Session # A8

Outcomes of a Reverse Integration Model: Providing Medical Care in a Community Mental Health Clinic

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CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.

Conference Resources

Slides and handouts shared in advance by our Conference Presenters are available on the CFHA website at http://www.cfha.net/?page=Resources_2018

Slides and handouts are also available on the mobile app.

Learning Objectives

At the conclusion of this session, the participant will be able to:

- Describe Reverse Integration
- Understand a model of communication processes that includes and involves multiple interdisciplinary care providers and stakeholders.
- Discuss opportunities to grow this model in terms of sustainability or replication

Bibliography / Reference

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2. Gerrity, M. (2014). Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness. Milbank Fund. https://www.milbank.org/publications/integrating-primary-care-into-behavioral-health-settings-what-works-for-individuals-with-serious-mental-illness/. Retrieved August 14, 2018.
3. Gerrity, M. (2016). Evolving Models of Behavioral Health Integration: Evidence Update 2010-2015. Milbank Fund. https://www.milbank.org/wp-content/uploads/2016/05/Evolving-Models-of-BHI-Exec-Sum.pdf. Retrieved August 8, 2017.
4. Heath B, Wise Romero P, and Reynolds K. (2013). A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. https://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdfReference. Retrieved August 14, 2018.
5. Substance Abuse and Mental Health Services Administration (2017) HRSA Center for Integrated Health Solutions. SAMHSA Primary and Behavioral Health Care Integration (PBHCI) Program; http://www.integration.samhsa.gov/about-us/pbhci. Retrieved August 8, 2017.
6. Substance Abuse and Mental Health Services Administration (2017). SAMHSA's Performance Accountability and Reporting System (SPARS); https://spars.samhsa.gov/ Retrieved August 8, 2017.

Learning Assessment

A learning assessment is required for CE credit.

A question and answer period will be conducted at the end of this presentation.

What is Integrated Care?

- “systematic coordination of general and behavioral healthcare” – SAMHSA

Traditional Model

- Behavioral Health incorporated into medical setting such as primary care clinics or specialty care clinics
- Geared towards consumers who are engaged in medical care but may be reluctant to engage in behavioral health or have barriers that make accessing behavioral health difficult

Reverse Integration Model

- Located within behavioral health setting
- Brings primary care or medical care to consumers who may feel more comfortable in the behavioral health setting or may have barriers that make accessing these services difficult

Why Reverse Integration?

- Those with serious mental illness die on average 25 years earlier than the general population.
- Not explained by suicide.
- Significant health disparities
- Stigma at traditional setting

Health Disparities

- Center for Behavioral Health Statistics and Quality
- 10 year study of 238,811 adults
- Measured past month psychological distress
- 5 point scale

Health Disparities

- Nearly twice as likely to DIE from all causes, heart disease, and cancer/malignant tumors
- Over 3 times as likely to DIE from accidents, accidental poisonings, and assaults

Riverbend Integrated Center for Health

- SAMSHA grant funded 5 year pilot program
- Located in Concord New Hampshire
- Collaboration between Concord Hospital Family Health Center & Riverbend Community Mental Health Center

Vision

- Access to on-site **integrated primary care provider**
- Increased communication and coordination of care
- Improved transitional care
- Focus on client self-management and empowerment through health education
- Consistent monitoring of key health indicators
- Improved treatment adherence and wellness outcomes

Population

- Adults with Serious Mental Illness
- Tobacco Use: 58% Men, 55% women
- Obesity: 90% overweight or obese
- Employment: 80% unemployed and/or disabled.
- LGBTQ: 21%

Communication

- Face to face – open door policy
- Phone
- Email
- Mailbox
- Treatment teams
- Sharing of electronic and paper records

Treatment Teams

- Each consumer assigned to a mental health treatment team
- Weekly 1 hour meetings
- Attended by case managers, psychiatrist, mental health APRN, mental health nursing, peers

Integrated Treatment team (ITT)

- Integrated Care Manger- attend both ITT and mental health treatment teams. Manges referral to integrated primary care
- Peer- provides support to consumers, leads wellness groups
- In shape mentor- Health mentor working with clients at the YMCA
- Primary care provider
- Medical assistant
- Nurse
- Administrative Staff
- Director

Integrated Treatment Team

- Weekly
- 1 hour
- Topics discussed:
  - New referrals/recently referred
  - Hospitalizations both psych and medical
  - Clients of concern
  - Successes

Process Team

- Every other week
- 1 hour
- Agenda set prior to meeting
- Led by Director
- Attended by primary care provider, nurse, medical assistant, integrated care manager, peer, inshape health mentor, director, administrative staff

Barriers

- Language and Communication Style
- Health Records – Where is the Information?
- Time
- Resistance to Role Expansion

Impact

- Resource Utilization
- Patient Health Outcomes
- Patient Satisfaction
- Staff Satisfaction

Preliminary Data

- N = 132
- Comparing 12 months prior to integrated primary care to 12 months post

ER and Urgent Care

- Decreased ER utilization by 13%, Increase urgent care by 22%
- 337 ER visits vs 294 ER visits
- 85 urgent care vs 104 urgent care

Medical Hospitalizations

- Decrease Inpatient medical 72%, Observation 46%
- 39 Inpatient medical vs 11 inpatient medical
- 69 observation vs 37 observation

Mental Health

- Decrease Inpatient psych 29%
- 35 admissions vs 25 admissions

Patient Health Outcomes

- Those on BP medications (29% men 34% women)
  - 65% improved blood pressure
  - 78% improved a1c
- Those on diabetes medications (18% men 51% women)
  - 44% improved BMI
  - 66% improved blood pressure
  - 71% improved A1c levels.

Patient Satisfaction

- Perceptions of health- 26 % improvement
- Functioning in everyday life- 57% improvement
- Levels of psychological distress 19% improvement
- Social connectedness- 38 % improvement

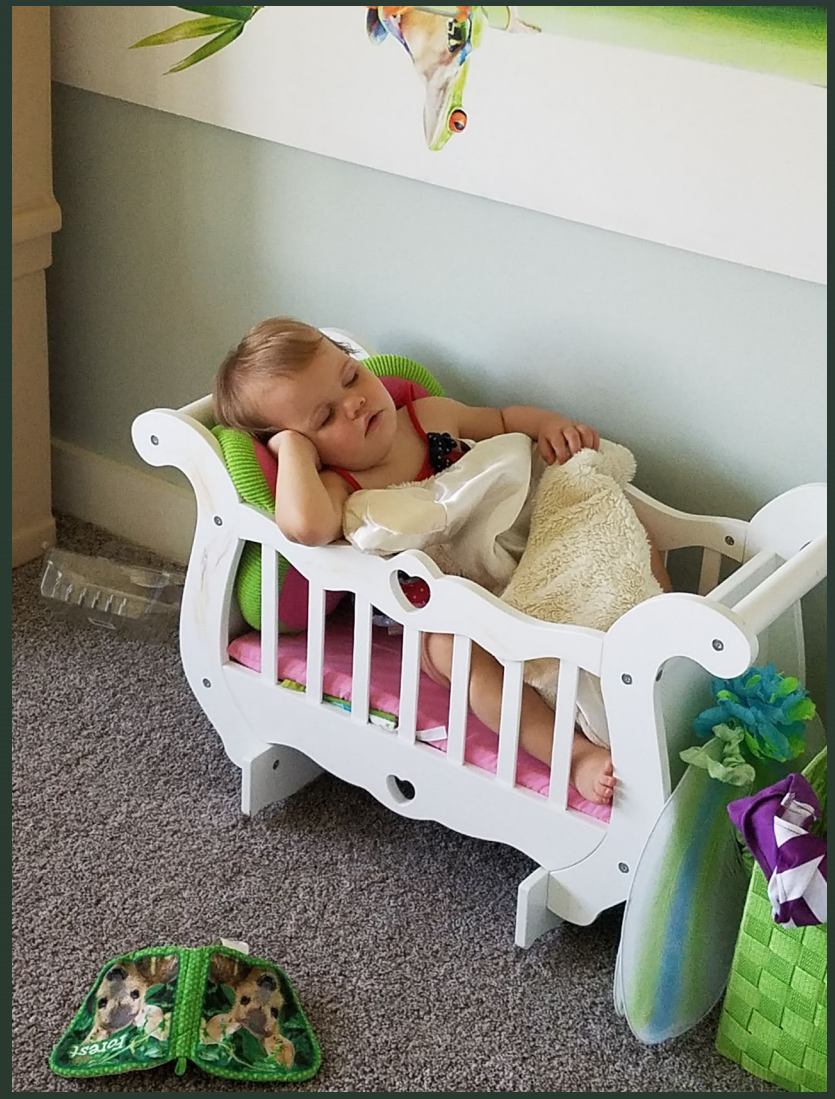
Staff Satisfaction

- Anecdotal
- Continued high volume of referrals. Just reached 400th enrollment, goal 500 by Sept 2019
- Increasing collaboration between teams-blurring lines between psych and medical

Sustainability and Replication

- Payment models
- Sharing medication lists, diagnoses, pertinent notes
- Accurate list of patient's treatment team
- All releases signed upon initiation of care and yearly
- Verifying medication lists
- Encouraging patient's to bring a friend/family member, take notes, review records patient's bring with them

Questions?



Session Evaluation

Use the CFHA mobile app to complete the evaluation for this session.

Thank you!

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