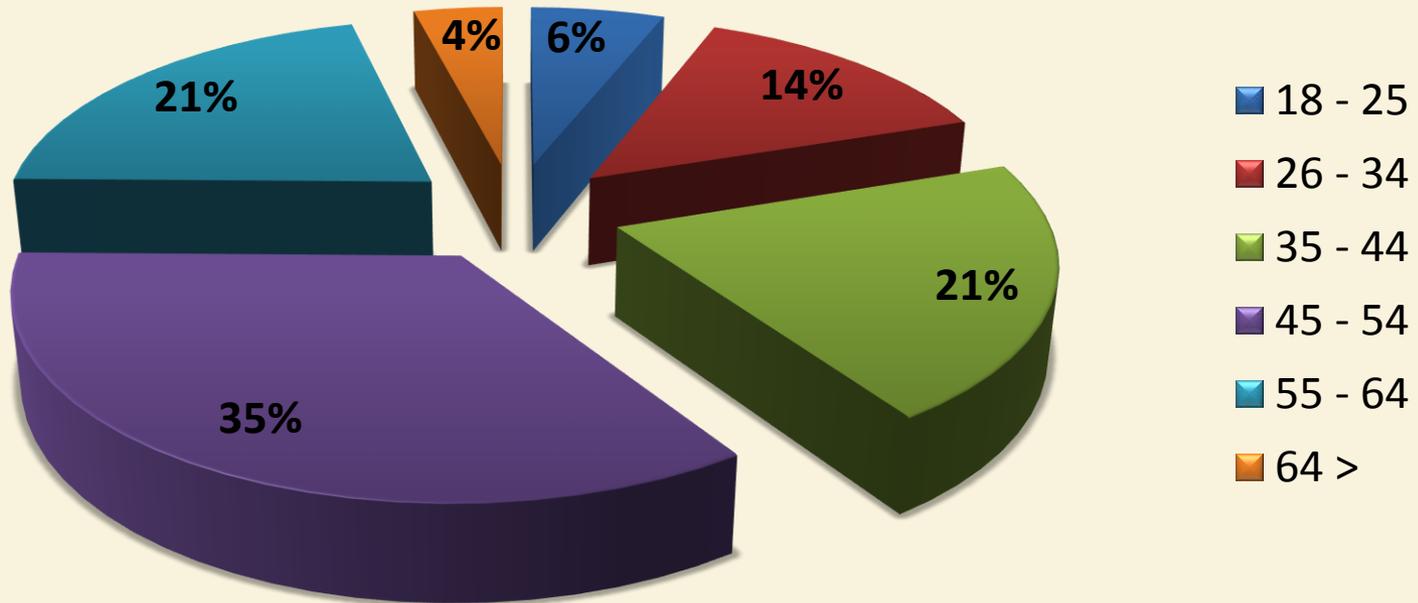
Participants by Gender



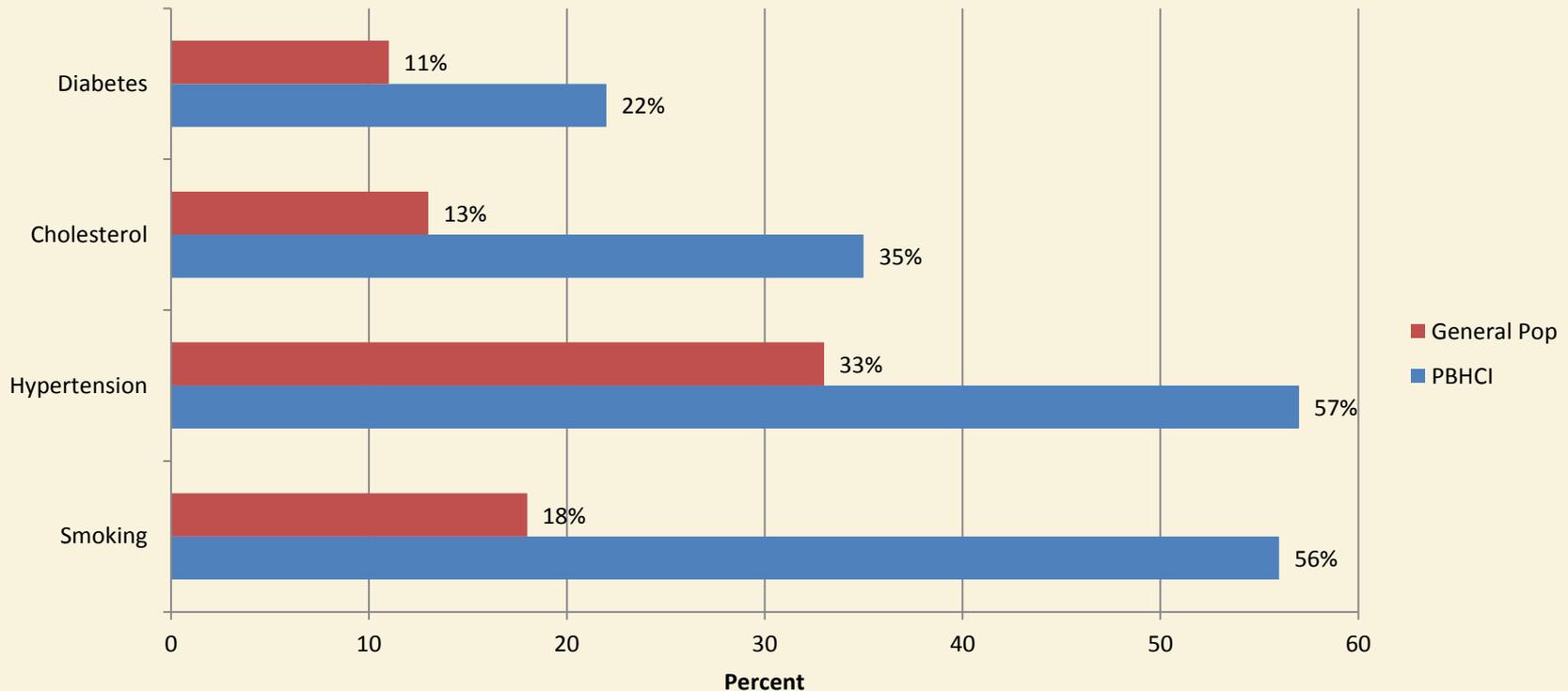
Participants by Race and Ethnic Group



Participants by Age



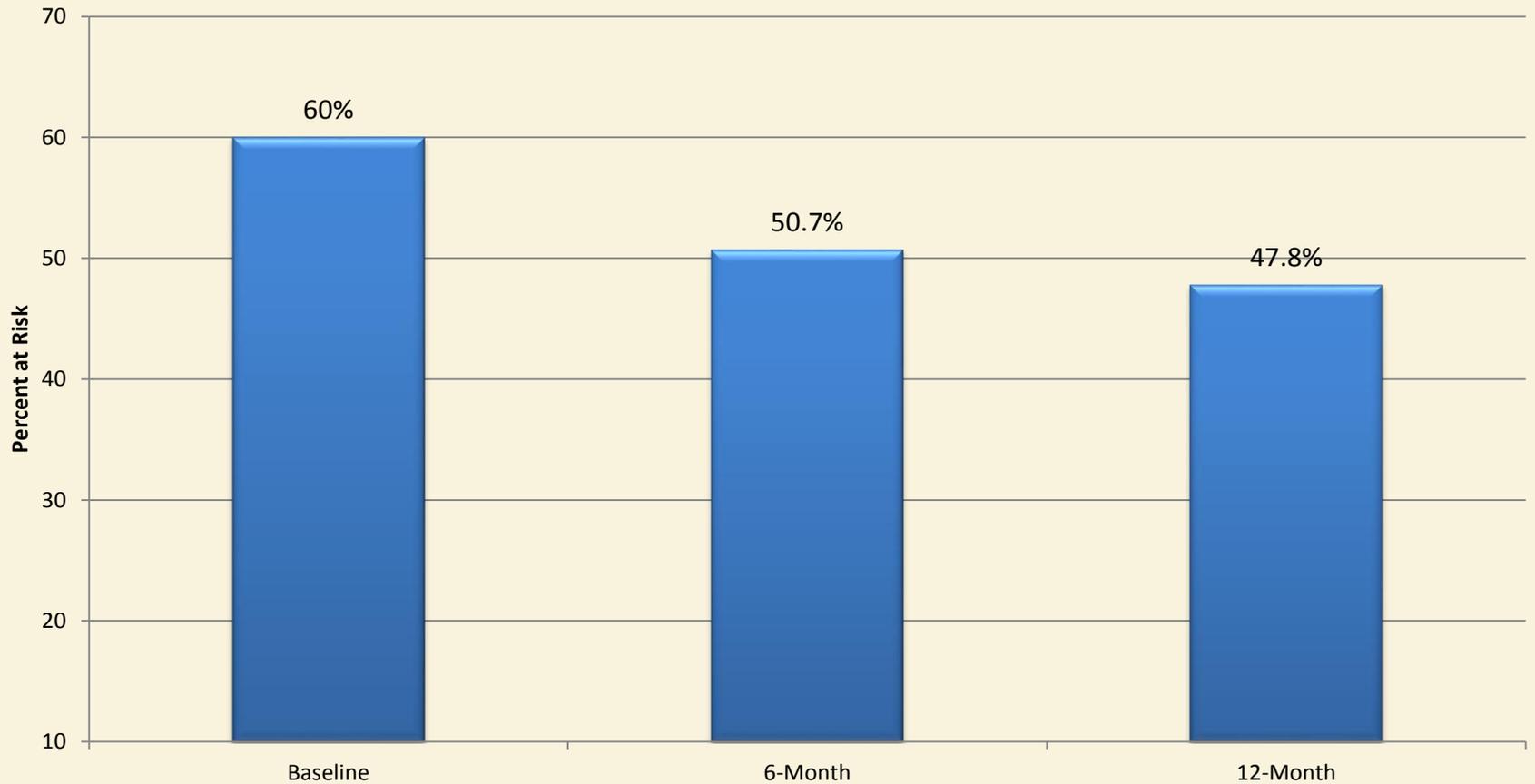
Overall Physical Health Risks



Sources: "The health consequences of smoking – 50 years of progress: a report of the Surgeon General." – Atlanta, GA. : U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

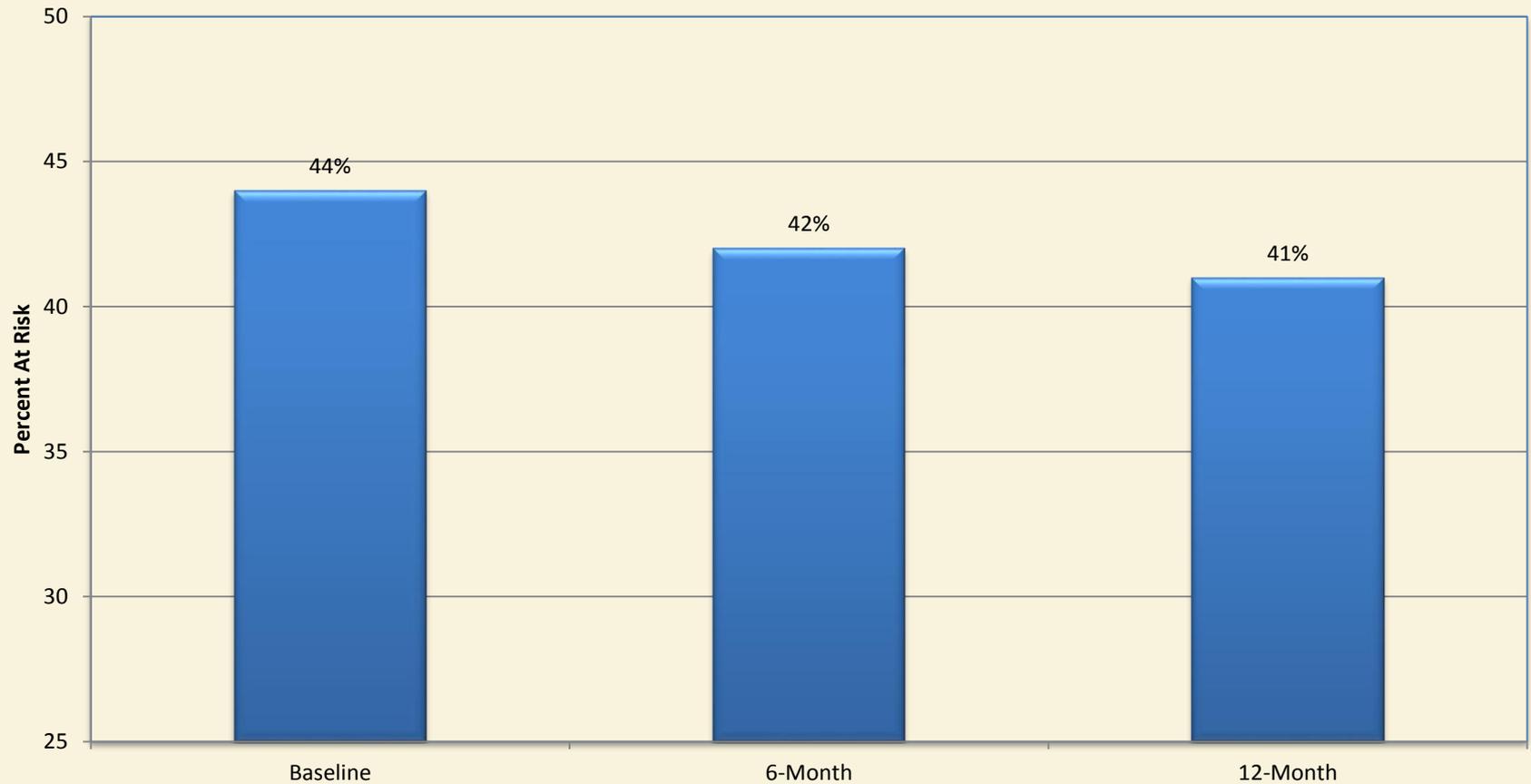
Blackwell DL, Lucas JW, Clarke TC. "Summary health statistics for U.S. adults: National Health Interview Survey, 2012." National Center for Health Statistics. Vital Health Stat 10(260). 2014

Overall Health



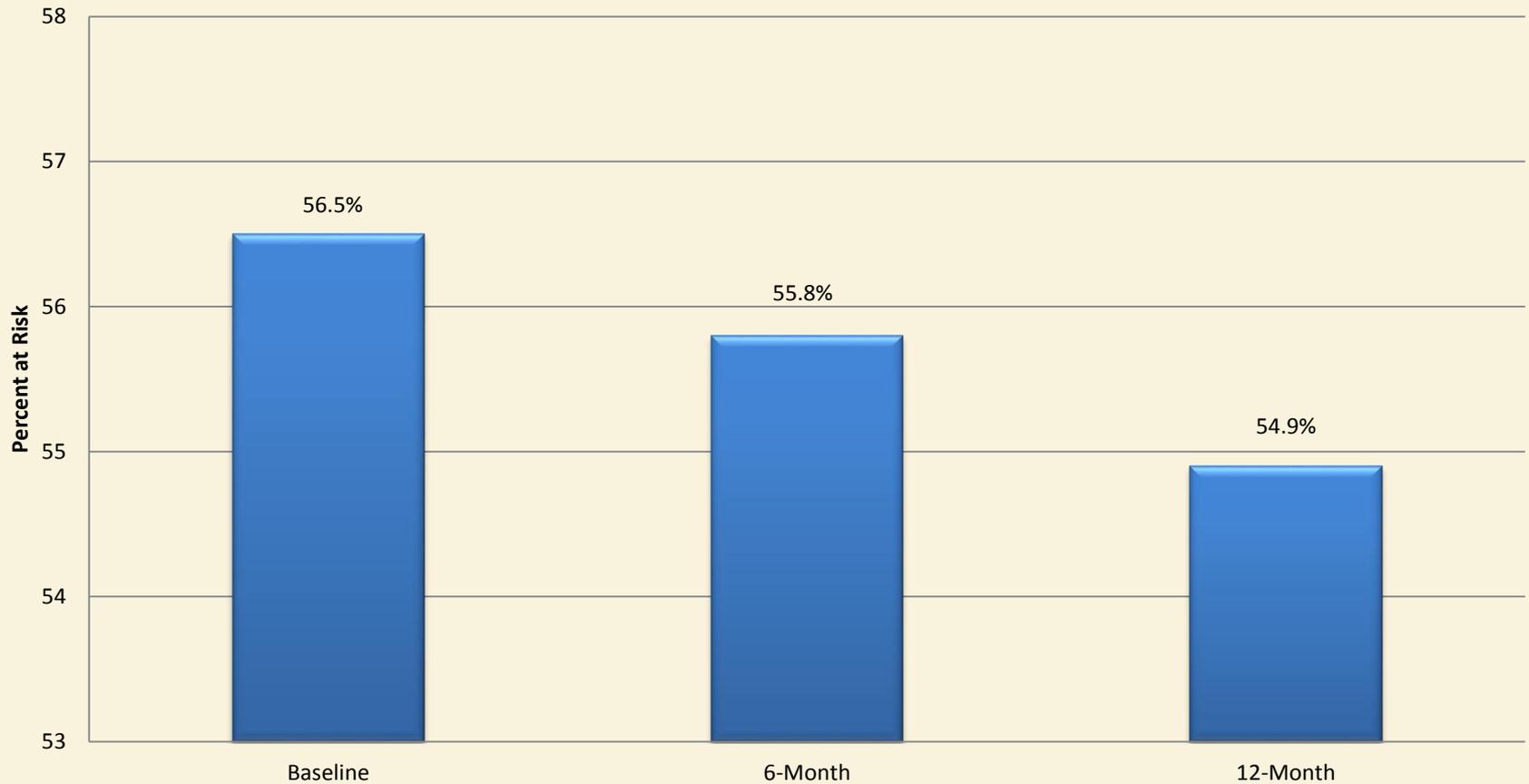
Statistically significant, $p < .001$

Physical Health Outcomes: Blood Pressure (Diastolic)



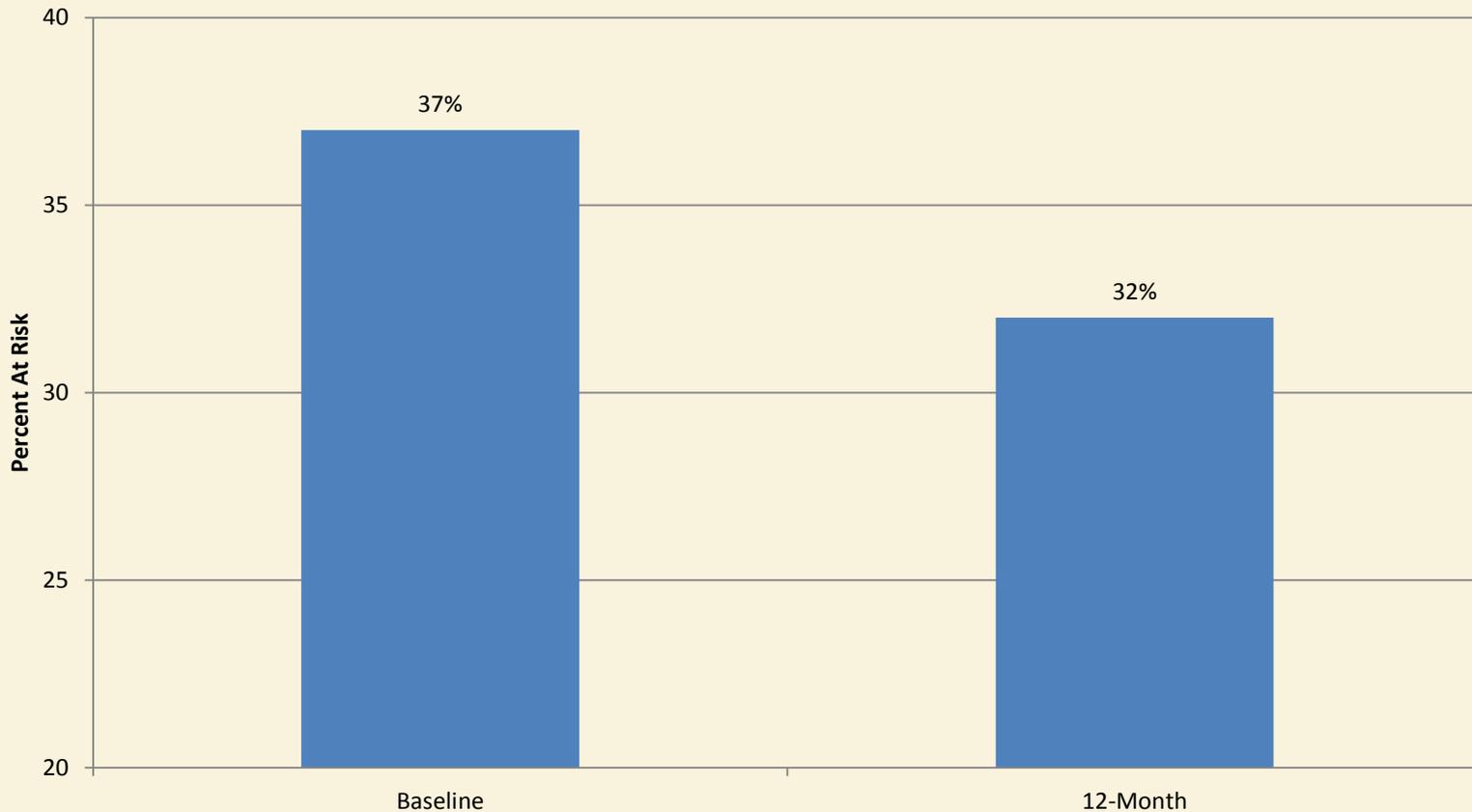
Statistically significant, $p < .001$

Physical Health Outcomes: Blood Pressure (Systolic)



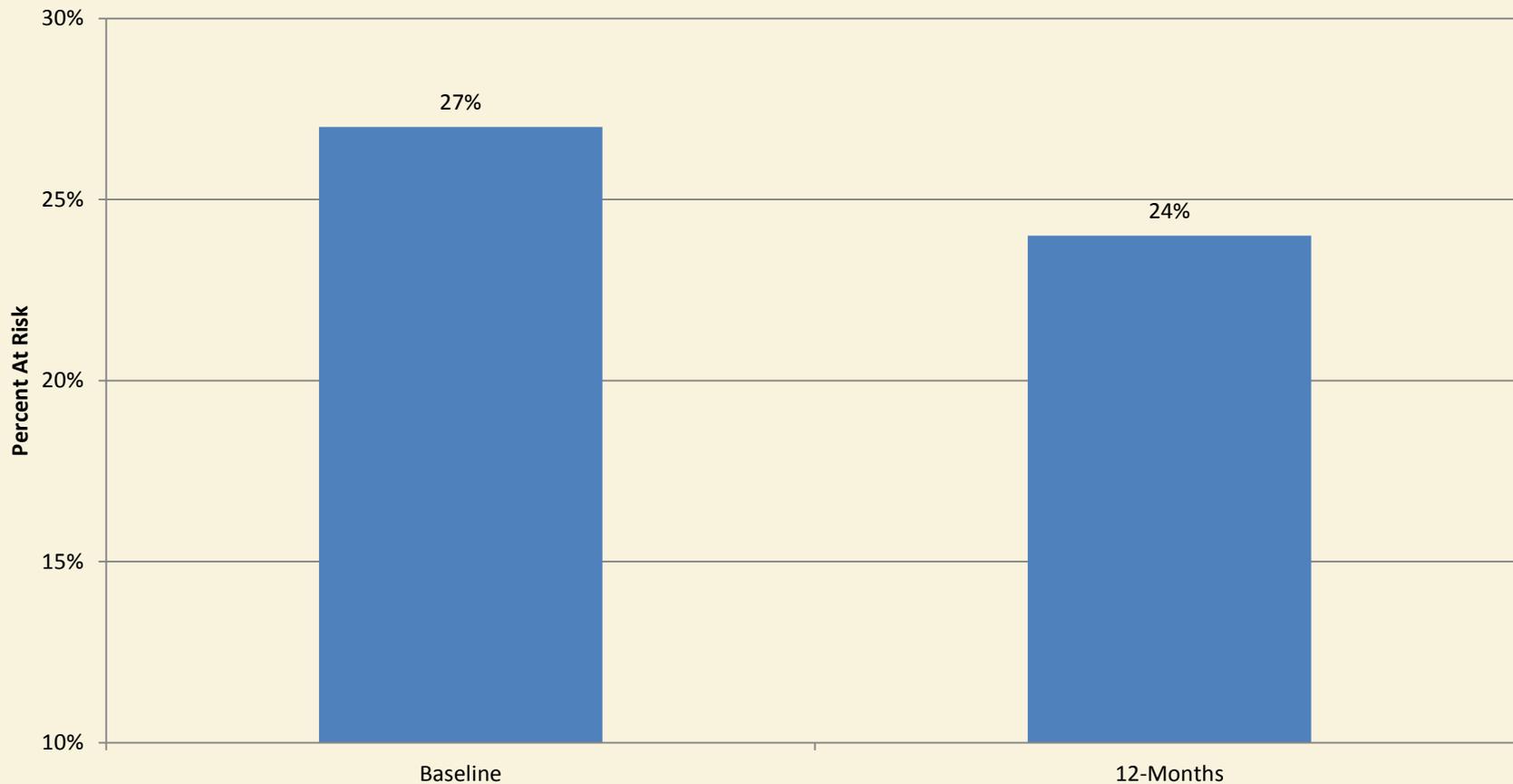
Statistically significant, $p < .001$

Physical Health Outcomes: Total Cholesterol



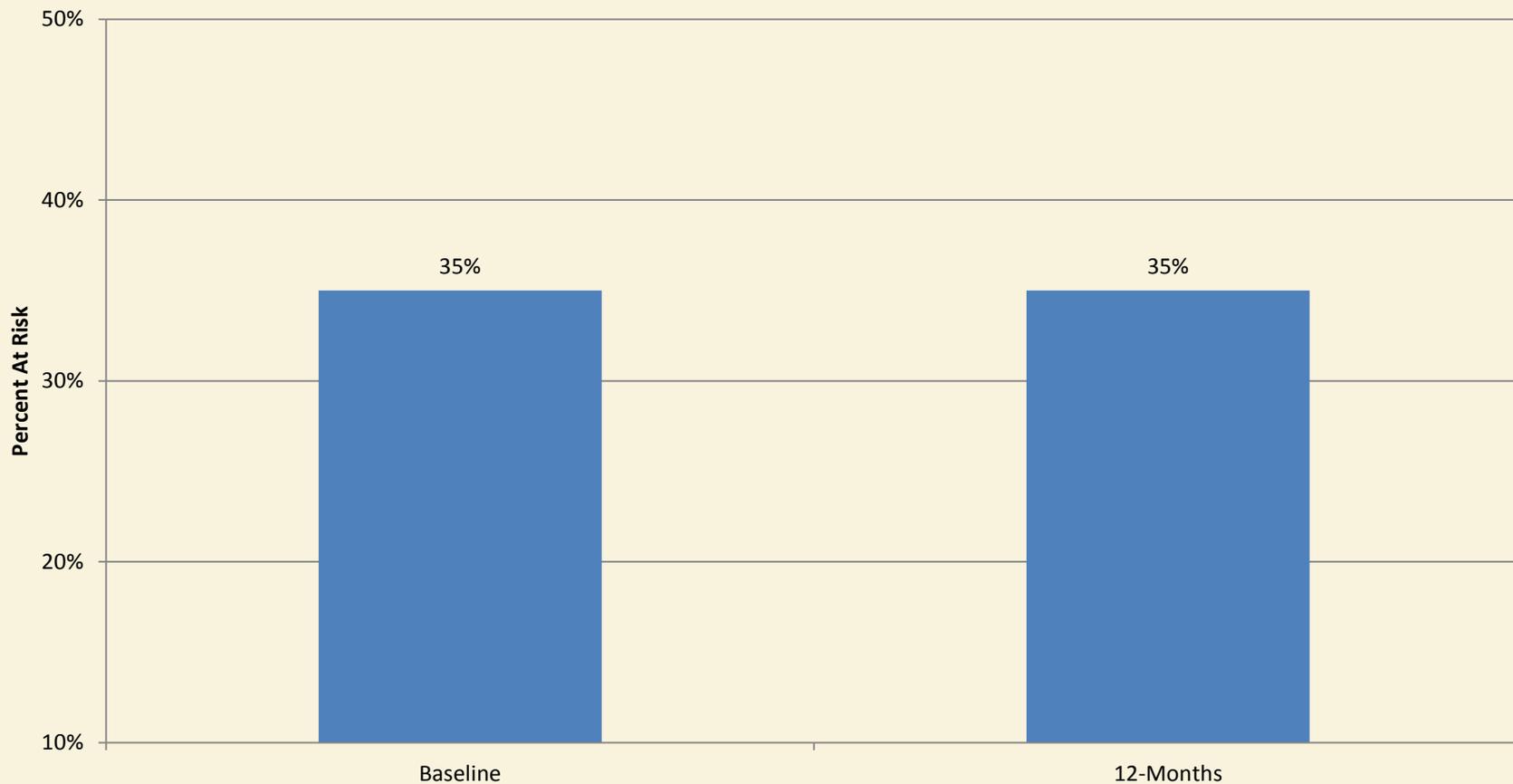
Statistically significant, $p < .001$

Physical Health Outcomes: High Risk HDL



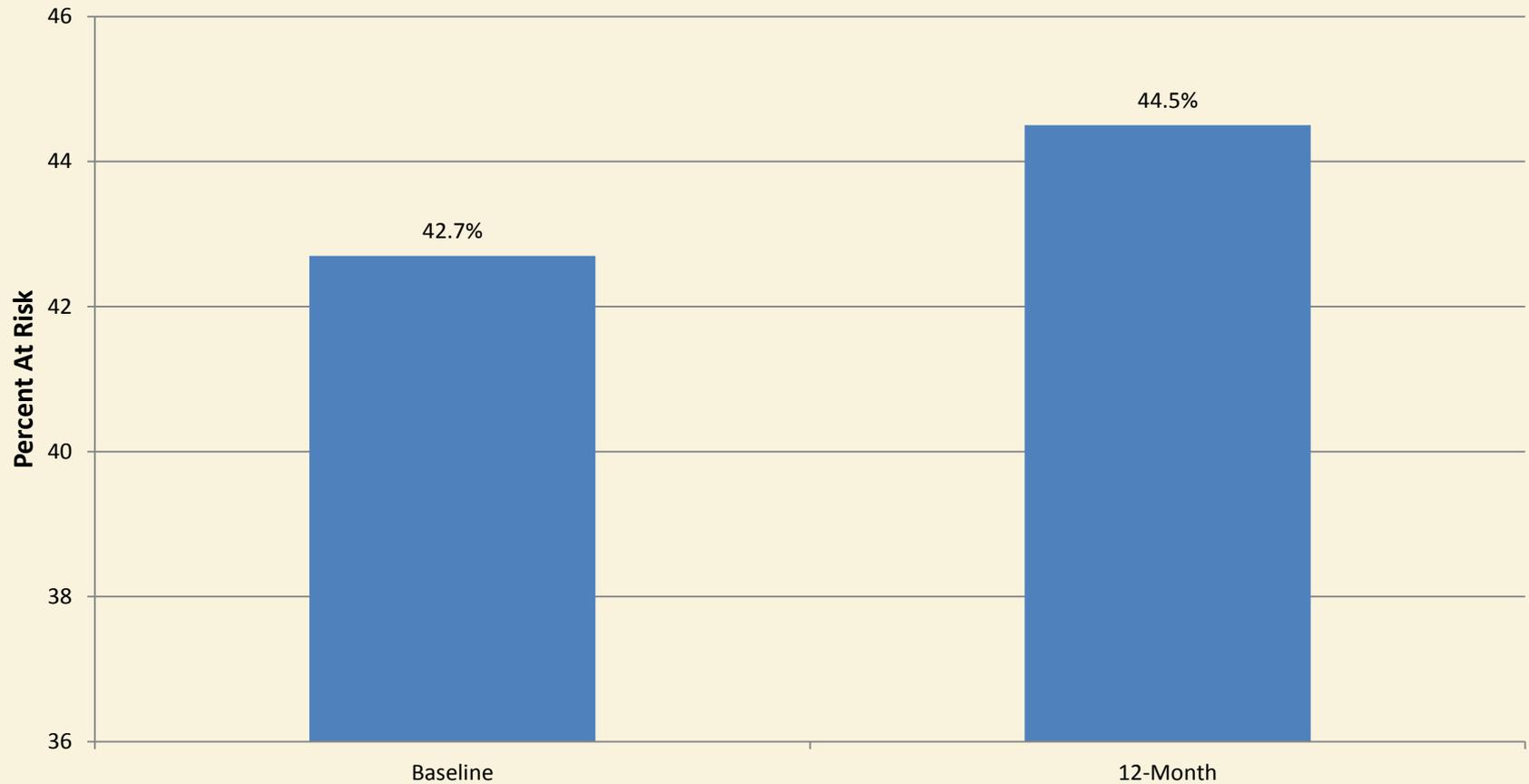
Statistically significant, $p < .001$

Physical Health Outcomes: High Risk LDL



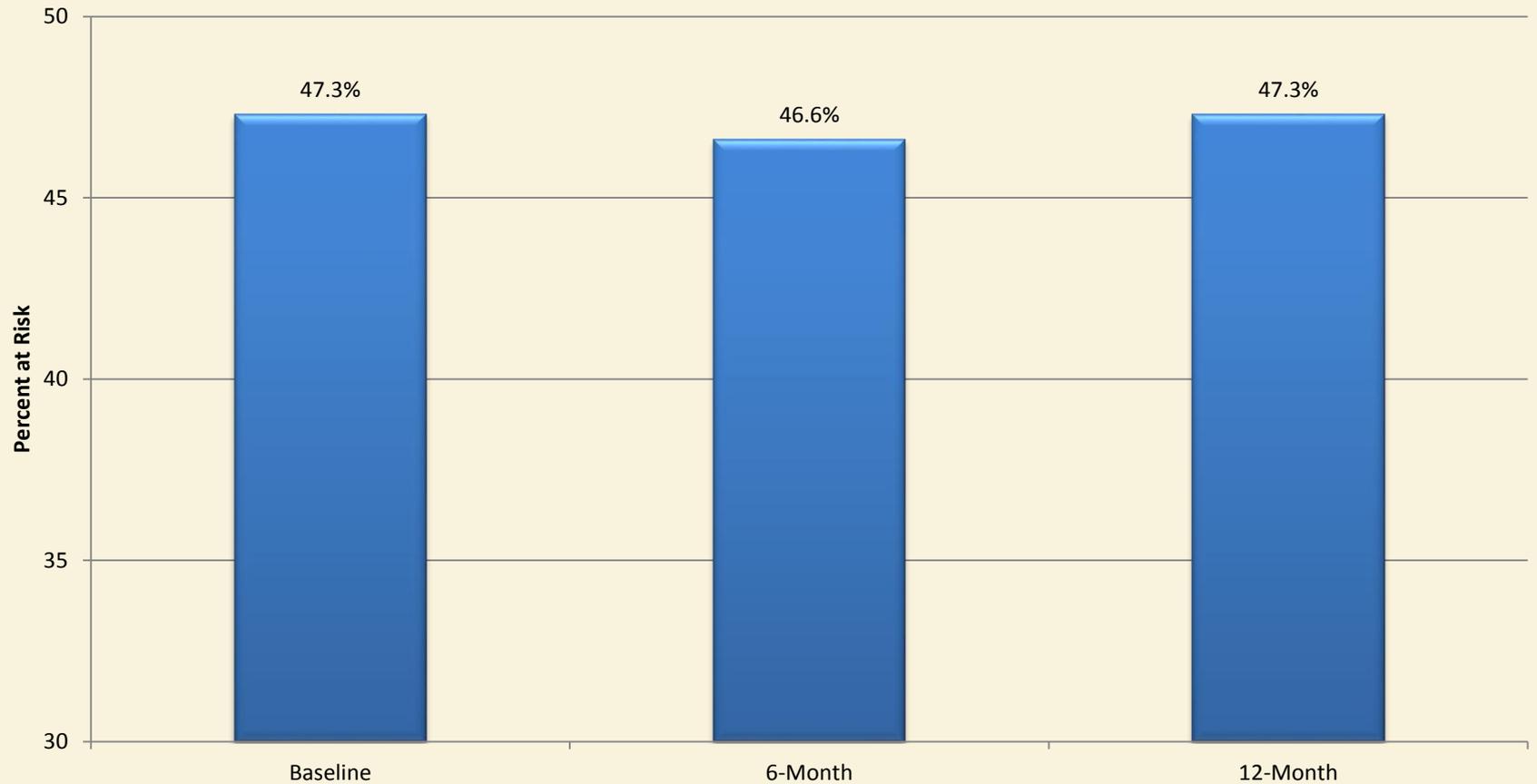
Not statistically significant

Physical Health Outcomes: Triglycerides



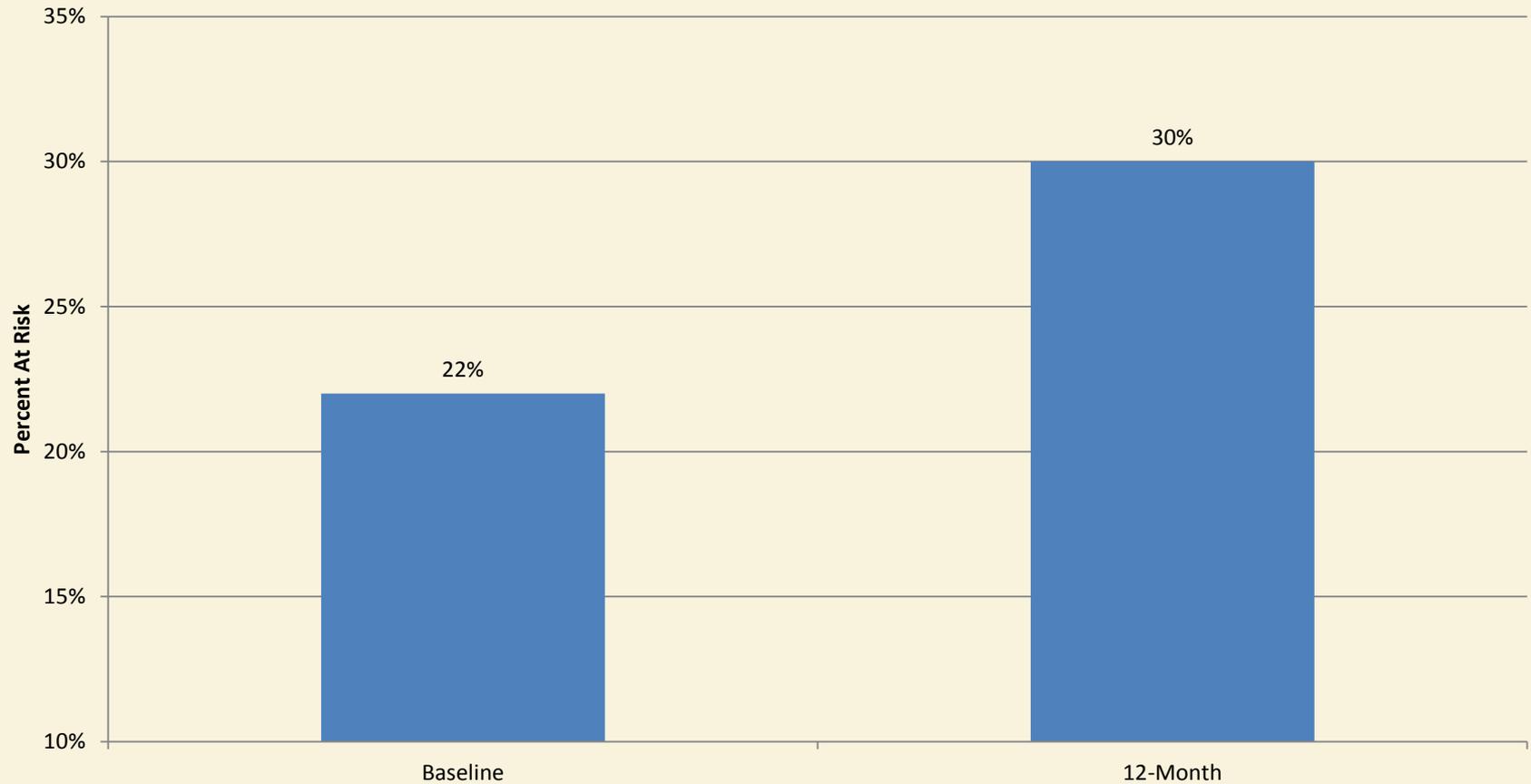
Statistically significant in wrong direction, $p < .001$

Physical Health Outcomes: Breath CO



Not statistically significant

Physical Health Outcomes: HgbA1c

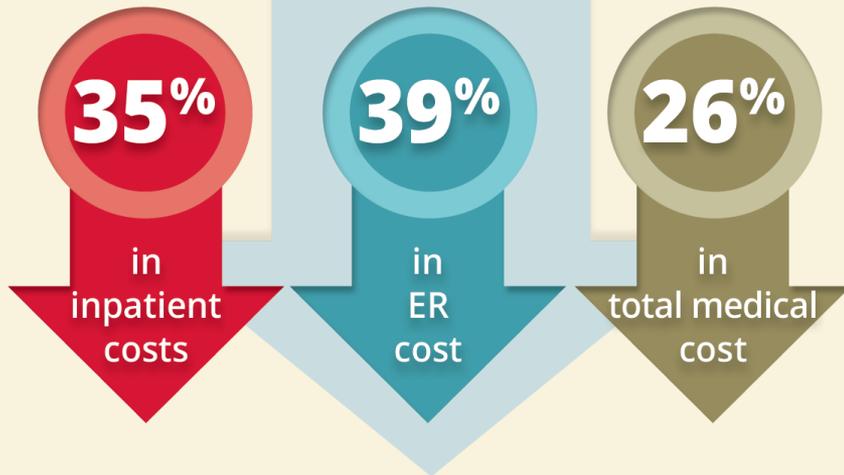


Statistically significant in wrong direction, $p < .001$

Integration Works

INTEGRATION WORKS

Community-based addiction treatment can lead to...



Reduce Risk → **Reduce Heart Disease**
(for people with mental illnesses)

Maintenance of ideal body weight (BMI = 18.5 – 25)



35%-55% decrease in risk of cardiovascular disease

Maintenance of active lifestyle (~30 min walk daily)



35%-55% decrease in risk of cardiovascular disease

Quit Smoking



50% decrease in risk of cardiovascular disease

Institute for Community Living

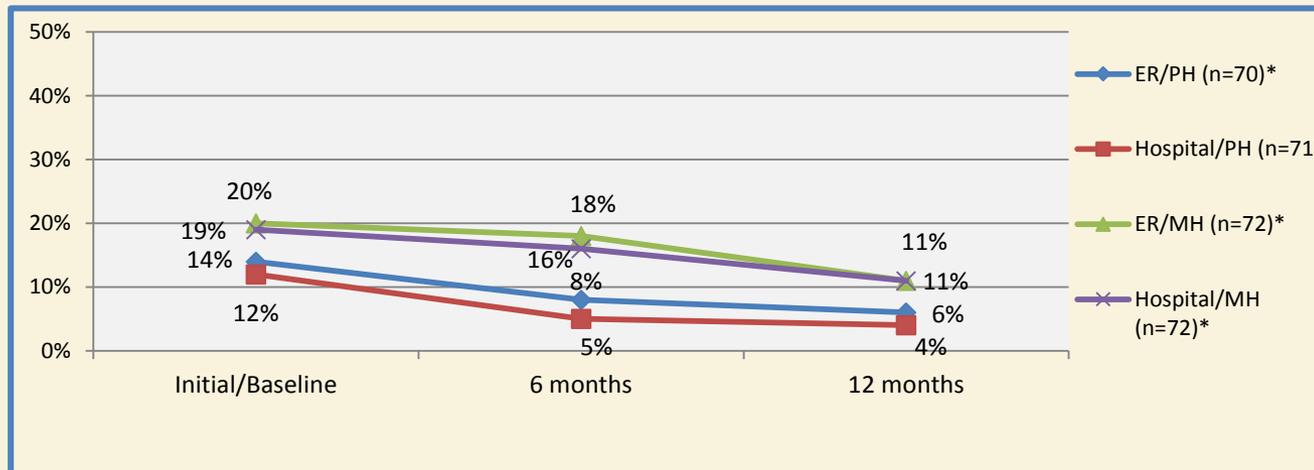
HLQ – ER visits & hospital admissions

EMR-Based Healthy Living Questionnaire (HLQ)

This is an 18 item self-report that is not part of the PBHCI grant. However, ICL administers this questionnaire to track ER visits, hospital admissions, missed medical appointments and the desire to establish a physical health goal.

The individuals (n=72) reflected below are those who have both an initial NOMs and HLQ assessments and a treatment plan with a 12 month period available for analysis.

ER visits and hospital admissions for physical health and mental health reasons over time, expressed as percentage of entire cohort from initial to 12 month treatment plan[^] (all= $p < .05$)

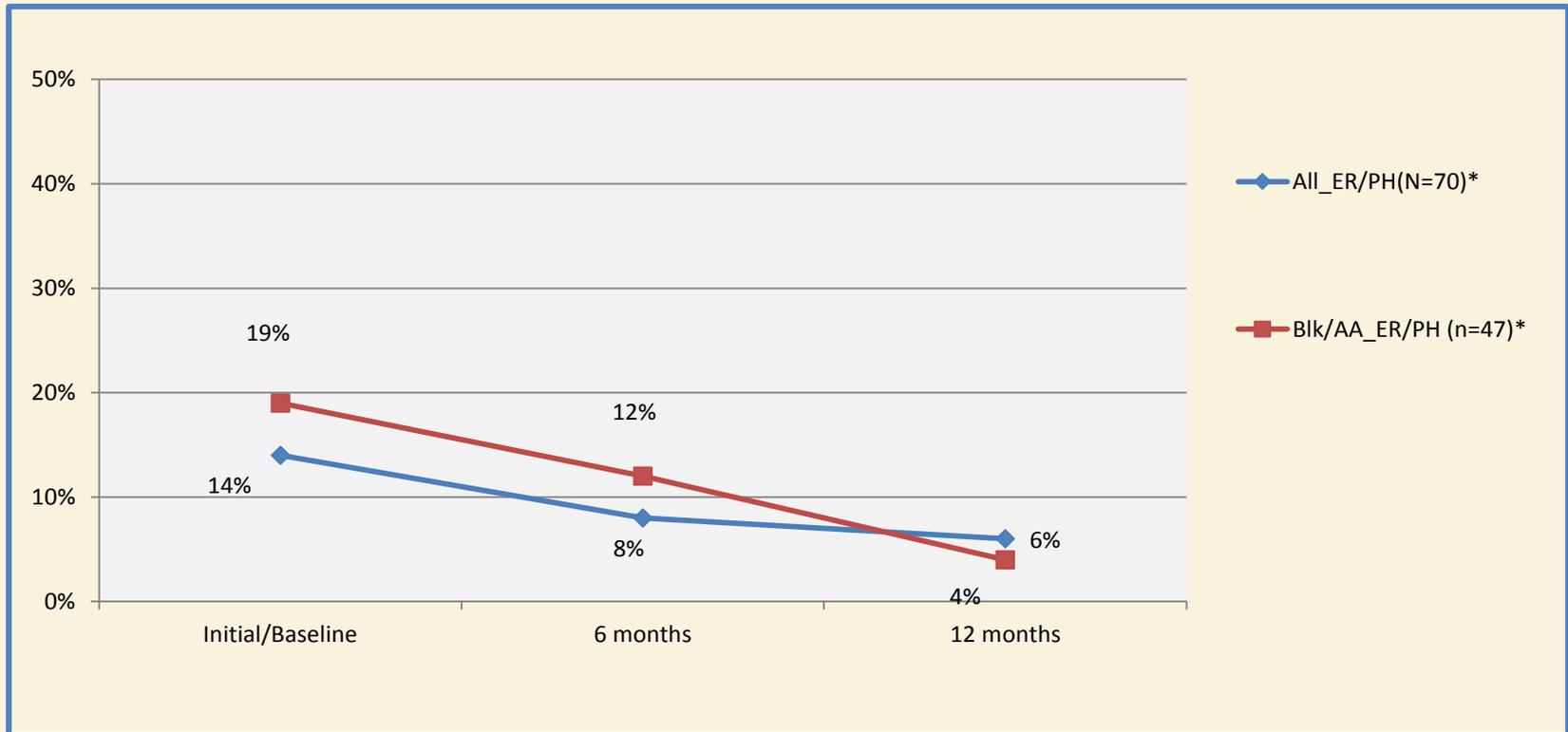


[^]Number of reports naturally vary over time points in conjunction with length of time in services

*statistically significant

ER Visit for Physical Health Reasons

Percentage of participants with a ER visit for physical health reasons over a 3 month period, over time:



*statistically significant

Selected Alumni Programs

- Appalachian Tallahassee, FL
- Lifestream Leesburg, FL
- Centerstone Nashville, TN
- Tri-County CMH Bennettsville, SC
South Carolina DMH

Model – The Apalachee Center

Cohort III Grantee in Tallahassee, FL

Website: <http://apalacheecenter.org/>

Contact: Sue Conger



NEWS CENTER

INPATIENT SERVICES

OUTPATIENT SERVICES

RESIDENTIAL SERVICES



View News

View Services

View Services

View Services

Model – The Apalachee Center

Challenges as a grantee

Started grant in partnership with FQHC

- Biggest challenge was the partnership
- Difficulty merging the two cultures
- Difficulty in matching expectations
- Difficulty in sharing data across two systems, including scheduling.

Model – The Apalachee Center

Current status:

- Hired an ANRP to pull the services in-house, who works closely with in-house psychiatry
- Team based care
- Care managers coordinate with in-house medical and psychiatric services and work w/ outside specialists
- In the midst of implementing a new EHR to better meet their needs

Model – South Carolina State Department of Mental Health

Cohort III Grantee

Website: <http://www.state.sc.us/dmh/>

Contact: Christian Barnes-Young



Challenges – South Carolina State Department of Mental Health

- Changing partners: Began with a partnership with CareSouth Carolina (FQHC) which ended during Year 2 of the grant, and then began partnering with a hospital.
- Loss of Partner: End of grant funding coincided with the closing of partnering hospital
- Coincided with change in Project Director and retirement of CMHC director
- Internal lack of policies and procedures to do what was needed, and as a governmental entity, this halted progress.
- Difficulty blending of the cultures
 - Primary Care & Behavioral Health
 - Private and Public sector health services

Model – South Carolina State Department of Mental Health

Current status:

- Continuing to provide wellness and care coordination services
- Made the decision not to provide medical services directly due to:
 - Difficulty in recruiting a primary care
 - Difficulty with billing primary care within a behavioral health billing system
- Have re-established / repaired the relationship with original partner – CareSouth Carolina and are in the process of establishing an MOU to deliver primary care at no cost to the agency
- Note - Program serves three counties and is extremely rural

Model – South Carolina State Department of Mental Health

Achievements:

- Recognition by the state as a Blue Ribbon Program
- Recognition as the site with the greatest decrease in amount of carbon monoxide emissions by clients
- A minimum of three lives saved (as evidenced by consumer calls)
- Has been a part of setting the direction for the state on how services are delivered by the Department of Mental Health (SC)
- Changed internal processes by:
 - Focusing on best and promising practices to direct care
 - Consultation with MTM to implement collaborative documentation, enhanced access to care and engagement strategies

Model – Lifestream Behavioral Health Center

Cohort III Grantee – Leesburg, FL

Website: <http://www.lsbc.net/Home.aspx>

Contact: Rick Hankey



Challenges – Lifestream Behavioral Health Center

- Focused on sustainability early on – required a lot of internal and external planning, buy-in and investment.
- Securing funding for primary care services provided within a behavioral health setting
- Getting other organizations to buy into integration
 - Other organizations did not understand why Lifestream consumers did not get primary care from existing providers
 - Little understanding of the challenges initially by internal management and staff as well

Model – Lifestream Behavioral Health Center

Accomplishments:

- Expanded services to a second clinic
- Due to focus on sustainability, Lifestream was able to continue services without interruption when grant funding ended.
- Moving the organizational culture into total integration.
 - Health and wellness is infused within all services provided
 - Includes treatment plans and daily services
- Having the ability to demonstrate effectiveness through outcomes and success stories.

Lessons Learned

- Different models of integration
- Importance of having strong leadership and partnerships for both mental health/behavioral health and primary care
- Having clear expectations of all the partners involved, especially as it relates to sustainability of the program and services post grant
- Having an EHR that reflects mental health and primary care, using an integrated treatment plan
- Using data to demonstrate impact, especially the cost of having multiple chronic conditions and the overuse of the ER/Emergency Department beds
- Peers are KEY to successful program

THANK YOU !

Questions

