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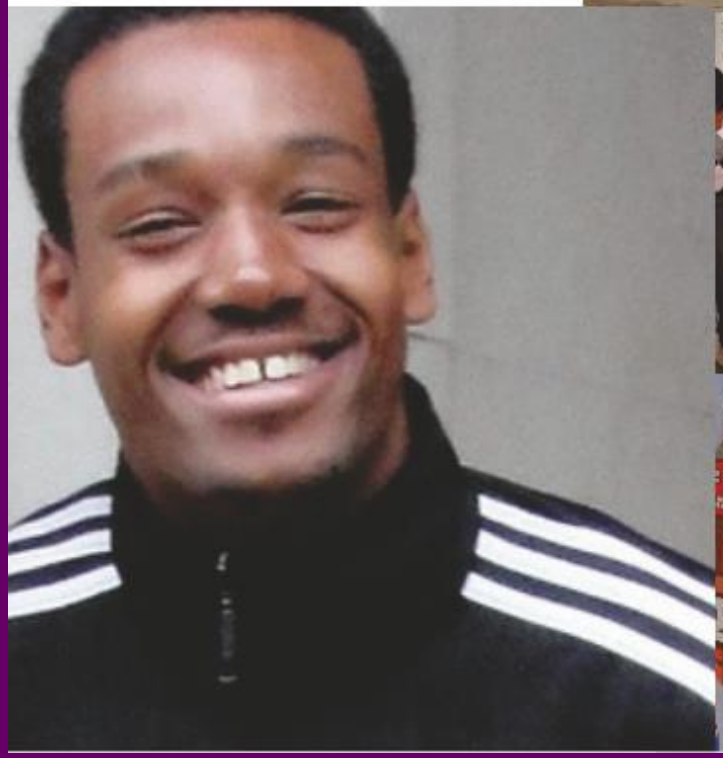

Primary Care Integration at ICL PROS

People Get Better With Us

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PROS Implementation Academy
November 20th, 2015

Who we are

- NYC not-for-profit
- 100+ programs and 10,000 individuals, majority in Brooklyn: housing, case management, ACT, clinics, homeless shelters, health home, and PROS

ICL PROS

- Census: 210
- Number of staff: 25
- Number of groups: 56
- Sex: 60% men, 40% women
- Race/ethnicity: majority African American, with some Latino, Asian, and Caucasian
- Low SES; some live in shelters
- East NY: violence, poverty, low resources, few options for healthy food

Objectives

At the end of this session, participants will be able to:

- Explain the rationale for **integrating treatment** of physical health, mental health, and substance use in PROS programs
- Describe two approaches that promote integrated care: **self-management support** and **nursing-supported care management**
- **Strategize implementation** or improvement of service integration in PROS programs

The Crisis

- People with serious mental illness (SMI) die an average of 25 years earlier than those in the general population
- 60% of excess mortality is due to treatable and preventable medical conditions (eg, heart disease, stroke, diabetes)
- 20% of NYS Medicaid beneficiaries responsible for 75% costs, spending $30K vs. $2500 annually (many have SMI and substance use disorders)
- This is our PROS population!

NASMHPD 2006

Medicaid Long-Term Care in New York: Variation by Region and County

Why greater risk with mental illness?

- **Symptoms** of mental illness such as avolition and low energy lead to reduced physical activity
- Changes in appetite, medication side effects and income make it harder to maintain a healthy **diet**
- Antipsychotics and other **medications** increase risk of dyslipidemia, diabetes and stroke
- **Substance use** increases symptoms, worsens self care and has direct health effects
- **Trauma** is linked to worse physical health
- Decreased **access** to care

PROS well-suited for integration

- Participants may come frequently and see multiple staff daily, allowing close follow-up
- The nurse is part of the staffing pattern and can run wellness groups and do care management
- The model is person centered, which naturally translates to using motivational techniques to change health behaviors

Chronic Care Model

- Health Care Organization
  - **Self-Management Support**
  - Delivery System Design
  - Decision Support
  - Clinical Information Systems

Self-management

- Wellness education
- Motivational interviewing to support change
- Action steps to build momentum towards better health
- Tools facilitating conversations around health

Self-Management Toolkits

- Healthy Living / Diabetes Workbooks and disease-specific modules
- Mini Cards
- Quik Guides and trainings
- Letters to PCPs and psychiatrists

Materials available on ICL intranet and with limited license agreement

Chronic Care Model

- Health Care Organization
  - Self-Management Support
  - **Delivery System Design**
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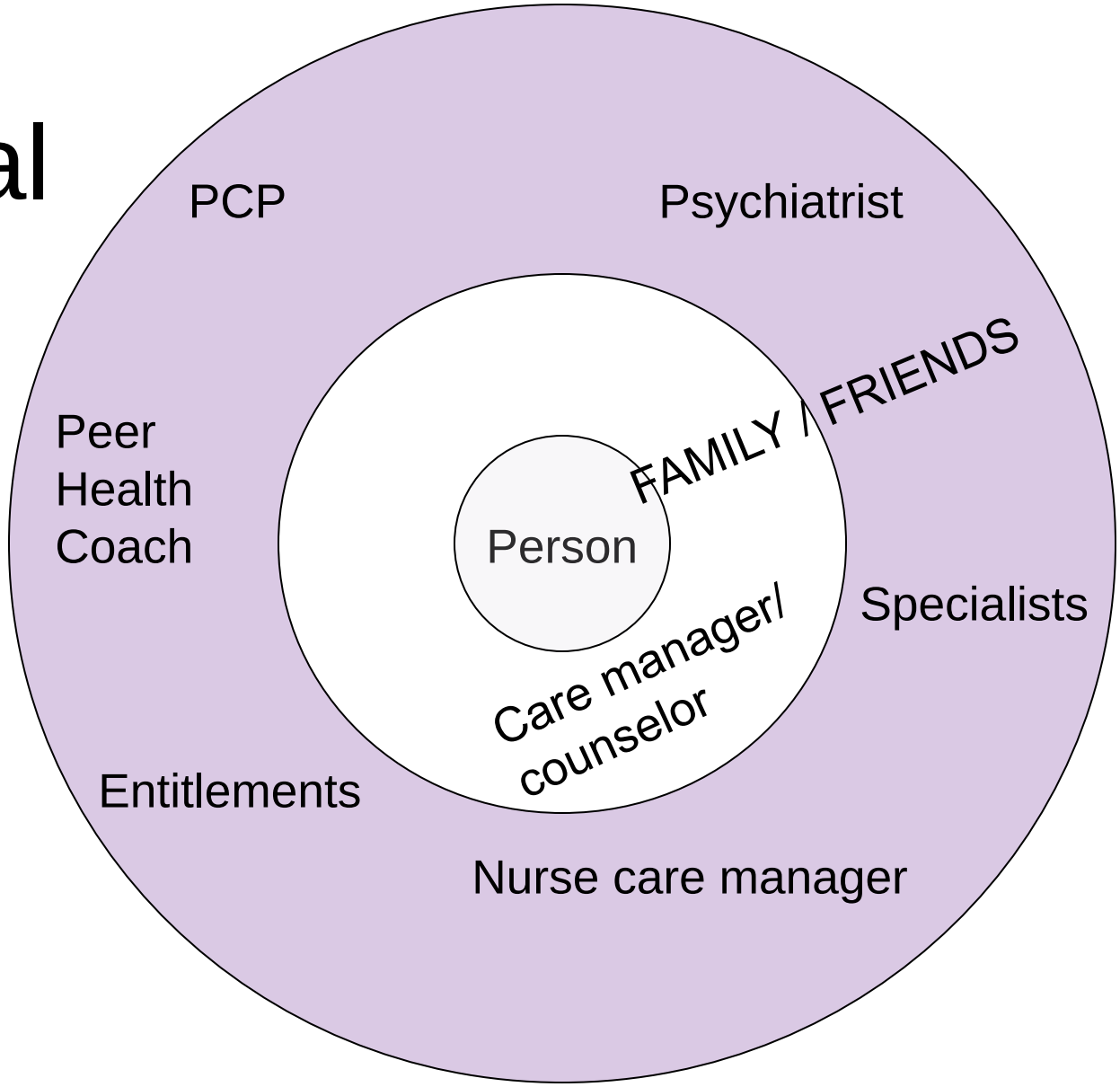
Recommendations for Mental Health Programs from the Four Quadrants Model

- Imbed a primary care provider within the mental health program
- For a population with high physical health needs, use a nurse care manager

ICL Behavioral Health Medical Home Model



Care management

- Collaborative process
- Manage various aspects of health
- Improve coordination of care

Center for Health Care Strategies, Inc., 2007

Nursing-supported care management

- Medical risk screening at intake
- Risk stratification and treatment planning in collaboration with nurse care manager
  - Acute risks
  - Adherence issues
  - Need for higher level of care
- Registry to track risk and outcomes
- Monthly multidisciplinary review
- Liaison with medical providers

Nursing-supported care management

- Direct individual and group intervention with higher risk individuals
- Training of behavioral health workers in disease management
- Improved primary care quality and outcomes
- A PROS nurse can be a care manager!

Role of the PCP

become the individual's PCP

vs.

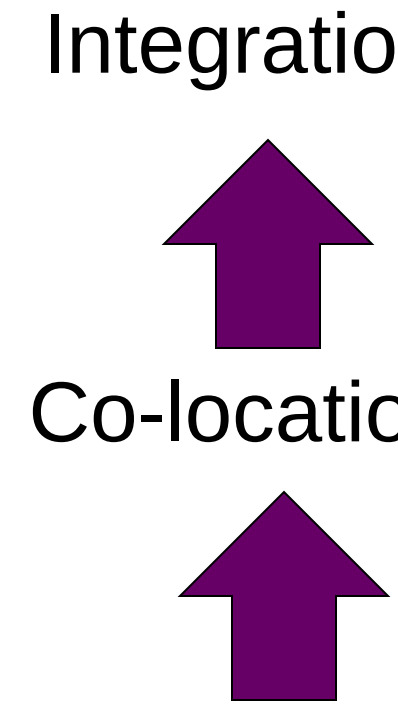
provide education, support, monitoring and referral

Two paths to the person-centered healthcare home

- Become a full-scope healthcare home, i.e. a Federally Qualified Health Center (FQHC)
- Partner with a full-scope healthcare home

Mauer 2009

Levels of Integration



SAMHSA, 2013

Reimbursement challenges

- Billing for primary care services is challenging in the PROS system
- ICL is currently using grant money to pay for physical health services
- May open licensed Article 28 primary care clinic next to PROS program (licensing affects many things)

Staffing

- Need medical personnel well-versed in both physical and behavioral health care
- Active, assertive outreach skills
- Match to the clinic population / culture
- Flexible and willing to experiment
- More training programs needed

Primary care vs. behavioral health culture

- Medical vs psychosocial models
- Top-down vs. consensus decision-making
- Physician vs. social service leadership
- What's the bridge?
  - Self-management
  - Nurse care management
  - Health Homes
  - Home and Community Based Services

The future?

- Managed care: pay for performance or capitated rates
- Delivery System Reform Incentive Payment (DSRIP)
- Health and Recovery Plans (HARPs)

Chronic Care Model

- Health Care Organization
  - Self-Management Support
  - Delivery System Design
  - **Decision Support**
  - Clinical Information Systems

Need decision support tools that can:

- Engage and guide behavioral health staff in integrating best practices into existing **workflow**
- Facilitate **decision making** in real time
- Receive **feedback** from the person-centered multidisciplinary team
- **Support health goal-setting** for persons served
- Make integration part of the **routine and culture**

ICL's Decision Support Tools

1. Healthy Living Clinical Pathway
2. Health Risk Screening
3. Healthy Living Questionnaire
4. Healthy Living self-management tools
5. Physical health treatment goal planner

Institute for Community Living, Inc.
Residence.

Client Name:
Case#:
Age: M / F
Date:

HEALTH RISK SCREENING

Do you see a primary care provider for a check-up at least once a year? *Primary care provider name/contact info.*	Yes	No
Do you see a dentist for a check-up at least once a year? *Dentist name/contact info.*	Yes	No
Names and contact info for any other health professionals.		
Do you have any of the following health problems?		
o High blood pressure	No	Yes
o High cholesterol	No	Yes
o Obesity	No	Yes
o Heart problems	No	Yes
o Stroke	No	Yes
o Cancer (type:_____)	No	Yes
o Diabetes	No	Yes
o Asthma or lung disease	No	Yes
o Thyroid problems	No	Yes
o Liver problems/ hepatitis	No	Yes
o Seizures	No	Yes
Do you have other health problems? *If yes, which ones?*	No	Yes

	Medication names	Dose	Frequency	Reason	Take as prescribed?	
1					Yes	No
2					Yes	No
3					Yes	No
4					Yes	No
5					Yes	No
6					Yes	No
7					Yes	No
How many doses of your meds do you miss each week?					None	#

Do you have any of the following symptoms? *Circle the ones you have.* havewave headache Vision problems Hearing problems Trouble breathing Cough Chest pain Vomiting Diarrhea Abdominal pain Blood in stools Difficulty urinating Cloudy urine Frequent urination Muscle pain Joint swelling Numbness Weakness	No	Yes
Do you do some physical activity that gets you out of breath for at least 30 minutes, a few times per week? *What kinds of physical activity do you do?(circle them)* Walking Dancing Sit-ups Push-ups Weights House cleaning Yoga Basketball Running Swimming Football Stretching Taking the stairs Other:_____	Yes	No
Do you eat 3 meals every day? *If not, how many times a day do you eat?*_____	Yes	No
Do you eat foods from all food groups every day? *Circle the food groups you eat every day.* Vegetables Milk/cheese Breads/cereals/rice/ potatoes/beans Fruits Meat/fish/eggs	Yes	No

Have you and your primary care provider discussed the following important health screenings to protect your health?			
o Weight	Yes		No
o Blood pressure	Yes		No
o Glucose	Yes		No
o Cholesterol	Yes		No
o Sexually transmitted disease	Yes		No
o HIV	Yes		No
o *If you are over 50.* Colon cancer	Yes	n/a	No
o Women. Pap test, Mammogram	Yes	n/a	No
o Men. Prostate cancer	Yes	n/a	No
Have you had a flu shot this year?	Yes		No

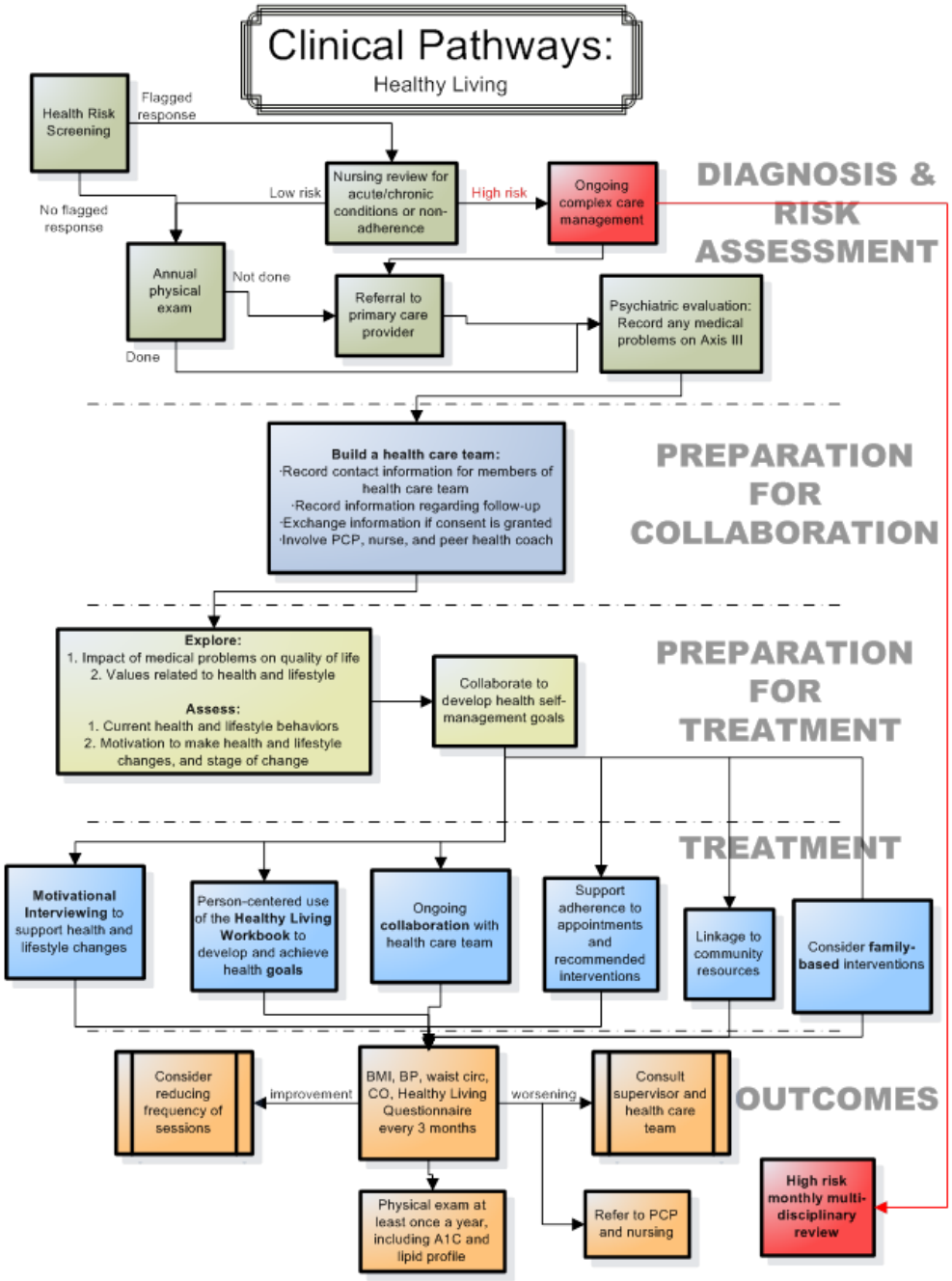
→ If you have circled any answers in the right-side column, make an appointment with a primary care provider to talk about your health!

Form completed by: _____ _____ _____
Name Signature Date

MEDICAL RISKS AND NEEDS LIST

This list can be used to identify persons served with higher levels of health risk and needs, and is intended to facilitate team discussions involving case managers, supervisors and nursing and medical staff.

	RISKS	NEEDS
LOW RISK	All axis III conditions adequately controlled	**Healthy Living** self-management training **Primary care check-ups at least once a year**
	Non-Adherence to medical appointments & prescribed treatments	**Motivational interviewing & engagement** **Closer observation** For example: -documenting and rescheduling appointments -obtaining consultation reports -counting pills and maintaining dosette boxes -keeping a log (e.g. of blood glucose) **Frequent communication with medical providers**
		Emergency room if: -unexplained chest pain or severe abdominal pain -loss of ability to move, see or speak


Clinical Pathways:
Healthy Living
Health Risk Screening
Flagged response
No flagged response
Low risk
Nursing review for acute/chronic conditions or non-adherence
High risk
Ongoing complex care management
DIAGNOSIS & RISK ASSESSMENT
Annual physical exam
Not done
Done
Referral to primary care provider
Psychiatric evaluation: Record any medical problems on Axis III
Build a health care team:
·Record contact information for members of health care team
·Record information regarding follow-up
·Exchange information if consent is granted
·Involve PCP, nurse, and peer health coach
PREPARATION FOR COLLABORATION
Explore:
1. Impact of medical problems on quality of life
2. Values related to health and lifestyle
Assess:
1. Current health and lifestyle behaviors
2. Motivation to make health and lifestyle changes, and stage of change
Collaborate to develop health self-management goals
PREPARATION FOR TREATMENT
TREATMENT
Motivational Interviewing to support health and lifestyle changes
Person-centered use of the Healthy Living Workbook to develop and achieve health goals
Ongoing collaboration with health care team
Support adherence to appointments and recommended interventions
Linkage to community resources
Consider family-based interventions
Consider reducing frequency of sessions
improvement
BMI, BP, waist circ, CO, Healthy Living Questionnaire every 3 months
worsening
Consult supervisor and health care team
OUTCOMES
Physical exam at least once a year, including A1C and lipid profile
Refer to PCP and nursing
High risk monthly multi-disciplinary review

Chronic Care Model

- Health Care Organization
  - Self-Management Support
  - Delivery System Design
  - Decision Support
  - **Clinical Information Systems**

Type: Outpatient TP Review
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Healthy Living Questions

Please complete the following 8 health-related questions. For Q9, if 'yes' is clicked, please add a physical health goal within this Treatment Plan Review.

1. Did you see a PCP for a check up in the past three months?

○ Yes ◉ No ○ Not Obtainable

2. How would you rate your health in the past three months?

Good

3. During the past three months, how many times did you go to the ER

a. for a mental health issue? 0 times

b. for a physical health issue? 0 times

4. During the past three months, how many times were you admitted to the hospital

a. for a mental health issue? 0 times

PROBLEM—Physical Health

GOAL—Improved Physical Health

OBJECTIVES

Learn/ Practice:

Reduce stress

- Identify one stress-reducing activity
- Schedule relaxation x times per week

Obtain medical/ dental exam

- Identify accessible PCP/ dentist

Regular physical activity

- Identify one way to increase activity
- Keep a daily record of physical activity

Good nutrition

- Schedule meals at regular times
- Plan to eat more vegetables
- Learn portion control using the plate method

Safer sex

Learn/ Practice

Disease Self-Management

Type II Diabetes

- Schedule A1c, Blood pressure, Cholesterol, kiDney, Eye and Foot exams
- Obtain/ use glucometer

COPD/Asthma

- Identify two triggers for asthma attacks/ COPD exacerbations
- Obtain/ use preventive medications

Hepatitis C

- Identify two ways to prevent transmission
- Discuss pros/ cons of treatment with PCP

Hypertension

- Schedule blood pressure monitoring
- Plan to reduce salt intake

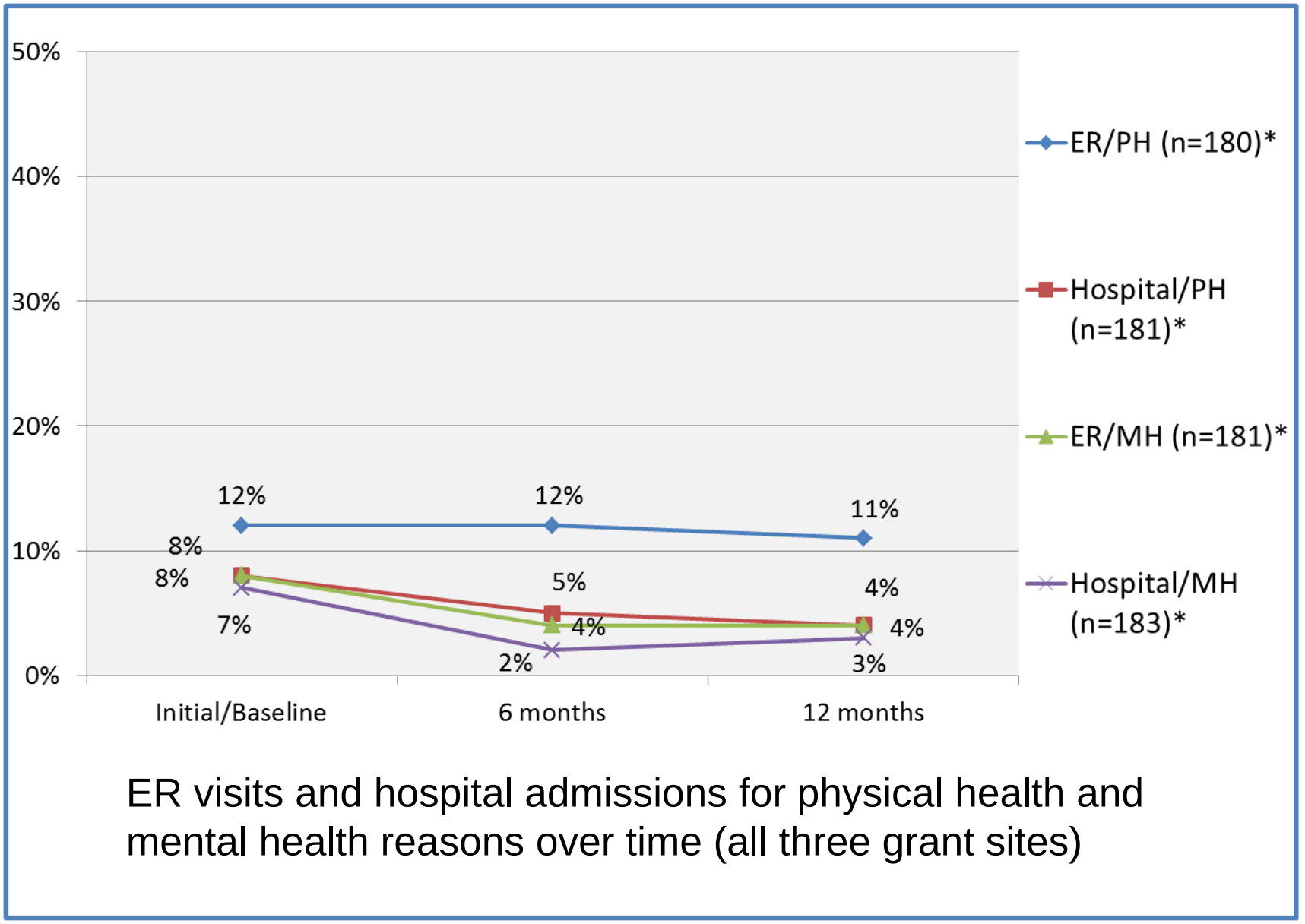
Seizures

- Identify two ways of decreasing injury risk

Electronic health record integration

- Most commonly, separate primary care and behavioral health records used
- Workarounds often needed for integrated records, e.g. for treatment planning
- Regional Health Information Organizations (RHIOs) promise to facilitate information sharing
- Future: integrated multi-provider treatment plans

Outcomes



ER visits and hospital admissions for physical health and mental health reasons over time (all three grant sites)

Hospitalizations for PROS participants

- Between first and second PROS treatment plan (6 months):
  - The number of people reporting psychiatric hospitalizations decreased from 21% to 16% ($n = 63$, $p < 0.001$)
  - The number of people reporting other hospitalizations decreased from 15% to 13% ($n = 62$, $p = 0.012$)

Lessons Learned…so far

- Self-management is the foundation of integrated care.
- A committed and versatile nurse can bridge a number of gaps between primary care and behavioral health.
- The PROS model addresses the first two points with its person-centered focus and on-staff nurse. Access to primary care can improve by providing it at PROS.
- Buy-in from behavioral health staff can be challenging, but streamlined tools and prompts can make it easier.
- Regulatory, reimbursement and information sharing parameters are expected to shift in favor of integration.

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Thank you!

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