Community Mental Health Affiliates, Inc.
New Britain, CT – Cohort II

“If I Knew then What I Know Now...”
Options to Health (O2H) Mission

To improve the quality of life of CMHA adult patients with serious mental health or substance use disorders who do not have a physician in the community through access to primary medical care, wellness programs, and the integration of medical and psychiatric treatment.

O2H Integrated Primary Care and Behavioral Health Team

The Hospital of Central Connecticut (THOCC)
Primary Care Clinic Staff:
  Physician Supervisor – William Rabitaille
  APRN – Lauren McTeague

Community Mental Health Affiliates, Inc. (CMHA)
Integrated Care Staff:
  Project Director – Linda Filipetti
  Project Manager – Marie Mormile-Mehler
  Program Coordinator – Fran Cerasuolo
  Performance Improvement Coordinator – Lisa Daley
  Medical Case Manager
  Medical Assistant

University of Connecticut Health Center
  Evaluator – Jane Ungemack
Primary Care: All care will be provided by an Advanced Practice Registered Nurse (APRN) with experience working with mentally ill populations under the physician’s supervision.

Integration of Care: A case manager will work with patients to maintain appointments and communicate regularly with all medical services to ensure integrated care.

Services offered: Besides behavioral health and primary care services, the program will link participants to medical services that promote wellness, prevention and illness management. Examples of these medical services are referrals to dietitians, dentists, smoking cessation counselors, drug rehabilitation and other wellness services.

Eligibility: All seriously mentally ill (SMI) clients who either do not have a primary care provider or who are not regularly seeing primary care services.

Overall Goal: Improve access to primary care, empower and educate consumers, improve health status, and reduce unnecessary hospital utilization.

Overall Goals:
1. Encourage Long-Term Primary Care Through an Integrative Behavioral Health and Primary Care Model
2. Improve Health Status and Symptom Management
3. Provide Access to Other Health Services
4. Reduce Unhealthy Behaviors
5. Promote Preventive Care

O2H: Disease Prevention & Health Promotion Programs

- Healthy Eating and Lifestyle
- Smoking Cessation
- Exercise Classes
- Shopping for Healthy Food on a Fixed Income
- Heart Health Tips of the Week
- Diabetes: Recognizing the Signs
- Wellness Week
- Care Coordination
O2H Accomplishments & Successes

- Unique partnership with THOCC, a community-based hospital; most PBHCI behavioral health grantees partnered with FQHCs
- Strong support from THOCC and CMHA leadership, clinical and administrative staff for integrated care model
- Intake data showed that one-in-three CMHA patients did not have a PCP
- CMHA changed its intake process to incorporate standardized health screening of all patients
- All clients had opportunity to enroll in O2H, although the O2H target population was patients without a PCP
- 375 clients were enrolled and received O2H services
- Increased client access to health care, including specialists, x-ray and lab services (one-stop shopping) through Primary Care Clinic site at THOCC

O2H Accomplishments & Successes

- Developed Health and Wellness Service System open to all agency clients.
- Annual Health Fairs attended by 100-200 clients and staff featuring:
  - Blood pressure, blood sugar and cholesterol screenings
  - Cooking demonstrations
  - Talks on health, nutrition and tobacco cessation
- Wellness “Walk in the Park” for 170 staff and patients
- CMHA obtained Accent TVs (Health Info) in client waiting rooms
- CMHA adopted Smoke Free Campus policy in January 2013 and a system-wide effort to promote tobacco cessation among patients and staff
- $175,000 grant from the CT Department of Public Health to provide Tobacco Cessation Services to SMI population
- SAMHSA HIT Grant of $200,000 for electronic medical record enhancements, including shared records and CCD
O2H Accomplishments & Successes

• CMHA prescribers and nurses gained access to THOCC EMR to better coordinate medical and psychiatric care
• CMHA adopted an integrated care model, breaking away from the traditional silo approach
• CMHA’s experience with PBHCI led to its participation on the state Planning Committee for Behavioral Health Homes and positioned CMHA for changes in the health care system
• CMHA selected as one of Connecticut’s first Behavioral Health Homes in July 2014
• Model selected for a special site study by RAND

O2H Accomplishments & Successes

• Accessed and linked THOCC data to O2H NOMS data to investigate O2H program impact on hospital services utilization, including ED, inpatient medical and inpatient psychiatric services
• Data analyses showed lower ED utilization from one year before enrollment in O2H to one year after enrollment in O2H
• Increased THOCC Outpatient Clinic staff’s acceptance of treating patients with SMI
• O2H medical staff recognized by THOCC medical staff as the “go to” consultants regarding patients with SMI
• THOCC obtains direct connection with mental health treatment resources; CMHA obtains a direct connection with primary care resources for patients
• THOCC gains resource for dealing with patients with psycho-somatic disorders
• More comprehensive, integrated care provided to patients
**Demographic Characteristics of O2H Clients**

**Race/Ethnicity**

<table>
<thead>
<tr>
<th>Race</th>
<th>Number of Patients</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>192</td>
<td>55%</td>
</tr>
<tr>
<td>Black</td>
<td>51</td>
<td>15%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>103</td>
<td>30%</td>
</tr>
<tr>
<td>Native American</td>
<td>15</td>
<td>4%</td>
</tr>
<tr>
<td>Asian</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>Hawaiian</td>
<td>4</td>
<td>1%</td>
</tr>
<tr>
<td>Alaskan</td>
<td>1</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

**Total Patients Recruited**: 374 Clients

**Percent of O2H Clients with Improved Health Indicators from Baseline to Most Recent Assessment**

<table>
<thead>
<tr>
<th>National Outcomes Measures</th>
<th>No Longer At-risk</th>
<th>Outcome Improved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure - Systolic</td>
<td>16.3%</td>
<td>17.9%</td>
</tr>
<tr>
<td>Blood pressure - Diastolic</td>
<td>14.6%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Blood pressure - Combined</td>
<td>17.1%</td>
<td>16.3%</td>
</tr>
<tr>
<td>BMI</td>
<td>5.0%</td>
<td>43.8%</td>
</tr>
<tr>
<td>Waist Circumference</td>
<td>3.3%</td>
<td>23.3%</td>
</tr>
<tr>
<td>Breath CO</td>
<td>6.3%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Plasma Glucose (fasting)</td>
<td>13.3%</td>
<td>33.3%</td>
</tr>
<tr>
<td>HDL Cholesterol</td>
<td>0.0%</td>
<td>15.8%</td>
</tr>
<tr>
<td>LDL Cholesterol</td>
<td>0.0%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Triglycerides</td>
<td>0.0%</td>
<td>21.1%</td>
</tr>
</tbody>
</table>
Percent of O2H Clients with Improved Outcomes from Baseline to Most Recent Assessment

<table>
<thead>
<tr>
<th>National Outcomes Measures</th>
<th>Positive at 2nd Interview</th>
<th>Outcome Improved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy overall</td>
<td>48.7%</td>
<td>15.4%</td>
</tr>
<tr>
<td>Functioning in everyday life</td>
<td>40.6%</td>
<td>45.3%</td>
</tr>
<tr>
<td>No serious psychological distress</td>
<td>57.8%</td>
<td>7.0%</td>
</tr>
<tr>
<td>Never using illegal substances</td>
<td>81.0%</td>
<td>10.2%</td>
</tr>
<tr>
<td>Not using tobacco products</td>
<td>28.1%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Not binge drinking</td>
<td>89.9%</td>
<td>6.7%</td>
</tr>
<tr>
<td>Retained in the community</td>
<td>91.3%</td>
<td>12.7%</td>
</tr>
<tr>
<td>Had a stable place to live in the community</td>
<td>62.2%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Attending school regularly/employed/retired</td>
<td>12.2%</td>
<td>6.5%</td>
</tr>
<tr>
<td>No involvement with criminal justice system</td>
<td>98.4%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Were socially connected</td>
<td>59.0%</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

O2H Accomplishments & Successes

- Ramon, a latino male with undiagnosed heart disease, referred by CMHA outpatient clinician to O2H 3 years ago; saw O2H APRN and got medication for cholesterol and high blood pressure. He attended nutrition, exercise, smoking cessation and behavioral health groups regularly, lost weight and had his cholesterol and blood pressure under control. He was incarcerated for a year and recently returned to CMHA and O2H.
Number of Hospital Visits Before and After Patient Enrollment in O2H

<table>
<thead>
<tr>
<th>Type of Hospital Visit</th>
<th>In Year Before O2H Enrollment</th>
<th>In Year After O2H Enrollment</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department</td>
<td>821</td>
<td>645</td>
<td>0.01</td>
</tr>
<tr>
<td>Inpatient Medicine</td>
<td>23</td>
<td>32</td>
<td>0.20</td>
</tr>
<tr>
<td>Inpatient Psychiatric</td>
<td>47</td>
<td>40</td>
<td>0.49</td>
</tr>
</tbody>
</table>

Inpatient Days and Length of Stay Before and After O2H Enrollment

<table>
<thead>
<tr>
<th>Type of Visit</th>
<th>Inpatient Days Before O2H Enrollment</th>
<th>Inpatient Days After O2H Enrollment</th>
<th>Average Change in Inpatient Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Medicine</td>
<td>76 Days 23 Visits 3.3 days/visit</td>
<td>103 Days 32 Visits 3.2 days/visit</td>
<td>0.1 days/visit</td>
</tr>
<tr>
<td>Inpatient Psychiatry</td>
<td>677 Days 47 Visits 14.4 days/visit</td>
<td>458 Days 40 Visits 11.5 days/visit</td>
<td>2.9 days/visit</td>
</tr>
</tbody>
</table>
O2H Challenges & Outcomes

- Difficulties in hiring and retaining medical staff, especially APRNs, who understand and have experience with SMI population
- Limited training for medical staff in working with SMI population
- Difficulty in engaging clients in wellness programs, particularly smoking cessation groups
- High no show rate in the primary care clinic, fluctuating between 30-50%
- Follow-up NOMS rate fluctuated between 40-60% due to difficulties in reaching clients for reassessments

O2H Challenges & Outcomes

- Difficulty getting buy-in from behavioral health care clinicians to providing integrated care model
- Overcoming social stigma from general primary care clinic staff towards SMI clients
- Accessing specialists for services, despite the project coordinator’s numerous connections with them
- Chaotic hospital waiting room environment often caused patients to become agitated
- Even with additional supports, some patients had difficulties following through with health care recommendations
O2H Challenges & Outcomes

• Coordinating separate medical record systems; primary care provider using a paper record and CMHA using EMR which has own E-prescribe program.
• 2-year delay with vendor in import of CCD file from THOCC
• The NOMS mental health outcome measures and one-group study design could not discriminate between behavioral health and integrated care effects

Moving Forward

• CT Departments of Social Services and Mental Health and Addiction have designated CMHA as a “Behavioral Health Home” for 450 SMI clients annually
• The O2H project will morph into a Behavioral Health Home
• CMHA will receive BHH funding for Care Management (Nurse Care Managers) and Care Coordination under the Behavioral Health Home
• THOCC will sustain APRN services for the O2H population
Words of Wisdom:
What We Wish We’d Done Differently

• Educate and obtain buy-in from your behavioral health clinicians on the value and importance of integrated care
• Enlist your medical director as a project champion
• Hire APRN staff who are experienced with and committed to the population
• Consider hiring a Nurse Care Manager (RN) vs. Medical Case Manager (BA level staff) to manage medical aspects of clients’ care plans
• Add incentives for individual and group participation in wellness programs
• Make free Nicotine Replacement Therapy part of the tobacco cessation program