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Development and Implementation of an Integrated Primary Care and Behavioral Health Program

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Cherry Street Health Services

- Cherry Street Health Services (CSHS) is a not-for-profit, 501(c)(3) Federally Qualified Health Center (FQHC) that was established in 1988.
- CSHS operates at 12 health center locations in Kent and Montcalm counties and in 68 schools.
- Health services provided include: family medicine, pediatrics, obstetrics and gynecology, internal medicine, behavioral health, general dentistry, optometry, ophthalmology, general radiology, and mammography.
- In 2010, CSHS provided care to 51,125 individuals, of which 53% were covered by Medicaid.
- In 2009, there were over 166,000 patient visits.

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Touchstone *innovarè*

- Private, non-profit, 501(c)(3) corporation formed in 1998 through the merger of three similar organizations with roots dating to1956.
- Provides outpatient psychiatric, therapy, case management, and psychosocial rehabilitation services for individuals with serious psychiatric conditions.
- Co-occurring substance use disorders are common in the client population (40%).
- During 2010, approximately 2,900 clients were served.
- 85% of clients served have Medicaid, and 45% of clients served also have Medicare.
- In 2010, there were 92,800 client encounters.

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Proaction Behavioral Health Alliance

- Private, non-profit 501(c)(3) corporation formed in 1968.
- Originally established as Project Rehab to provide outpatient and residential substance abuse treatment.
- Currently, provides residential treatment for federal and state correctional systems; outpatient counseling for mental health, substance use, and co-occurring disorders; medication assisted treatment (i.e., methadone, suboxone); and employee assistance programs.
- Mental health and/or substance use issues common among those in the correctional system.
- Approximately 176,000 outpatient encounters and 56,700 residential days per year.

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Chronic Care Management

of

Multiple Health Conditions

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The Chronic Care Model

Developed by The MacColl Institute
® ACP-ASIM Journals and Books

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Why?

- Is the Wagner Chronic Care Model the most effective approach to help individuals manage their chronic health conditions?
- Does it make sense to treat multiple chronic health conditions together, rather than separately through different programs for each condition?
- Is a serious psychiatric condition, such as schizophrenia, bi-polar disorder, or substance use disorder, a chronic health condition?

Acute versus Chronic

- The distinction is between acute care and chronic care.
- Chronic care management can be designed to simultaneously address multiple chronic health conditions, some of which are psychiatric.
- The integration is primarily integration across all chronic health conditions.
- Wherein the distinction between behavioral and physical becomes irrelevant.

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Planning Workgroups

- Culture Change
- Curriculum
- Client Selection
- Information Technology
- Evaluation
- Finance
- Practice Management
- Space
- Staff Selection

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The Team's Purpose

- *To help individuals manage their chronic health conditions, so their conditions do not interfere with how they want to lead their lives.*

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Integrated Care

- One location
- All chronic conditions treated together
- Team approach
- One treatment plan
- One EMR
- Equal access to all providers
- Interventions tailored to stage of change

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The Integrated Development Team (IDT)

- The IDT was created to find out what an interdisciplinary team, including health coaches, would need to know and to have in order to effectively help its patients manage multiple chronic health conditions.
- Health coaches are licensed social workers with Master's of Social Work (MSW) degrees.
- IDT members receive four to six hours a week of release time from their current positions on Tuesday mornings.
- For funding reasons as well as support and interest from the local public mental health authority (network180), individuals who were current clients of Touchstone or Proaction were invited to participate in this Institutional Review Board (IRB) approved formative study.

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Purpose of the IDT

- Formed in February 2010
- Team is made up of staff from all 3 agencies
- Design, test, measure, & redesign processes and procedures
- Gain feedback from patients
- Develop practice management procedures
- Develop procedures for coding and billing

The IDT

- Internal Medicine Physician
- Nurse
- Psychiatrist
- Medical Assistant
- Health Coach (3)
- Pharmacist

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Health Coaching

- Roots are in substance abuse
- Early 1990's
- Replaces the "Do as I instruct you" model
- Holistic approach to treating chronic conditions
- Helps patients become informed and activated
- Provide primary interventions when appropriate to the condition

The Learning Curve

- Terminology confusion—MI is not a MI, a note is not a note, objective is not an objective, a psychosocial what?
- Lack of one uniform documentation system—In this case, the presence of two electronic health record (EHR) systems.
- Old habits delivering care—This is not outpatient therapy, episodic acute care, or case management.
- Feeling overwhelmed by the complexity—So many disease states, so much to learn, and so much that used to be 'not my problem.'
- Reframing existing views on patient behaviors–It is not resistance or non-compliance. Instead, thinking in terms of the stages of change and motivational interviewing.

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Team Members' Initial Experiences Delivering Integrated Health Care

- "Ive come to bond with [the other IDT members], I know these people, I care about these people. Where before, they were strangers to me."
- "I can be much more effective helping someone, because I'm not just…isolating mental health from their other health issues. I can see [patients' health] more as a comprehensive picture and [the] things I can offer that I couldn't offer before because I was ignorant of that medical piece."
- "Mental health and physical health are practicing right next to each other, so we can use each other as resources to help the patient. It's not that we didn't try that before, but the nature of the practices [did not] allow that."

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Profile of 15 Patients with Multiple Chronic Health Conditions

- 1 to 5 DSM Axis 1 diagnoses, mean of 1.8 diagnoses
- 1 to 10 other chronic health conditions, mean of 5.4 other chronic conditions
- 7 patients with personality disorders
- Range of 3 to 15 chronic health conditions, mean of 7.7 chronic health conditions

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Most Common Chronic Conditions

Condition	Number of Patients with the Condition
Hypertension	8
Schizoaffective Disorder	8
Hyperlipidemia	6
Gastro Esophageal Reflux Disease (GERD)	6
Asthma	5
Back Pain, Chronic	4
Bipolar 1	4
Insulin Dependent Diabetes Mellitus (IDDM)	4
Diabetes, Type 2	4

One Patient's Chronic Health Conditions

- Morbid Obesity
- Osteoarthritis
- Benign Hypertension
- Schizoaffective Disorder
- Diabetes, Type 2
- Sleep Apnea
- Fibromyalgia

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Another Patient's Chronic Health Conditions

- Hypertension
- Glaucoma
- Alcohol Dependence
- IDDM
- GERD
- Schizoaffective Disorder
- Hepatitis, Viral C

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A Patient with an Extreme Number of Conditions

1. Insomnia
2. Restless Legs
3. Post Traumatic Stress Disorder
4. Attention Deficit Hyperactivity Disorder
5. Eczema
6. Asthma
7. Polysubstance Dependence
8. Hypoglycemia
9. Borderline Personality Disorder
10. Irritable Bowel Syndrome
11. Amenorrhea
12. Depressive Disorder, Not Otherwise Specified
13. Gender Identity Disorder
14. Allergic Rhinitis
15. Back Pain, Chronic

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Lessons Learned from Motivational Interviewing

- A quote from an otherwise enlightened article on chronic pain management:

  "If the patient is unwilling to be compliant, though, the prognosis is poor. Under such circumstances, the physician must carefully consider whether or not it is advisable to continue treating the patient, especially in cases where the patient continues to use opiod pain medications excessively."

- It is time to stop thinking in terms of 'resistance' and 'non-compliance.'
- Instead, recognize that patients always do their best given their experiences and environments.
- It is our task to help patients make different choices, to become informed and activated.

Team Members' Perceptions of Initial Outcomes among Patients

- "[P]atients are keeping their follow-up appointments. I personally haven't seen many no shows. The patients come in and seem like they are following up with their providers. As for patients who are not [receiving care from] the IDT team, we will refer them to a psychiatrist, and they'll say, "Oh, I didn't go." The doctor will refer them again, and on the next visit, the [patients] just don't comply with it."
- "One of my clients right now is saying his depression has lowered significantly. Not that it's gone, but I think that's because we have been able to talk about his medical issues too. I've been much more open about discussing that and how his diabetes affects [his depression]."
- "Diabetic management—one patient in particular made amazing strides. And it wasn't just his diabetes. Mood-wise from the time I first saw him, and I think I've seen him three times between now and when I saw him last week, it's almost like he is a different person. He was upbeat, his mood was good, [and] his sugars were under control for the first time in who knows how long."

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Psychiatric Facility Utilization

- From April 2009 to December 2010:
  - 11 admissions
  - 6 individuals
  - 2 individuals had 3 admissions, and 1 individual had 2 admissions.
  - 114 days
- From January 2010 to December 2010:
  - 5 admissions
  - 4 individuals
  - One individual had two admissions.
  - 51 days
- Since joining the IDT: 0 admissions, 0 days

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Patient Activation Measure (PAM-13)

- LEVEL 1: May not yet believe that the patient role is important
- LEVEL 2: Lacks confidence and knowledge to take action
- LEVEL 3: Beginning to take action
- LEVEL 4: Has difficulty maintaining behaviors over time

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PAM – 13 Results

Among Patients Enrolled in June and July 2010

Patient ID	Level at Time 1	Level at Time 3
IDT-001	1	4
IDT-002	4	4
IDT-003	1	2
IDT-004	3	3
IDT-005	1	1
IDT-006	4	3
IDT-007	1	3

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Patients' Initial Experiences Receiving Integrated Health Care

- "I like the coordination. I like the idea that no matter who you talk to on your team they are aware of everything about you versus me always having to remember something."
- "I like the time saving it brings through the system, and money too. Why [should] I have to spend money on going to ten different places, when I can just go to one."
- "I like the fact that my doctor knows what my psychiatrist is doing and vice versa."
- "[M]y psych meds [are] down. At one time, I had a table full of pills. Now, I don't have it like that, so the team helped me get down to that. So, I'm on one [medication] now and doing pretty good I guess."

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Patients' Initial Experiences Receiving Integrated Health Care (Continued)

- "Since I've been coming to this team, I stopped drinking, and I feel like that's a really huge thing."
- "[M]y diabetes, too, is under control also through the diet [the IDT] gave me. It's also because I was a drug addict, and I've come off of drugs now—that I'm sure influenced it."
- "You're dealing with mental problems, and you're dealing with physical problems, and all those…combine sometimes, and it makes you feel like nothing is going right. To me, when I see Dr. Platt and my psychiatrist and [my] health coach, I feel stronger than I was. Because I didn't know which way I was going. I had no use for life or people or anything and it caused big problems. But right now, I'm feeling hopeful."
- "I've got friends who could so use this. They are not doing as good as really they need to be from my perspective. I wish I could say, 'Hey, there is this great place that you can go.'"

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Lessons Learned from the Initial Implementation

- Do not begin with a concept, start with the patients. Otherwise, staff have nothing tangible to which to relate the concept (e.g., the chronic care model).
- Use health coaching and team huddles until staff begin practicing and can generalize from their experiences.
- Learning *about* something is not learning to do it. Staff training needs to be followed by ongoing practice under expert supervision. That means everything, from specific interventions to the language used to discuss patients.
- To break old habits, new behaviors need to be modeled and reinforced.

Future Direction

- The full team will begin providing chronic care management in October 2011, coinciding with the Heart of the City Health Center opening.
- This team will serve approximately 600 CSHS patients, all of whom will have at least one chronic health condition.
- Approximately 250 of the team's patients will have a co-occurring chronic psychiatric or substance use condition.
- The team will expand and operate full-time.
- The team will no longer be known as the Integrated Development Team, but will operate as The Durham Clinic within CSHS.

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The Durham Clinic Staff

- Internal Medicine Physician (1FTE)
- Psychiatrist (0.5 FTE)
- Health Coach (6 FTE)
- Nurse (1 FTE)
- Medical Assistant (1 FTE)
- Case Manager (2 FTE)
- Peer Support/Recovery Coach (1 FTE)
- The following services will also be available:
  - Pharmacy
  - Nutrition Counseling
  - Benefits Acquisition
  - Housing and Transportation Referrals

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Evaluation Plan Overview

- A quasi-experimental, time series design with a comparison group will be used.
- The evaluation plan protocol has been approved by the Michigan Department of Community Health IRB.
- The intervention group will be comprised of 600 adult patients with chronic health conditions who will receive comprehensive chronic care management services in the Durham Clinic at the Heart of the City Health Center.
- The comparison group will include approximately 600 adult patients also with chronic health conditions who will continue to receive care as usual at another CSHS site.
- Data will be collected from both the intervention and comparison groups for three years following their enrollment, beginning in October 2011.

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Data Collection Schedule

- Some physiological health status data, such as blood pressure and body mass index, will be collected at each physician visit.
- Other patient data will be collected at baseline (the first visit after study enrollment) and then at 6 month follow-up intervals.

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Outcome Measures

- Depression: Patient Health Questionnaire (PHQ-9)
- Anxiety: Generalized Anxiety Disorder 7-item (GAD-7) Scale
- Substance Abuse: CAGE
- Psychosis: Clinical Global Impression-Schizophrenia Scale (CGI-SCH)
- Pain: Brief Pain Inventory
- Body Mass Index (BMI)
- Tobacco Use
- Blood Pressure
- Lipid Profile
- Fasting Blood Sugar, Hemoglobin A1c Test (HbA1c)

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Outcome Measures

- Patient Activation, PAM-13
- Self-perceived health status, EQ-5D
- Cost and claims data regarding the following:
  - Inpatient admissions and days
  - Emergency room visits
  - Pharmacy
  - Clinic visits
  - No show rates
  - Others as available

Thank you!

Q & A