Integration of Physical Health in a Behavioral Health Setting

NJAMHAA 2019 Fall Behavioral Healthcare Conference

October 17, 2019
Educational Objectives

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

1. Define Integrated Care
2. Describe evidence-based rationale concerning integration of physical health in a behavioral health setting
3. Define and implement a tracking system for physical health outcome measures in a behavioral health outpatient setting
What is Integrated Care?

- Systematic coordination of general and behavioral healthcare
- Integrating mental health, substance abuse, and primary care services produces the **best outcomes**
- Mental health and general medical care providers working together
- Integrated Care is the **new gold standard**
- Opens door to:
  - Collaboration
  - Timely Care
  - Improved quality
  - Accessible
  - Effective
  - Parity

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The PROBLEM

People with mental illness die earlier than the general population and have more co-occurring health conditions.

68% of adults with a mental illness have one or more chronic physical conditions.

more than 1 in 5 adults with mental illness have a co-occurring substance use disorder.

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EB Rationale for Integrated Care

• Persons with SPMI are at **higher risk** for medical problems such as HTN, CAD, and DM (Ludman et al., 2000)

• On average, person with serious mental illness **die 25 years earlier** than the general population (Lutterman et al., 2003)

• Premature mortality is predominantly due to chronic diseases and cardiac events alone account for more deaths than suicide (Parks et al., 2006)

• Our patients have **limited access** to effective medical care (Unützer et al., 2006)

• Patients with comorbid mental and physical illness experience decreased work productivity (Katon, 2009)

• Comorbidity increases the cost of care
Why Integrate Care?

Premature death from medical conditions prevents recovery from mental illness.

It's a medical fact that once you’re dead of a heart attack you cannot recover from schizophrenia.

Joe Parks, M.D.
Director, Missouri Institute of Mental Health
Distinguished Professor of Science,
University of Missouri - St. Louis
Medical Directors' Council of the National Association of State Mental Health Program Directors (NASMHPD)
Early Mortality Factors

Factors contributing to preventable, premature death

- **Cardiovascular disease** is associated with largest number of deaths
- Higher rates of diabetes, obesity, asthma, arthritis, epilepsy, and cancer
- Lack of comprehensive primary and behavioral healthcare, or trauma-informed care
- **Modifiable** risk behaviors (e.g., smoking, poor nutrition, inactivity, substance use, lack of sleep)
- Higher rates of poverty, homelessness, unemployment, incarceration
- Side effects of psychotropic medications
- **Social isolation, trauma, stigma, and discrimination**
Low Treatment Rates of Metabolic Disorders in People with Schizophrenia

- Baseline data from 1460 subjects from the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) schizophrenia study
- Non-treatment rates ranged from 30.2% for diabetes, to 62.4% for hypertension, and 88.0% for dyslipidemia.
- Improvements in health screening and monitoring are needed

Cost of Care with Comorbid Illness

- Cost of treating common diseases is **higher**
- Mental Health problems **increase risk** for physical health problems
- Rates of cardiovascular disease, diabetes, and pulmonary disease are substantially **higher** among disabled individuals in Medicaid with psychiatric conditions

From SMHSA Presentation: Pamela Hyde, JD
The solution lies in integrated care – the coordination of mental health, substance abuse, and primary care services. Integrated care produces the best outcomes and is the most effective approach to caring for people with complex healthcare needs.
Benefits of Integrated Care

“What Gets Measured Gets Managed”

- **Increased** access to care (Druss et al., 2010)
- **Improved** health outcomes including for blood pressure, BMI, triglycerides (Chen et al., 2011)
- **Decreased** hospital admissions (Druss et al., 2001)
- **Decreased** morbidity and mortality (Parks et al., 2008)
INTEGRATION WORKS

Community-based addiction treatment can lead to...

- 35% in inpatient costs
- 39% in ER cost
- 26% in total medical cost

Reduce Risk

- Maintenance of ideal body weight (BMI = 18.5 – 25)
- Maintenance of active lifestyle (~30 min walk daily)
- Quit Smoking

Reduce Heart Disease (for people with mental illnesses)

- 35%-55% decrease in risk of cardiovascular disease
- 35%-55% decrease in risk of cardiovascular disease
- 50% decrease in risk of cardiovascular disease
One integration program* enrolled 170 people with mental illness. After one year in the program, in one month:

- 86 spent fewer nights homeless
- There were 50 fewer hospitalizations for mental health reasons
- 17 fewer nights in detox
- 17 fewer ER visits

This is $213,000 of savings per month. That’s $2,500,000 in savings over the year.

Integration works. It improves lives. It saves lives. And it reduces healthcare costs.
Sources

www.dsamh.utah.gov/docs/mortality-morbidity_nasmhp.pdf
www.samhsa.gov/co-occurring/topics/data/disorders.aspx
www.samhsa.gov/data/nsduh/2k8nsduh/2k8results.pdf
www.cdc.gov/features/vitalsigns/SmokingAndMentalIllness
www.ncbi.nlm.nih.gov/pubmed/16912007


Heritage Behavioral Health Center, based on data in...
CCBHC Overview

The CCBHC program is authorized under Section 223 of the Protecting Access to Medicare Act (PAMA) (PL 113-93). Program objectives are to integrate behavioral health with physical health care, increase consistent use of evidence-based practices, improve access to high-quality care and demonstrate cost efficiencies. States selected participated in a two year demonstration project NJ is one of two states utilizing a Prospective Payment Rate system.
PUBLIC POLICY STATEMENT POSITION ON INTEGRATING PHYSICAL AND BEHAVIORAL HEALTH CARE

Individuals living with behavioral health conditions, especially those with severe mental illness, are at the greatest risk of early death often due to uncoordinated and poorly managed physical health. Our most vulnerable citizens deserve integrated care that offers appropriate services to improve overall health outcomes and the opportunity for achieving wellness and recovery.

In New Jersey, one third of individuals living with mental illness also abuse drugs and alcohol. For many, treatment remains inadequate and unavailable. The lack of coordination and integration of physical and behavioral health services in New Jersey leaves many at increased risk of serious health conditions and/or falling through the cracks.
What is the state of NJ’s Policy Environment in terms of supporting integrated care for people with SMI and/or SMI/SUD?

New Jersey’s Vision for Physical and Mental Health Integration

- Expand network of integrated providers across the care continuum
- Target Serious Mental Illness (SMI) and Substance Use Disorder (SUD) populations
  - Fully integrate managed care coverage
- Expand managed care’s role in managing non-traditional services

The CCBHCs represent an opportunity for states to improve the behavioral health of their citizens by: providing community-based mental and substance use disorder services; advancing integration of behavioral health with physical health care; assimilating and utilizing evidence-based practices on a more consistent basis; and promoting improved access to high quality care.

https://www.nj.gov/humanservices/dmhas/initiatives/integration/ccbhc.html
CCBHC at Rutgers UBHC

- UBHC converted three outpatient clinics to CCBHC on July 1, 2017 with total caseload in excess of 4000 individuals
- Wei Ji Point (Ambulatory Withdrawal Management) opened December, 2017
- CCBHC members have enhanced access to case management services (wellness visits), supportive employment, psych rehab services. To date, 4500 CM services delivered
- Peer Services are integrated into treatment teams, 600 services
- Quality metrics reinforce screenings for Metabolic Syndrome, SUD, Depression, Suicide (C-SSRS)
- Same Day/Next Day Access
- Awarded SAMHSA Expansion Grant for Newark location
Health Home Learning Collaborative

- Requirement of CCBHC to be a BHH or work towards becoming one
- Participated in National Council Learning Collaborative
- Pilot project initiated in Edison location
- Focus of pilot:
  * To improve primary care collaboration
  * Use data to drive decision making
  * Create clinical processes to support integrated care
- Expanded to the New Brunswick, Newark and Monmouth Junction locations
# Screening Survey

## CCBHC HEALTH SURVEY

**Date Administered:** ____, ____ / ____

**UBHC MRN#**

**Name:**

First

Last

**B/P** __________ P __________ R __________ Height __________ ” Weight __________ Lbs. BMI __________

**Primary Care Physician:**

- □ Yes
- □ No

*(Note: If no PCP – Make appointment with Yaffa Rose Clinic and document in the EMR)*

**Primary Care Physician Name:**

__________ _____ ___________, □ MD □ DO Telephone (_____) _______ - ________

**PCP seen in the last year:**

- □ Yes
- □ No

**Appointment with PCP Made:**

- □ Yes
- □ No

**Date of Appointment:** ____, ____ / ____

### Please ask the consumer the following questions:

- **About how long has it been since you last visited a doctor for a routine checkup?**
  
  [A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.]
  
  - □ Within past year
  - □ Within past 2 years
  - □ Within past 5 years
  - □ 5 or more years ago
  - □ Don’t know/Not sure

- **Have you ever been told by a doctor, nurse or health care professional that you have diabetes or high blood sugar?**
  
  - □ Yes
  - □ No

- **Have you EVER been told by a doctor, nurse or other health professional that you have high blood pressure?**
  
  - □ Yes
  - □ No

- **Have you EVER been told by a doctor, nurse or other health professional that you had angina or coronary heart disease?**
  
  - □ Yes
  - □ No

- **Have you EVER been told by a doctor, nurse or other health professional that you had a stroke**
  
  - □ Yes
  - □ No

- **Have you EVER been told by a doctor, nurse or other health professional that you have had asthma?**
  
  - □ Yes
  - □ No

- **Have you EVER been told by a doctor, nurse or other health professional that you had a heart attack, also called a myocardial infarction?**
  
  - □ Yes
  - □ No

- **Have you EVER been told by a doctor, nurse or other health professional that you had any other types of cancer?**
  
  - □ Yes
  - □ No

- **Have you EVER been told by a doctor, nurse or other health professional that you had any other types of cancer?**
  
  - □ Yes
  - □ No

- **Have you EVER been told by a doctor, nurse or other health professional that you had AIDS, Hepatitis, Other Infectious Diseases?**
  
  - □ Yes
  - □ No

- **What is your current smoking status?**
  
  - □ Current smoker - now smokes every day
  - □ Current smoker - now smokes some days
  - □ Former smoker –When did you quit?
  - □ Never smoked
Results: BMI (n=3813)

- 33% Normal
- 28% Overweight
- 22% Moderately Obese
- 17% Severely Obese
Results: PCP

- 16% do not have a PCP (n=555)
- 80% had routine check up in the last year (n=2,942)
  
  - Within 2 years? 8.7% (n=306)
  - Within 5 years? 3.6% (n=116)
  - 5 or more years? 1.8% (n=48)
**Results: Health Conditions (n=2,467)**

- **HIGH BLOOD PRESSURE**: 23.00%
- **ASTHMA**: 17.65%
- **DIABETES**: 11.90%
- **CANCER**: 11.50%
- **INFECTIOUS DISEASE**: 3.10%
- **CHD**: 2.75%
- **HEART ATTACK**: 2%

**ACTIONS**

- Integrating problems into treatment plan
- Health and Wellness education – staff and people served
- Wellness Stations at each Site
- Tracking trends for individual and program level improvements
Results: Smoker (n=3937)

- Never: 53.5%
- Former: 14.1%
- Some days: 8.7%
- Every day: 23.7%
Wellness Stations – fostering self monitoring
New Brunswick Wellness Station
Success Stories
References


• Raney L, Bergman D, Torous J, Hasselberg M. Digitally Driven Integrated Primary Care and Behavioral Health: How technology can expand access to effective treatment. *Curr Psychiatry Rep.* 2017 Sep 30;19(11):86


• Unützer et al. The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes. *Information Health Center, Brief May 2013.*

References

- National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council: Measurement of Health Status for People with Serious Mental Illness, 2008, October. Alexandria, VA.
- Morbidity and Mortality in People with Serious Mental Illness (July 2006). National Association of State Mental Health Directors; Medical Directors Council (pp 14-15).

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References


