BEHAVIORAL AND PHYSICAL HEALTH INTEGRATION

An Integrated Medical Home Model

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Behavioral Health

- According to the World Health Organization, unipolar depression was the third most important cause of disease burden worldwide in 2004. Unipolar depression was in “eighth place in low-income countries, but at first place in middle- and high-income countries.”
- The National Institute of Health reports that:
- Approximately 1 in 5 adults in the U.S.—43.8 million, or 18.5%—experiences mental illness in a given year.
- Approximately 1 in 25 adults in the U.S.—10 million, or 4.2%—experiences a serious mental illness in a given year that substantially interferes with or limits one or more major life activities.
- An estimated 46% of homeless adults staying in shelters live with serious mental illness and/or substance use disorders.
- Approximately 20% of state prisoners and 21% of local jail prisoners have “a recent history” of a mental health condition.
- A 2008 study published in the American Journal of Psychiatry put the cost of Serious Mental Illness (SMI) in the U.S. at $193.2 billion.

Physical Health: Diseases and Serious Mental Illness

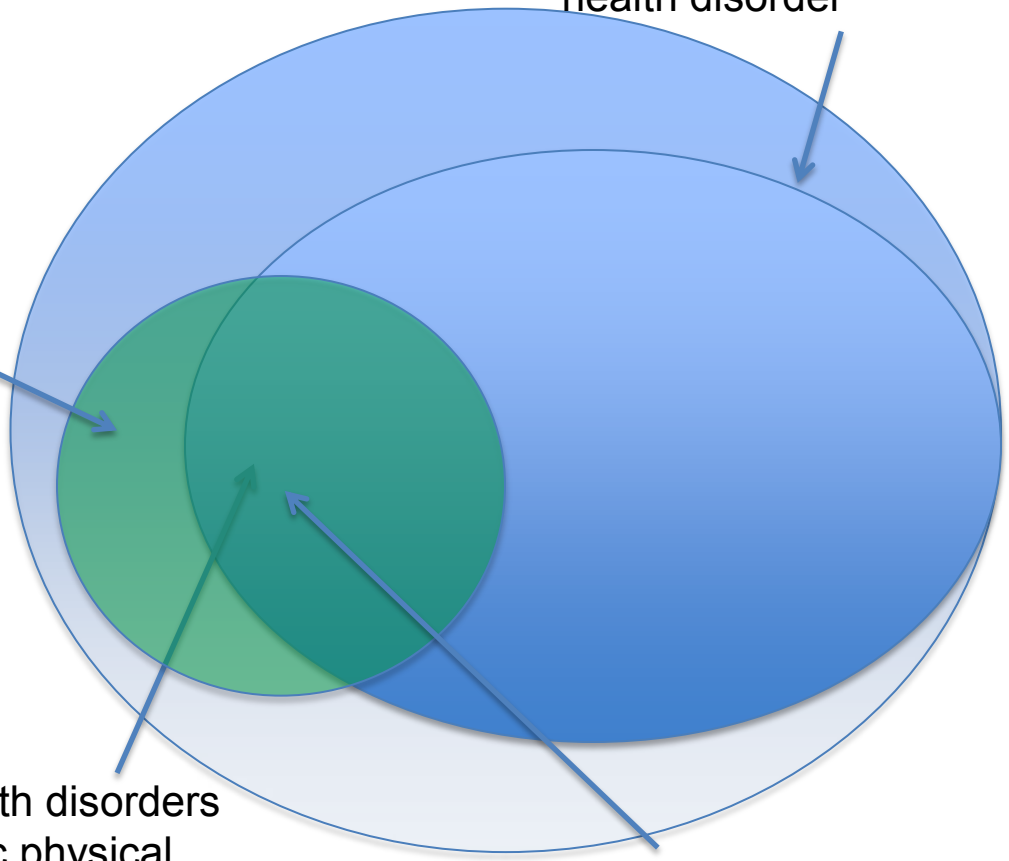
Disease category	Physical diseases with increased frequency
Bacterial infections and mycoses	Tuberculosis (+)
Viral diseases	HIV (++), hepatitis B/C (+)
Neoplasms	Obesity-related cancer (+)
Musculoskeletal diseases	Osteoporosis/decreased bone mineral density (+)
Stomatognathic diseases	Poor dental status (+)
Respiratory tract diseases	Impaired lung function (+)
Urological and male genital diseases	Sexual dysfunction (+)
Female genital diseases and pregnancy complications	Obstetric complications (++)
Cardiovascular diseases	Stroke, myocardial infarction, hypertension, other cardiac and vascular diseases (++)
Nutritional and metabolic diseases	Obesity (++), diabetes mellitus (+), metabolic syndrome (++),hyperlipidemia (++)
(++) very good evidence for increased risk, (+) good evidence for increased risk	

World Psychiatry: 2011 Feb; 10(1): 52–77

How Big is the Problem?

58% of the adult population has some type of chronic physical health disorder

25% of the adult population has some type of mental health disorder



68% of adults with mental health disorders also have some type of chronic physical health disorder

29% of adults with chronic physical health disorders also have some type of mental health disorder

"Mental Disorders and Medical Comorbidity," Research Synthesis Report, February 2011, Robert Wood Johnson Research Foundation

Why Integrate Behavioral and Physical Health Services?

- The lifespan of people with severe mental illness (SMI) is shorter compared to the general population. (About 25 yrs. shorter) This excess mortality is mainly due to physical illness.
- Cardiovascular death among those with serious mental illness is 2 to 3 times that of the general population.
- Negative cardio-metabolic effects of newer psychotropic medications increase the rates of obesity, diabetes, and hyperlipidemia among those treated.
- Rand Corporation: Improving the Physical Health of Adults with Serious Mental Illness
- Health outcomes for consumers who received integrated services improved for some chronic conditions – diabetes, cholesterol, and hypertension – but not for obesity and smoking.
- Three features of programs were associated with greater consumer access to integrated services: Co-location of services; Integration of practices; and Staff perceptions of belonging to a team
- Kaiser Family Foundation Study: The physical distance between separate physical and behavioral health provider settings can itself pose a significant barrier to coordinated care. Especially for Medicaid beneficiaries and other low-income people, the child care and transportation costs associated with making trips to multiple locations can be prohibitive. Increasingly, an approach that is being used to address this problem is “co-location” – the provision of physical and behavioral health care at the same site.

Integrated Medical Health Home Project – Critical Components

- This project is to establish an Integrated Medical Health Home for high risk members with Serious Mental Illness (SMI) who also have chronic physical health illness
- The Integrated Medical Health home will:
- Share data through a common electronic health record
- Utilize a Person Centered bio-psycho-social Interdisciplinary Team approach
- Provide mental health and physical health services at the same location
- Become the member's Primary Care Provider
- Complete a comprehensive physical and mental health assessment
- Address all of the member's mental health and physical health needs – including all pharmacy, preventive health, condition treatment needs, and coordination with specialist services
- Address social support needs
- Collect data to demonstrate quality of care metrics, such as HEDIS and customer satisfaction measures
- Collect data to establish efficient delivery of care

Be Well Partners in Health - CCE

- Be Well Partners in Health is a Care Coordination Entity selected by the Department of Healthcare and Family Services (HFS) to develop a care coordination model for adults who have been diagnosed with serious and persistent mental illness and who may also have concurrent medical and/or substance use issues.
- Be Well offered, through a network of providers, services to approximately 1,500 adults residing in Chicago during 2014 and 2015.
- In January, 2016 Be Well partnered with Cigna-HealthSpring with the mutual goal of extending care coordination efforts to include the “Intensivist” approach within under-served communities.
- The end goal is to increase the number of clients receiving the best services in the least restrictive environment.

The Bio-Psycho-Social Model

- The bio-psycho-social model offers community teams that include, at a minimum, a psychiatric nurse (bio), a LCSW or LCPC (psycho) and a bachelor's level mental health specialist (social).
- Each team engages with a given client to enable the focus of care to shift from time to time in response to the needs of each client.
- The teams reflect the communities that they serve and include both men and women.
- The first intervention following evaluation is to engage the client with a PCP and specialists as required.
- The Intensivist model is community-based and allots whatever time is required over whatever period to successfully engage the client with providers.

Models of Integrated Care

- FQHC: In this model, the PCP and often psychiatric providers share an electronic medical record system and are located in the same physical space. Currently, because Specialists and PCPs frequently practice at different physical locations, it is seldom that the client is able to meet with multiple providers on the same day. It is unknown the degree to which the providers actively collaborate on a given case.
- Community Mental Health Model: Many community mental health centers house psychiatric providers on site and are adjacent to an FQHC location (such as the relationship between Trilogy and Heartland or Thresholds and the UIC clinics). These models most likely have separate medical records and communication between providers depends on the model of collaboration.
- Multi-specialty Office Practice: In this model the PCP will most frequently engage a psychiatric provider to provide services on site once or twice a week. The psychiatric provider may or may not chart in the PCP's medical record system.

Models of Integrated Care

- The Care Coordination Model: All practitioners are located at different sites and one of the responsibilities of the care coordination team is to serve as vehicles of communication among practitioners.
- Integrated Medical Health Home: In this proposed model, a PCP and psychiatric practitioner are co-located at a site and the client sees both on the same day.
- In this model, intensive in-home services such as administration of injectable long acting antipsychotic medication or hand delivery of medication trays may occur to provide stability of medication administration. The client may be picked up at their home, taken to the clinic, transported to a pharmacy and returned home.
- The care coordination staff work with the client in an ongoing way to assure the appropriate follow-up and follow-through.

Challenges

- Clients are often unwilling to keep medical appointments (finance/transportation/motivation)
- Few psychiatrists who have an outpatient practice and are willing to see Medicaid clients outside an FQHC practice
- For the few available psychiatrists willing to see Medicaid clients, there are long wait times (30-45 days). Consequently, clients obtain medication through inpatient hospitalization
- Appropriate releases of information to allow for the exchange of mental health and substance use information are not usually sought or obtained from clients resulting in barriers to communication between providers.
- Post visit compliance

Care Coordination

- Secures release of information from client to exchange information between treating providers as needed under 42 CFR Part 2
- Do whatever is required to establish a relationship between the client and a responsive PCP
- Work actively with the client to set and keep appointments with other specialists and agencies
- Intensive in-home services: this may occur in a shelter, under a bridge, or wherever the client can be located
- Assure adequate transportation is available
- Meet with each provider to communicate what is occurring in all parts of the treatment plan and conduct ongoing analysis for gaps in care

Cigna-HealthSpring & Be Well Integrated Medical Health Home Project

- Identify two co-location offices in under-served areas of Chicago (West Side & South Side)
- Identify PCPs (M.D.s/APNs) and Psychiatric providers (Psychiatrists/Psych APNs) willing to meet with each client collaboratively and discuss the plan together and with the client
- Ensure transportation to and from appointments and involve the care coordination teams to assure that clients make their appointments and understand the follow-up plans
- Care coordination teams work collaboratively with the client to execute follow-through - this may include activities such as, attending appointments with the client, advocating with housing providers, delivery of services in the home or other community locations, etc.

Cigna-HealthSpring & Be Well Integrated Medical Health Home Project

Health Plan contributions

- Enhanced fee schedule – moving to a pay-for-quality model using an upside gain approach
- Transportation assistance – In addition to the standard Medicaid Transportation benefit
- Pharmacy consultation resources
- Interdisciplinary Care Team approach between Member/caregiver, clinic personnel, treating providers, and health plan staff, including Social Worker, licensed BH staff, RN level nurses, Intensive Outpatient Program providers, Plan Medical Director, Care Coordination staff, and others as needed
- Data analysis resources
- Intensive outpatient mental and physical health program support
- Member Engagement
- Direct contact with the potential members to explain the program and concept of an integrated medical home
- Open house events with appropriate give-a-ways to make the clinic a familiar and comfortable environment
- Health Screening events with incentives

Beginning Outcome Measures

- Admits/K* for physical health conditions
- Admits/K for mental health conditions
- Readmission/K for same or similar mental health condition within 30 days of discharge
- Readmission/K for same or similar diagnosis
- ER visits/K for physical health conditions
- ER visits/K for mental health/substance use conditions
- Follow-up following inpatient discharge – 7 and 30 days
- Rate/K for diabetic members receiving a HgA1c test
- Rate/K for diabetic members with HgA1c less than 8
- Medication Adherence (measured as Possession of days covered – PDC)
- Percent of Health Home members with a PDC of 80% or greater for chronic physical health medications
- Percent of Health Home members with a PDC of 80% or greater for mental health medications
- Quality of Life Improvement – baseline and periodic completion of a PHQ9 showing improvement across time

* Admits per thousand members

Next Steps

- Identify community providers capable and willing to participate
- Ensure that these potential Integrated Medical Health Home providers fully understand the concepts of integration, coordination, and intensive follow-up required
- Explore the data collection capabilities of potential providers
- Discuss funding mechanisms and the approach across time:
- Enhanced fee schedule
- Movement toward up-side only quality outcome dependent payment options