Integrated Health: Linking Behavioral Health and Primary Care at the Local Level

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Burden of Disease

Burden of Disease:
Lead Contributing Disease Categories to DALYs

1. Neuropsychiatric Disorders 28.47
2. Cardiovascular Diseases 13.94
3. Malignant Neoplasms 12.57
4. Unintentional Injuries 6.69
5. Sense Organ Disorders 6.61
6. Respiratory Diseases 6.57
7. Musculoskeletal Diseases 3.84
8. Digestive Diseases 3.31

Percent of Total DALYs; U.S. & Canada

Data courtesy of WHO
Persons with serious mental illness die younger than the general population. However, recent evidence reveals that the rate of serious morbidity (illness) and mortality (death) in this population has accelerated.

Persons with serious mental illness (SMI) are now dying 25 years earlier than the general population.

Increased morbidity and mortality are largely due to treatable medical conditions that are caused by modifiable risk factors such as smoking, obesity, substance abuse, and inadequate access to medical care.
No Health Without Mental Health

- St Clair County data:
  - General Health “Fair or Poor”: 22.9% (MI 17.3%)
  - Poor Physical Health: 16.4 % (MI 13.1%)*
  - Poor Mental Health: 17.8% (MI 12.7%) #
St Clair County Community Mental Health (SCCCMH) received a grant to enhance IHC capacity. (Fiscal year 2013-2014)

St Clair county Health Department supplied a nurse experienced in case management of high risk individuals as a “shared” resource. (December 1, 2013)

St Joseph Mercy Port Huron-Physician Hospital Organization (PHO) cooperated with shared educations programs and meetings. (MiPiCT) organizations)
• To improve healthcare coordination among mental health and primary care provider.
• To enhance local implementation of integrated health efforts.
Expected Outcomes

- Outreach to 100% of primary care providers in St. Clair County that share clients with CMH.
- Confirmation that CMH clients are correctly identifying their physicians.
- To begin holding care management meetings.
- To implement training initiatives for behavioral health and primary care.
Methods

- Evaluated the Oasis electronic records system at CMH.
- Interviewed with clinicians at CMH to identify perceived barriers to care between CMH and primary care physicians.
- Interviewed with primary care physician offices to identify perceived barriers to care between CMH and primary care physicians.
- Created educational opportunities for clinicians.
Evaluated the Oasis Electronic health record system.

- To evaluate quality of self reporting by CMH clients.
- To identify clients primary care provider (PCP).
- Identified the systems’ capacity for identifying medical diagnosis accurately.
Barriers

- No medical diagnosis in chart.
- Demographic incomplete.
- Medications not up to date or missing.
- Comorbidities are not consistent.
- No immunization information.
- PCP not identified or more than one identified.
- No place for specialist information.
- Information difficult to access.
1721 client charts

- Client charts included in survey: 829
- PCP did not participate: 560
- Physician is out of county: 116
- Physician is not a PCP: 42
- Refused to name physician: 9
- Had no physician reported: 165
86 Physicians Identified

- Did not participate (53%)
- Participated (47%)

Physicians participation in St. Clair County
829 Evaluated Clients

- 663 (80%) Correctly identified their PCP
- 85 (10%) Incorrectly identified their PCP
- 81 (10%) No release/unable to access

Legend:
- Blue: Correctly identified their PCP
- Red: Incorrectly identified their PCP
- Green: No release/unable to access
663 Clients That Correctly Identified PCP

- 384 (58%) 2014
- 219 (33%) 2013
- 25 (4%) Before 2013
- 35 (5%) No date available

Total: 663 clients
Interviewed 48 clinicians at Community Mental Health.

- Identify perceived barriers to care between CMH and primary care physicians.
- Identify perceived barriers to care within their own facility.
Barriers

- High case loads.
- Clients frequently change physicians.
- Offices not receiving/retaining information.
- Intake not thorough.
- Clients refusing care from PCP.
- Clients refusing to sign a release for PCP.
- Need specific diagnosis codes for comorbidities.
- Physicians will not address mental health recommendations from mental health physician.
- Uncomfortable speaking to medical personnel.
- Frequent ER visits.
- Little contact with nursing at CMH.
- Open work environment makes it noisy and difficult to work.
Established the accuracy of self reported PCP visits by CMH clients.

- Each physician office was contacted and visit with IHC requested.
  - letters were taken to each PCP describing the project, and identifying Vivian as legitimate investigator on behalf of SCCCMH.
  - Oasis information reviewed with PCP for accuracy.
  - Elicited feedback on concerns and coordination of care issues.
Barriers

- Unsure who to contact at CMH/unable to get past the front desk.
- Disregard correspondence because it is too vague/unsure what it expected.
- No follow-up from referrals.
- Very uncomfortable prescribing medications to patients that have recently been discharged from CMH.
- Unsure what CMH offers/qualifications.
- Diagnosis is not included in coordination of care letters.
- Clients get double billed for labs.
- Feel clients get bad advice from the access line.
- Not notified when client is hospitalized with mental health concerns.
Limited to one year of funding.

Overall lack of resources (human and capital) in all capacities.

Staff turnover at CMH resulted in numerous changes in grant leadership and priorities.

Culture of care in Mental health “social services” vs. medical culture in PHO and Local Health Dept. i.e “spoke different language”
Collaboration

Care management meeting began in 2013.

- Partnered with Mercy PHO to hold quarterly meetings.
- Invitations were sent to primary care offices, CMH clinicians and Mercy PHO case managers.
- Strengthened by IHC work.
To identify and address educational needs of CMH staff.

- Identified nine important health care needs
  - Chronic pain
  - COPD
  - Diabetes
  - High cholesterol
  - Hypertension
  - Obesity
  - Smoking cessation
  - Chronic Hepatitis C
  - Immunizations
Proposed Measures of Success at onset of initiative

Staff will develop relationships with primary care offices and develop methods to improve service delivery outcomes, providing more comprehensive, coordinated care between and among mental health and primary care offices.

Outcome

both medical and mental health caseworkers have expressed the desire to continue with combined meetings.
The percentage of individuals without a primary care physician will decrease.

Outcome

The actual number of CMH clients without PCP’s was very low, the real issue lies in communication between providers.
Proposed Measures of Success at onset of initiative

A forum will be created for primary care and mental health care providers to access difficult treatment cases and coordinate integrated treatment plans.

Outcome
This continues to be discussed and negotiated. CMH providers proposed a designated time each week to talk with PCP’s, PCP’s favor a portal where clinical question and conditions can be placed as situations arise.
Proposed Measures of Success at onset of initiative

To implement training initiatives for behavioral health and primary care.

COORDINATION OF CARE VIA OASIS

- Noted below are three key Electronic Health Record (EHR) developments in OASIS pertaining to Coordination of Care correspondence and e-filing.
- The Coordination Of Care (COC) Letter/Forms were updated in April. Responses to the COC letter from the Primary Care Practitioner (PCP) can be directly attached or scanned for quick review in OASIS.
- The Medical Chart is in the process of being updated this summer to allow physicians to quickly access essential scanned documents such as COC information and hospital discharge packets pending approval by the regional OASIS Group.
- A Transition Of Care document is being developed per Meaningful Use requirement to help link an individual to other places of care. Via Direct Messaging, this document shall be sent securely, swiftly, and directly to the PCP or medical specialist. This will be a significant improvement over faxing as well as snail-mailing.

Outcome

CM PROJECT
LESSONS / IMPRESSIONS TO-DATE

Major Concerns from Physicians’ offices
- PCPs’ office staff are typically unable to get past the CMH program’s front desk to speak to someone regarding their patient.
- Access to the system is too difficult to navigate. Not helpful to their practice, as they prefer their patients having the option to enter CMH care on a walk-in basis.

Major Concerns from Care Managers
- Case loads are too high and continue to grow.
- They are uncomfortable working with the medical portion of integrative care, as they do not feel they are qualified.

Current impressions at this point in the project
- Most physicians indicate that they are interested in integrative care but do not demonstrate the willingness to do what it takes to collaborate with the CMH system.
- Most physician offices are not comfortable with prescribing high dose psych meds. As they are concerned about collateral from the drug. However, most are willing to extend the lines of communication with CMH.
- All provider offices were very pleased with the COC letters.
- Care Managers feel passionate about serving the patients on their case loads but also identify a need for ongoing training and program support.
- Care Managers think that integrative care is good thing but faces considerable challenges.
- St. Croix County ranks low in terms of immunizations for all ages (e.g., pertussis, flu).
Other Outcomes

• Developed COC letters.
  Name and contact information for clinician.
  Current mental health diagnosis.
  Current medication list from CMH.

• Request for specific information.
  Medical diagnosis with codes.
  Current medication list from PCP.
  Last set of labs.
  Date of last visit.

• Created packets of outreach materials and delivered to all PCP’s in St. Clair County.

• Educated clinicians about the importance of signed releases for integrative care.
Alcohol and Substance Use Disorders

- Studies report that alcohol and other substance use disorders co-occur in 40-70% of the population with SMI. Accidents, suicide and aggressive actions are known to be increased among persons with co-occurring disorders.

- Discussion of local SCCCMH morbidity data suggests death by/or complicated by controlled substance use second leading cause of death in this population.
Evaluated all 1721 charts from our survey and developed criteria to evaluate use of Opioid and benzodiazepine use.

- Reported a pain disorder
- Reported use of any pain medication.
  - Resulted in 496 client charts.
  - MAPS were pulled on all clients to see controlled prescription history.

Noted very few clients were prescribed opioids by CMH providers.

Noted very poor reliability of CMH records for reporting pain syndromes of controlled substance use.
496 Clients evaluated

- 34%: Clients with neither opioids or benzodiazapines
- 29%: Clients with both opioids and benzodiazapines
- 37%: Client with either an opioid or a benzodiazapine
Did deceased CMH clients have a PCP?

- Did not have PCP: 3 (4%)
- Had a PCP: 71 (96%)

Deceased clients
Deaths from 9/14/12-6/24/14

- Natural deaths: 79%
- Intoxication by heroin: 4%
- Intoxication of oxycodone and alprazolam: 1%
- Intoxication with multiple prescription drugs: 5%
- Hanging: 4%
- Unknown: 4%
- Gunshot to head: 3%
What Does the Future Hold for SCCCMH

- Continuation of the PHO meetings/working on initiating the MiPCT.
- Hiring a peer support specialist who will serve as a health coach.
- COC letters/discharge packets will be attached directly to the E-records for easy access for physicians.
- E-Systems upgrade enabling integrated e-labs, improvement of access to medical information.
- Survey of CMH caseworker of changes in perception and knowledge of IHC and medical conditions.
- Development of a more efficient referral system for physicians.
- Opening of a Medicaid medical clinic on site vs. an integrated program with one local primary care office???
Final Comments from CMH Administration

• “Vivian encountered typical pushback from both the CMH case manager and PC staff, but along the way she was able to develop working and trusting relationships with most of these people so reactant to change.”

• “And that most people accept but still wonder what the paradigms shifts will eventually do to their daily on the job tasks.”

• “Thank you again for bringing Vivian over to CMH, as I enjoyed her professionalism and good company.”


Morbidity and Mortality in People with Serious Mental Illness. Barbara Mauer, MSW, CMC National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council; October 2006
Questions?

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