

Grantee Presentation

Describing the process of engaging, assessing, planning, providing and monitoring comprehensive integrated services through a case illustration



Austin Travis County Integral Care

Health Integration Project (HIP)

Cohort: 3

Type of program: FQHC Partnership, Co-Located at two
CMHC locations

Primary care Model: The team consists of a Family Physician, a Registered Nurse, a Medical Assistant, a Medical Admitting Clerk, and a Case Manager. Primary care services embedded into the Community Mental Health Center. The Health Integration Project serves ATCIC consumers with Severe Mental Illness and Substance Use Disorders. Austin Travis Integral Care (CMHC) and CommUnityCare (FQHC) share electronic health record access.



Our client background (Reginald)

❑ Brief demographics

47 yr. old white male, Christian, never married, previously homeless for 2 yrs, who currently resides in an ATCIC transitional living facility.

❑ Mental health needs (including trauma history)

Reginald has a diagnosis of Bipolar and Anxiety Disorder, most likely PTSD. His father passed away as a result of ETOH abuse (11/2005). Reginald worked as caregiver for Mother for 3 years before she passed away (8/2008). He has since had multiple consecutive hospitalizations. Has a history of 3 suicide attempts by overdose and cutting. Reginald reports that his mother had Bipolar Disorder too.



Our client background

❑ Substance use problems (including tobacco use)

Reginald reported using cannabis within the last three months. He has a past history of ETOH, cocaine, amphetamines, and hallucinogenic use, but stated that he has not used for over two years. He reported no desire to drink because of his father's ETOH induced death. He is currently tobacco free.

❑ Health problems

Reginald suffers from; Obesity, Hypertension, Diabetes, Asthma, Seizure Disorder, Neuropathy, Edema, and Chronic Back Pain.



Our client background

❑ Health Indicators Data (Baseline 4/3/2012)

Blood pressure – 170/98

BMI – 33.94, 5'10", 237 lbs.

Glucose – 99 (Highest reading in EHR is 243 before Reginald saw us on 6/28/2011)

A1C – 6.5

Lipids – Total 224, HDL 42, LDL 182, Triglycerides 497

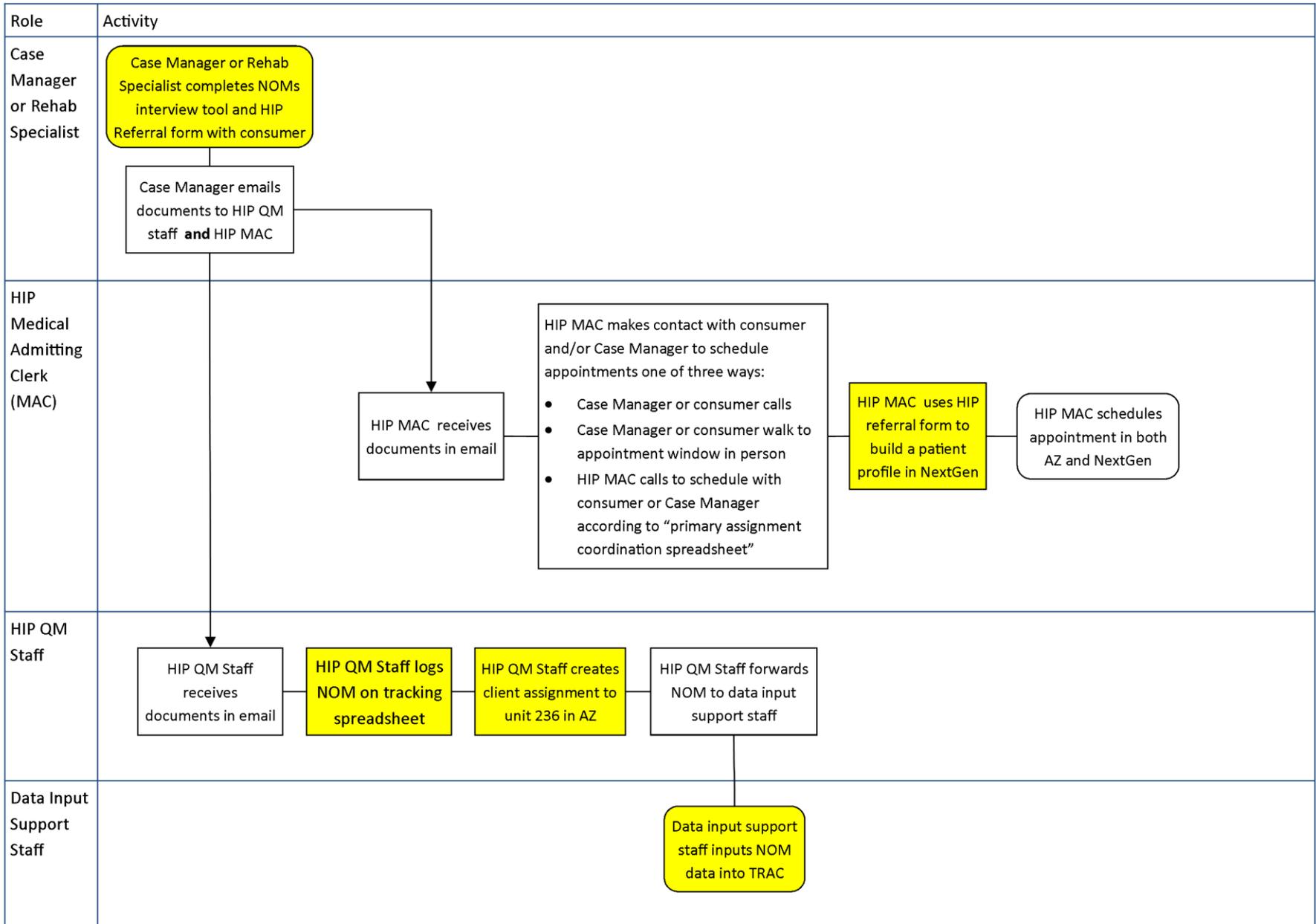


Initial engagement in the PBHCI service model

- Mental Health Case Manager informed Reginald of HIP services. After Reginald expressed interest, a referral to HIP was completed (12/7/2011).
- After the NOMs and referral were completed, Reginald received his appointment with the primary care team within one week.



HIP Referral Workflow



SAMHSA-HRSA Center for Integrated Health Solutions

Client Na Last, Fi	A7 Cl	EHR numbr	Client ID	SAI Name	SAI	unit Assig	Sub	LO L	Receive YIN	Baselin NOMS da	mont' reasse	DC da	Open	Close							
60380		3144310		HURLBERT, MEGAN	34446	257	3	3	Y	4/11/2012	10/8/2012	4/6/2013	10/3/2013	4/1/2014	9/28/2014	3/27/2015	9/23/2015	3/21/2016		10/6/2009	
185349		6126238		CLOSED					Y	4/13/2012									10/17/2012	3/6/2012	
126776		6108849		CLOSED					Y	4/17/2012									6/23/2012	6/2/2011	6/14/2012
185472		6123252		CLOSED					Y	4/17/2012									11/3/2012	2/6/2012	7/2/2012
66396		3038584		CANIFE, KARA	35080	251	3	3	Y	4/18/2012	10/15/2012	4/13/2013	10/10/2013	4/8/2014	10/5/2014	4/3/2015	9/30/2015	3/28/2016		3/12/2010	
184748		6130690		GILANI, SAMAIRA	34501	422	3	3	Y	4/18/2012	10/15/2012	4/13/2013	10/10/2013	4/8/2014	10/5/2014	4/3/2015	9/30/2015	3/28/2016		1/17/2012	
118602		6123664		UMBERGER, THOMAS	35455	257	3	3	Y	4/19/2012	10/16/2012	4/14/2013	10/11/2013	4/9/2014	10/6/2014	4/4/2015	10/1/2015	3/29/2016		1/3/2012	
165164		6061743		RIVERA, MELISSA	35324	251	3	3	Y	4/20/2012	10/17/2012	4/15/2013	10/12/2013	4/10/2014	10/7/2014	4/5/2015	10/2/2015	3/30/2016		4/5/2012	
178541		6106474		CLOSED					N	4/23/2012									6/6/2012	7/15/2011	6/4/2012
137865		6115752		PUGLISE, ELIZABETH	35044	271	4	4	N	4/23/2012	10/20/2012	4/18/2013	10/15/2013	4/13/2014	10/10/2014	4/8/2015	10/5/2015	4/2/2016		10/5/2010	
59708		6122285		DAVIS, SCOTT	35326	251	3	3	N	4/23/2012	10/20/2012	4/18/2013	10/15/2013	4/13/2014	10/10/2014	4/8/2015	10/5/2015	4/2/2016		2/20/1937	
63400		6112314		SNEED, BELVIN	33574	251	1	1	Y	4/25/2012	10/22/2012	4/20/2013	10/17/2013	4/15/2014	10/12/2014	4/10/2015	10/7/2015	4/4/2016		8/22/2011	
20071		3084821		SNEED, BELVIN	33574	251	1	1	Y	4/25/2012	10/22/2012	4/20/2013	10/17/2013	4/15/2014	10/12/2014	4/10/2015	10/7/2015	4/4/2016		9/29/2004	
186418		6129827		MCINNIS, JOHN DENNARD	35197	222	X		Y	4/26/2012	10/23/2012	4/21/2013	10/18/2013	4/16/2014	10/13/2014	4/11/2015	10/8/2015	4/5/2016		3/14/2012	
168394		6092213		STETSON, SARA	35040	251	1	1	Y	4/26/2012	10/23/2012	4/21/2013	10/18/2013	4/16/2014	10/13/2014	4/11/2015	10/8/2015	4/5/2016		5/3/2010	
165094		6129661		WANG, MOLLY	35302	251	1	1	Y	4/26/2012	10/23/2012	4/21/2013	10/18/2013	4/16/2014	10/13/2014	4/11/2015	10/8/2015	4/5/2016		3/20/2012	
183834		6129821		CLOSED					Y	4/27/2012									11/21/2012	11/1/2011	
133592		6131459		TAMER, RACHEL	35341	251	1	1	Y	4/27/2012	10/24/2012	4/22/2013	10/19/2013	4/17/2014	10/14/2014	4/12/2015	10/9/2015	4/6/2016		12/23/2010	
150210		6048933		FELDSTEIN, JOSINDA	35023	422	1	1	Y	4/27/2012	10/24/2012	4/22/2013	10/19/2013	4/17/2014	10/14/2014	4/12/2015	10/9/2015	4/6/2016		4/25/2012	
186110		6129828		STANLEY, DANILO	31474	486	1	1	Y	4/27/2012	10/24/2012	4/22/2013	10/19/2013	4/17/2014	10/14/2014	4/12/2015	10/9/2015	4/6/2016		3/22/2012	
185701		6136760		CHAGOLLAN, JHABEL	35183	251	3	3	Y	4/30/2012	10/27/2012	4/25/2013	10/22/2013	4/20/2014	10/17/2014	4/15/2015	10/12/2015	4/9/2016		2/28/2012	
163927		6129536		KELLOGG, AMIEE	35333	236			Y	4/30/2012	10/27/2012	4/25/2013	10/22/2013	4/20/2014	10/17/2014	4/15/2015	10/12/2015	4/9/2016		12/1/2011	
178688				CLOSED					Y	5/1/2012									8/22/2012	4/6/2012	
181890		6117017		STETSON, SARA	35040	251	1	1	Y	5/1/2012	10/28/2012	4/26/2013	10/23/2013	4/21/2014	10/18/2014	4/16/2015	10/13/2015	4/10/2016		3/16/2011	
147868		6046664		GOLDSTEIN, ANDREA	35188	422	3	3	Y	5/1/2012	10/28/2012	4/26/2013	10/23/2013	4/21/2014	10/18/2014	4/16/2015	10/13/2015	4/10/2016		8/25/2010	
92794		6062034		WANG, MOLLY	35302	251	1	1	Y	5/2/2012	10/29/2012	4/27/2013	10/24/2013	4/22/2014	10/19/2014	4/17/2015	10/14/2015	4/11/2016		1/17/2012	
30279		6129826		UMBERGER, THOMAS	35455	257	3	3	Y	5/3/2012	10/30/2012	4/28/2013	10/25/2013	4/23/2014	10/20/2014	4/18/2015	10/15/2015	4/12/2016		3/8/1996	
107961		6129852		CANIFE, KARA	35080	257	3	3	Y	5/3/2012	10/30/2012	4/28/2013	10/25/2013	4/23/2014	10/20/2014	4/18/2015	10/15/2015	4/12/2016		3/12/2010	
184880		6073245		JACOBI, CHRIS	35284	257	1	1	Y	5/4/2012	10/31/2012	4/29/2013	10/26/2013	4/24/2014	10/21/2014	4/19/2015	10/16/2015	4/13/2016		12/27/2011	
119427		3121374		CARTWRIGHT, AMANDA	35345	475	L		Y	5/4/2012	10/31/2012	4/29/2013	10/26/2013	4/24/2014	10/21/2014	4/19/2015	10/16/2015	4/13/2016		2/16/2012	
35675		3026573		CLOSED					Y	5/4/2012									1/22/2013	4/18/2012	11/7/2012
130460		6129925		HALL, JON SCOTT	33549	251	2	2	Y	5/7/2012	11/3/2012	5/2/2013	10/29/2013	4/27/2014	10/24/2014	4/22/2015	10/19/2015	4/16/2016		2/24/2012	
181748		6114107		RIVERA, MELISSA	35324	251	3	3	Y	5/7/2012	11/3/2012	5/2/2013	10/29/2013	4/27/2014	10/24/2014	4/22/2015	10/19/2015	4/16/2016		8/5/2011	
148788		3149446		RIVERA, MELISSA	35324	251	3	3	Y	5/7/2012	11/3/2012	5/2/2013	10/29/2013	4/27/2014	10/24/2014	4/22/2015	10/19/2015	4/16/2016		1/17/2011	
11397		542667		FRANK, ARIELLE	35271	257	3	3	Y	5/9/2012	11/5/2012	5/4/2013	10/31/2013	4/29/2014	10/26/2014	4/24/2015	10/21/2015	4/18/2016		8/12/2009	
119220		6102328		KELLOGG, AMIEE	35459	251	3	3	Y	5/9/2012	11/5/2012	5/4/2013	10/31/2013	4/29/2014	10/26/2014	4/24/2015	10/21/2015	4/18/2016		11/17/2011	
66803				CLOSED					Y	5/9/2012									1/22/2013	10/10/2011	
171051		6100785		FRANK, ARIELLE	35271	257	3	3	Y	5/10/2012	11/6/2012	5/5/2013	11/1/2013	4/30/2014	10/27/2014	4/25/2015	10/22/2015	4/19/2016		4/9/2012	
172813		6107591		GILANI, SAMAIRA	34501	422	3	3	Y	5/10/2012	11/6/2012	5/5/2013	11/1/2013	4/30/2014	10/27/2014	4/25/2015	10/22/2015	4/19/2016		4/30/2012	
185356		6131466		CLOSED					Y	5/11/2012									8/27/2012	2/20/2012	8/23/2012
80898		6029280		CLOSED					Y	5/14/2012									5/31/2012	6/16/2011	
147571		6131461		CLOSED					Y	5/14/2012									11/7/2012	4/27/2012	10/31/2012
123745		3133631		CAROLINA, PHILIP	681184	9000	3	3	N	5/14/2012	11/10/2012	5/9/2013	11/5/2013	5/4/2014	10/31/2014	4/29/2015	10/26/2015	4/23/2016		12/22/2010	
106937		2031144		CLOSED					Y	5/15/2012									10/29/2012	1/19/2010	



Referral to Health Integration Project (HIP) Primary Care Services

Consumers referred to HIP are expected to meet a minimum of **two** of the following criteria:

(Please use check boxes)

- Consumer is not receiving primary care services from a community provider or is not able to access their provider as needed.*
- Consumer has a long standing (chronic) physical health condition.*
- Consumer reports having been admitted to an Emergency department for physical health needs **2** or more times in the past month.*
- Consumer is likely to experience **substantial** difficulty in accessing community primary care services due to complications related to the behavioral health diagnosis and/or associated functional impairments.*

(For any questions related to eligibility please contact Matt at (512) 804-3811 or Matthew.Rich@atcic.org)

Name: _____ DOB: _____ Anasazi #: _____

SSN: _____ Phone #: (Home) _____ (cell) _____

Mailing address: _____

Primary Insurance Coverage: _____ Plan/Policy/ID #: _____

Guardian Name: _____ Phone #: _____ N/A

Current PCP: _____ N/A

Current medical problem (if any): _____

Primary Assignment: (Please check one)

_____ _____ _____

Initial engagement in the PBHCI service model

- Reginald no-showed to one appointment and cancelled another one before he was seen.
- After Reginald dropped out of Mental Health (MH) services due to non-attendance, he was re-engaged by the HIP case manager who was able to reinstate him with MH services and reschedule him for his primary care appointments.
- From the time of the referral, it took four months to re-engage and have Reginald start his treatment.

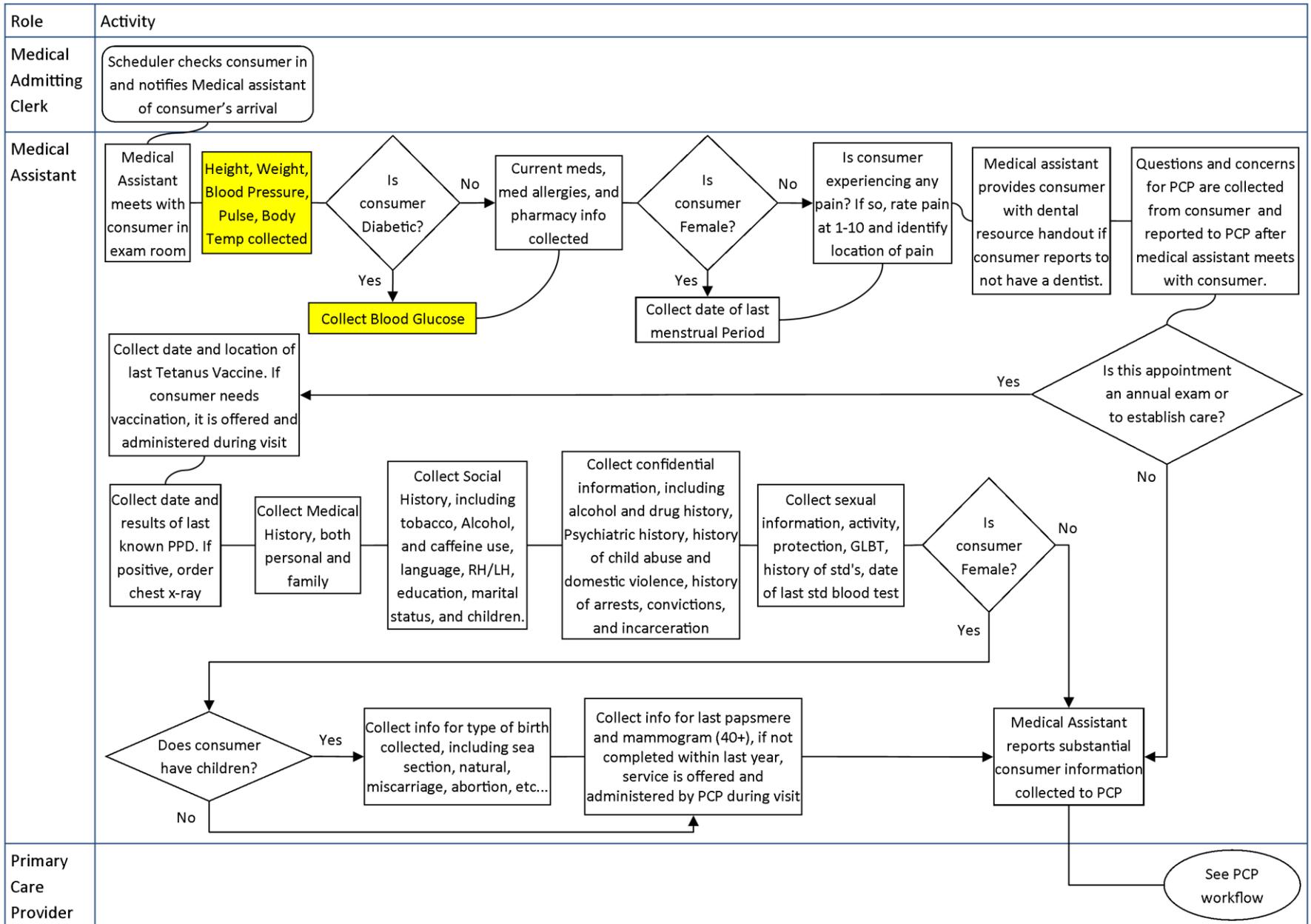


Assessment Process: Client H indicators

- Weight, Height, BMI, Blood Pressure, and Blood Glucose (if diabetic) collected by Medical Assistant at every appointment and entered into CommUnityCare (CUC) EHR.
- Blood labs, A1C, and lipid panel collected at CUC clinic with laboratory (located in same parking lot). Results entered into CUC EHR.
- H indicator data pulled by CUC decision support every 6 months.
- Data back-entered into TRAC



HIP Medical Assistant Appointment Workflow



	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1	mm	enc_timestamp	bp_systolic	bp_diastolic	weight_kg	height_cm	BMI_calc	coll_date_time	glucose	A1c	total cholesterol	HDL	LDL	triglyceride
2	100696	2/24/2011	120	83	100.2	174	33.1							
3	100696	10/12/2011	169	88	109.1	174	36.04	12/12/2011	112	6.6	170	74	54	208
4	100696	12/7/2011	156	84	110.7	174	36.56							
5	100696	1/18/2012	145	80	115.2	174	38.05							
6	100696	3/19/2012	158	82	118.1	174	39.01	3/19/2012		5.9				
7	100696	5/7/2012	148	91	118.4	174	39.11							
8	100696	6/20/2012	153	83	116.573	173.99	38.51							
9	100696	7/11/2012	138	85		173.99	38.95							
10	100696	8/27/2012	151	90		173.99	38.8							
11	100696	9/6/2012						9/6/2012	93	5.9	161	63	48	248
12	100696	10/10/2012	145	84		173.99	39.03							
13	100696	11/21/2012	126	69	117.48	173.99	38.81							
14	118822	2/15/2011	129	78		158.8	42.26							
15	118822	3/9/2011	160	97		158.8	41.93	3/9/2011	60	5.9	131	49	66	80
16	118822	10/24/2011	105	70	107.7	158.8	42.65							
17	118822	2/2/2012	118	75		158.8	40.92							
18	118822	3/7/2012	144	65	102.9	154.9	42.89	3/7/2012	112	5.8	140	47	75	92
19	118822	3/19/2012	130	70	103.2	154.9	43.01							
20	118822	4/2/2012	121	74		154.9	42.23							
21	118822	7/9/2012	176	108		154.9	41.19							
22	118822	9/10/2012	141	97	96.162	154.94	40.06	9/18/2012	95	6.0				
23	118845	3/9/2012	98	64	82.1	157	33.32							
24	118845	3/16/2012	107	63	84.8	154.9	35.34	3/26/2012	75		211	124	76	57
25	118845	8/7/2012	110	66		154.9	41.94							
26	140732	2/29/2012	176	112	95.5	163.8	35.59	3/8/2012	99		225	43	108	371
27	140732	4/11/2012	117	61	98	163.8	36.53							
28	156021	5/25/2011	172	113	86	160	33.59							
29	156021	8/12/2011	140	110		160	37.2							
30	156021	8/25/2011	126	78	100.7	160	39.34							
31	156021	11/9/2011	126	85	99.3	160	38.79							
32	156021	2/8/2012	140	93	98.9	160	38.63							
33	156021	4/16/2012	135	83	98.4	160.8	38.06	5/11/2012	102		171	42	95	169
34	156021	4/30/2012	140	100	99.3	160.8	38.4							

Assessment Process: Client H indicators

CLINICAL OUTCOMES

	Improved		Maintain		Same		Worsened		Not Applicable		Total	Positive Impact		No Impact	
Systolic	178	34%	89	17%	63	12%	189	36%	0	N/A	519	267	51%	252	49%
Diastolic	159	31%	210	40%	34	7%	116	22%	0	N/A	519	369	71%	150	29%
BMI	155	30%	73	14%	64	12%	227	44%	0	N/A	519	228	44%	291	56%
Glucose	18	5%	344	88%	7	2%	22	6%	128	N/A	391	362	93%	29	7%
A1C	11	12%	58	62%	16	17%	9	10%	425	N/A	94	69	73%	25	6%
Cholesterol	26	8%	226	66%	75	22%	17	5%	175	N/A	344	252	73%	92	27%
HDL	44	13%	66	19%	195	57%	39	11%	175	N/A	344	110	32%	234	68%
LDL	43	13%	157	46%	122	35%	22	6%	175	N/A	344	200	58%	144	42%
Triglyceride	21	6%	219	64%	77	22%	27	8%	175	N/A	344	240	70%	104	30%

*based on most recent MRN in "episode" and baseline MRN

- We plan to continue to track section H indicators after the grant



Planning: Individualized Integrated Care Plan

A. Primary care services:

- Frequency - 1-2 times a month
- Provider(s) - Family Physician and Dentist (Consumer receives dental treatment through CUC)
- Focus of service – Maintain compliance and stability with hypertension medication, diabetes management, and non-narcotic pain management plan. Find effective treatment for seizures and asthma.



Planning: Individualized Care Plan

B. Behavioral health services:

- Frequency – 1 to 2 times a week
- Provider(s) – Psychiatrist, RN, and Case Manager or Rehabilitative Specialist
- Person Centered Care Plan– “Better mental control, even mood, better sleep, decrease restlessness and fidgeting, and find suitable living arrangements” as stated by Reginald.



Planning: Individualized Care Plan

C. Wellness activities/services:

- Reginald is currently not engaged in wellness activities. He reports only an interest in radio and TV as he enjoys both.
- He has expressed interest in enrolling in In SHAPE and will start in one month.

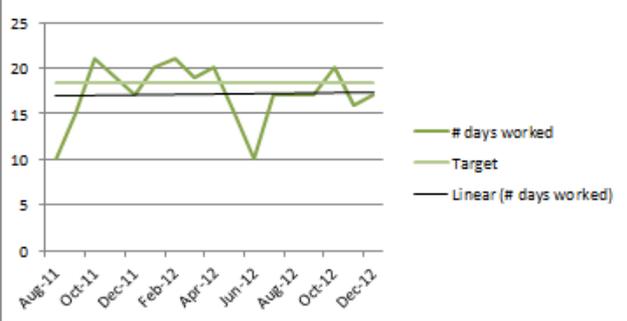


Progress Monitoring (H indicators and other health conditions)

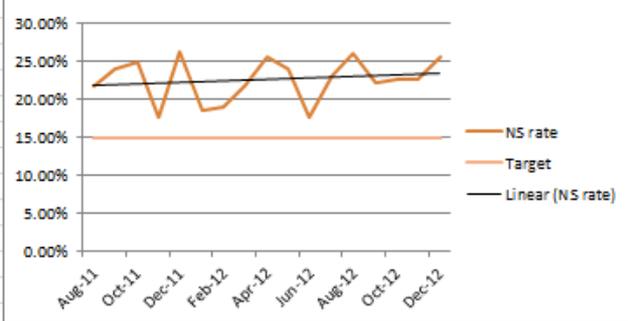
- Health status indicators are monitored at regular primary care appointments.
- The CUC EHR notifies of upcoming needed labs
- Medical chart note scanned into ATCIC EHR after every primary care visit.
- Information is shared between Treatment teams in person, by phone, and e-mail.
- All staff involved with clients' care are able to access and share information with them.



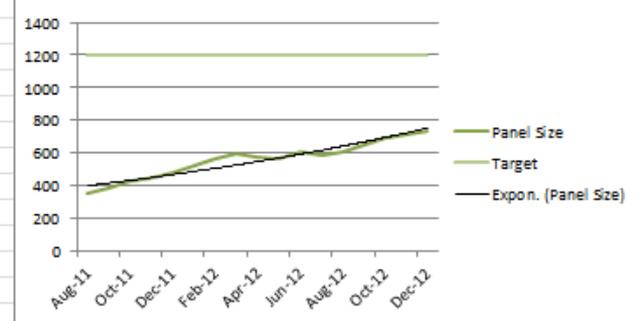
Days Worked



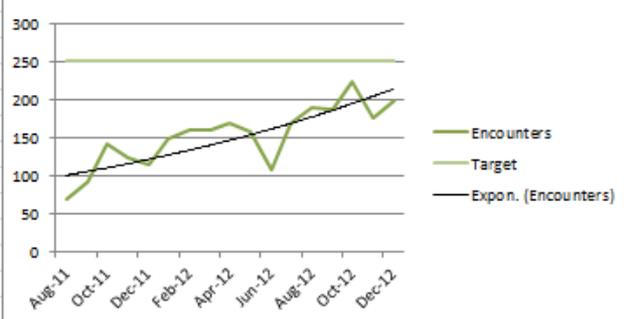
No-Show Rate



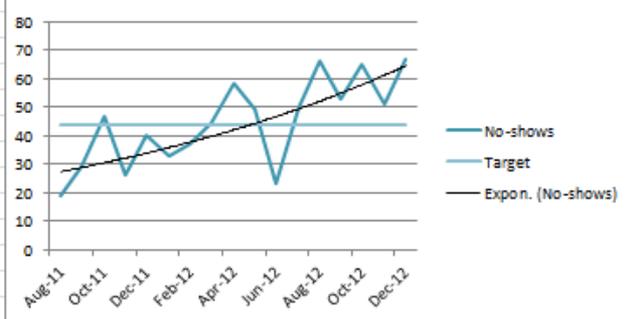
Panel Size



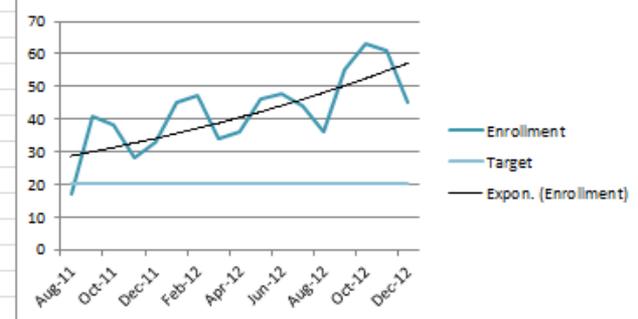
Total Monthly Encounters



Total Monthly No-Shows



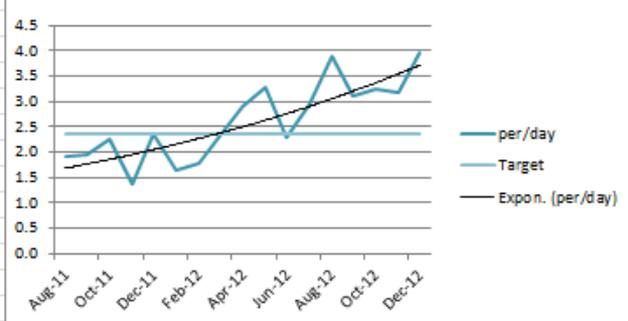
Monthly Enrollment



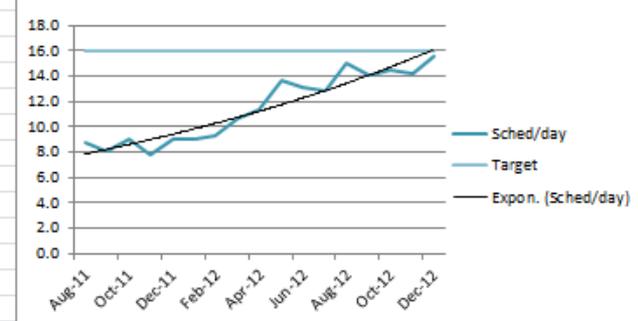
Encounters per Day



No-Shows per day



Scheduled per day



Our client background

❑ Health Indicators Data (Most Recent 1/3/2013)

Blood pressure – 122/70

BMI – 33.57, 5'10", 234 lbs.

Glucose – 85

A1C – 5.6

Lipids – (4/3/2012) Total 224, HDL 42, LDL 182,
Triglycerides 497

*lipid panel only collected once



Highlights

- Primary Care team is fully embedded within the mental health team which has enabled them to work together on behavioral and primary care planning. All primary care team members have received Mental Health First Aid and Preventative Management of Aggressive Behavior training and certifications.
- MH clinicians have attended the Case to Care Manager training to continue to be effective at facilitating physical health planning.
- In the case of this client, a push for housing was initiated by PCP, followed through by the HIP CM, and handed off to Mental Health CM.
- It is important we continue to pursue means to increase the accessibility and sharing of information to foster effective interactions between primary care and behavioral health.

