Integrating Behavioral and Physical Health Care

Kenneth S. Fink, MD, MGA, MPH
Hawaii State Medicaid Director
SMI and Physical Health

- Individuals with a severe mental illness (SMI) have a lifespan shortened 15-30 years
- Estimated 60% of this excess mortality is due to physical illness
- Increased prevalence of physical illnesses
  - Obesity, diabetes, cardiovascular disease, HIV, hepatitis, TB
Hawaii Medicaid and SMI

- Mandatory managed care for non-ABDs and ABDs
- Additional behavioral health services carved out
- Services available through Department of Health or through Community Care Services (CCS) program
- State decided to “reattach the head to the body” and carved in additional behavioral health services for non-ABDs
# Receipt of Additional Behavioral Health Services

<table>
<thead>
<tr>
<th>Populations</th>
<th>Department of Health</th>
<th>Health Plans (QUEST)</th>
<th>Health Plans (QExA)</th>
<th>Community Care Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured and ABDs</td>
<td>Yes</td>
<td>Yes</td>
<td>n/a</td>
<td>ABDs</td>
</tr>
<tr>
<td>Medicaid services</td>
<td>Yes</td>
<td>Yes</td>
<td>n/a</td>
<td>Yes</td>
</tr>
<tr>
<td>Non-Medicaid services</td>
<td>Yes</td>
<td>No</td>
<td>n/a</td>
<td>No</td>
</tr>
</tbody>
</table>

**Medicaid Services:**
- Crisis
- Case management
- Psychosocial rehabilitation
- Therapeutic residential
- Intensive outpatient hospital

**Non-Medicaid Services:**
- Representative payee
- Supported employment
- Peer specialist
- Clubhouse
- Housing
What We Learned and What’s Next

• Integration at the payer level did not improve care
• At best, care was as good carved in as when carved out
• Seeking to unify in a single behavioral health organization
• Greatest benefit will be also to include uninsured
• Working with Department of Health
Summary

- Recognize the need to improve medical care for individuals with SMI and are pursuing a new delivery model
- Hope CMS will approve FFP for services recommended by SAMHSA
- Appreciate evidence-based best practices for care integration
- Encourage continued coordination between SAMHSA and CMS
Maryland’s SAMHSA-Funded Health Integration Project (HIP)

Jennifer K. Crawford, JD, LCSW-C
Deputy Director
SAMHSA-HRSA Center for Integrated Health Solutions
National Council for Community Behavioral Healthcare
Family Services, Inc., Threshold Services, Inc. & Community Clinic, Inc.

LET’S GET HIP!

Illustration by Mona Caron, http://www.integratedprimarycare.com/
Health Disparities for those with Mental Illness

• Patients with severe mental illness (SMI) such as schizophrenia die 25 years earlier than the general population, largely due to treatable medical conditions (cardiovascular, metabolic disorders, diabetes and infectious diseases)

• Modifiable risk factors such as tobacco use (Vanable, Carey et al. 2003; de Leon and Diaz, 2005), alcohol use and misuse, obesity, diabetes, (Goff, Cather et al. 2005), poor nutrition, infrequent physical activity (Daumit, Goldberg et al., 2005), and in some cases the medication itself and injury account for about 30-40% of excess mortality (NASMHPD Report 2006)
HIP Primary/Behavioral Health Care Integration

Prevention & Wellness Activities
- Smoking Cessation
- Diabetes Management
- Fitness
- Nutrition
- Stress Management
- WRAP-client led Yoga

Family Services (OMHC)¹

Threshold Services (OMHC)¹

Community Clinic (FQHC)²

1 OMHC: Out-patient mental health clinic center
2 FQHC: Federally qualified health center
Nurse Care Manager’s Role

- Build relationships and enroll clients
- Record health screening information into EHR
- Collect and record SAMHSA-required data
- Bridge communications between primary care and behavioral health
- Set up appointments with the primary care provider
- Take blood work
- Provide health education
HIP Client Health Report

Client Name: Doe, Jane TRACID: XXXXXXXXXXX

<table>
<thead>
<tr>
<th>Indicator (Goal)</th>
<th>2/24/2011</th>
<th>9/15/2011</th>
<th>2/21/2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI (18.5 - 24.9)</td>
<td>36.4*</td>
<td>34.2*</td>
<td>37.9*</td>
</tr>
<tr>
<td>Weight</td>
<td>212</td>
<td>202</td>
<td>221</td>
</tr>
<tr>
<td>BP Systolic (&lt;=120)</td>
<td>114</td>
<td>138*</td>
<td>109</td>
</tr>
<tr>
<td>BP Diastolic (&lt;=90)</td>
<td>67</td>
<td>86</td>
<td>89</td>
</tr>
<tr>
<td>LDL (&lt;100)</td>
<td>200*</td>
<td>175*</td>
<td>118*</td>
</tr>
<tr>
<td>HDL (&gt;60)</td>
<td>55 *</td>
<td>50*</td>
<td>62</td>
</tr>
<tr>
<td>Triglycerides (&lt;150)</td>
<td>112</td>
<td>100</td>
<td>104</td>
</tr>
</tbody>
</table>

Client Health Goals and Readiness…
Action Steps…

Readiness Ruler

Not at all 0 cm 1 2 3 4 5 6 7 8 9 10 Very
Baseline Clinical Data

- 84% are overweight or obese
- 42% have indicators or significant risk factors for diabetes (A1C of 5.6 or higher OR a fasting glucose rate of 126 or higher)
- 37% have high blood pressure (over 130/80)
- 29% have total cholesterol over 210
- 52% smoke
Changes in Clinical Health Status: Baseline to 12 Months

Elevated BP: 37% at baseline; 32% at follow-up
  • Average BP for people with elevated BP at baseline: From 137/81 to 129/77

Elevated BMI: 82% at baseline; 81% at follow-up
  • Average BMI for people with elevated BMI at baseline: From 34.1 to 33.1.
  • But, 45% of clients have lost some weight. For people who have lost weight, the average weight loss is 4.5 lbs. One individual has lost 33 lbs. in the last year
HIP Client #1

**SITUATION**  A client was discharged from a four-year psychiatric hospitalization & had a blood sugar level of 327mg/dl but had only given a 28-day supply of his meds.

**OBSTACLES**  Client did not have a glucose meter or means to get one.

**ACTIONS**  Client enrolled in HIP, saw a primary care provider before his meds ran out, was given a glucose meter and taught how to use it.

**RESULTS**  The client now checks his blood sugar daily and watches what he eats. He attends a nutrition class and is very eager to lose weight to help control his diabetes. He joins the HIP walking group at least 2 times a week.
HIP Client #2

SITUATION  This adult Asian woman with paranoid schizophrenia had been without health care for over five years. She presented with uncontrolled diabetes and hypertension.

OBSTACLES  Client had little English, although she understood more than she could speak. With limited resources, she would have sought routine care through emergency rooms or 24-hour clinics.

ACTIONS  Through the collaborative effort of a psychiatrist, nurse, counselor, interpreter, and physician, client enrolled in HIP and had a full physical. She was subsequently diagnosed, treated, and educated for diabetes, hypertension, and high cholesterol.

RESULTS  Client has attended diabetes education classes. She has better control of diabetes, high blood pressure, and elevated cholesterol with diet, exercise, and oral medications.
HIP Client #2

SITUATION  This adult Asian woman with paranoid schizophrenia had been without health care for over five years. She presented with uncontrolled diabetes and hypertension.

OBSTACLES  Client had little English, although she understood more than she could speak. With limited resources, she would have sought routine care through emergency rooms or 24-hour clinics.

ACTIONS  Through the collaborative effort of a psychiatrist, nurse, counselor, interpreter, and physician, client enrolled in HIP and had a full physical. She was subsequently diagnosed, treated, and educated for diabetes, hypertension, and high cholesterol.

RESULTS  Client has attended diabetes education classes. She has better control her of diabetes, high blood pressure, and elevated cholesterol with diet, exercise, and oral medications.
HIP Client #3

**SITUATION** A 42-year-old male with a history of asthma and anxiety walked into the nurse practitioner’s office complaining of shortness of breath and saying his heart hurt. He was not in acute distress, but stated he should probably go to the emergency room to be checked out.

**ACTIONS** An appointment was made with a primary care provider within two hours. Client was given a breathing treatment, an EKG, and a change in his inhaler prescriptions. He was reassured by the provider that he was not having a heart attack but was given a referral for cardiac evaluation, as his EKG showed some abnormalities.

**RESULTS** Client was given the care he needed at the office of a primary care provider. Client returned to nurse’s office the next day to tell her how “his doctor” had helped him and explained everything to him.
For more information:
Current Project Director at Family Services Inc:
Arleen Rogan, Rogana@fs-inc.org
301-840-3203

Deputy Director Center for Integrated Health Solutions, National Council for Community Behavioral Healthcare
Jenny Crawford, jennyc@thenationalcouncil.org
202-684-7457 ext 284
Integrating Behavioral and Physical Health Care

National Association of Medicaid Directors

October 29, 2012
Agenda

• The Importance/Benefits of Integration
• Models of Integration
• Provider Challenges & Opportunities
Definition of Integration

- Integration of Care and Services Can be of Three Types:
  - Clinical Integration
  - Physician (or Clinician) Integration
  - Functional Integration
The Importance/Benefits of Integration

• Improve the Health and Wellness of Patients
• Help States With Their Most Expensive Medicaid Members
  – High Incidence of Mental Illness & Substance Use Disorders
  – Improve Quality and Lower Costs
• Coordinate Care
• Help Providers With Their Most Challenging Patients
Impact of Behavioral Health Conditions on Medical Costs

PMPM Medical Cost by Number of Behavioral Health Conditions

- 0 conditions: $479
- 1 condition: $982
- 2 conditions: $1,272
- 3+ conditions: $1,606
Models of Integration

• Identify High Risk & Clinical Complexity
• Care Coordination
• Training and Education
• Co-location/Partnerships
• Information Sharing
Provider Challenges

- Geographic
- Financial
- Organizational
- Cultural

Druss BG, Newcomer JW; J Clin Psychiatry 2007
Provider Opportunities

• Better Outcomes: Improve The Health Status of Patients
• Increase Knowledge of Behavioral Healthcare
• New Partnerships
Contact Information

Pamela Greenberg, MPP
President & CEO
Association for Behavioral Health and Wellness
(202) 449-7660
greenberg@abhw.org