Behavioral Health Integration: A Tale of Two Centers

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The Impact of Serious Mental Illness on Health

- 68% of people with a serious mental illness (SMI) also have physical health condition such as asthma, cardiovascular disease, diabetes, and hypertension.
- Adults with serious mental illness (SMI) in the United States die on average 25 years earlier than those in the general population.
- Increasing numbers of children and adolescents are being diagnosed with a serious emotional disturbance (SED) and chronic health condition such as obesity or asthma
- Barriers to primary care, coupled with challenges in navigating complex healthcare systems contribute to poor health outcomes in people with serious mental illness (SMI) and children and adolescents with serious emotional disturbance.

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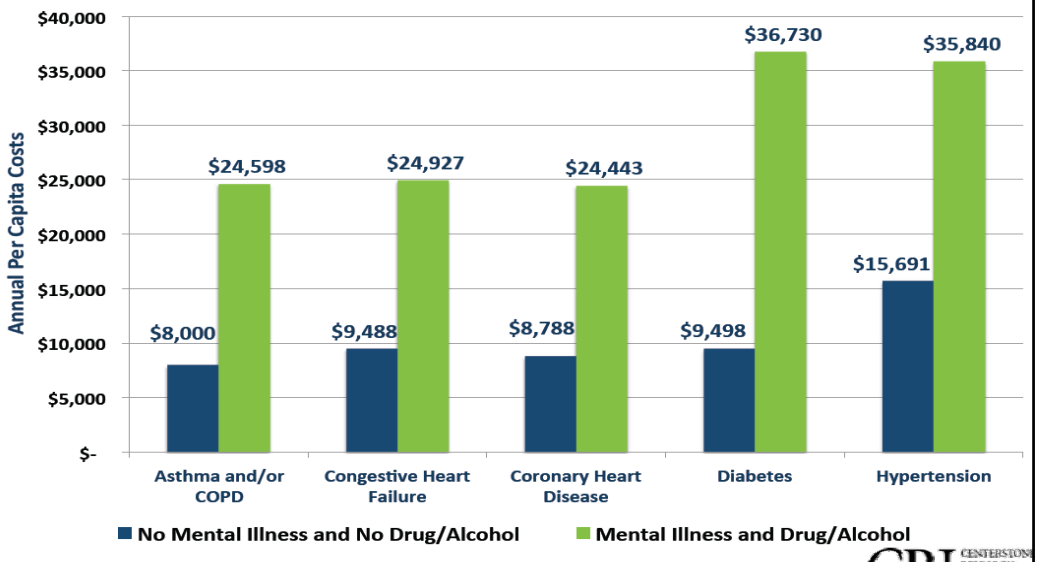
Impact of Behavioral Health Co-Morbidities on Medicaid Costs



The Solution: Health Homes

- Health Homes deliver care that focuses on the whole person and provides integrated healthcare coordination that includes primary care and behavioral healthcare.
- Health Homes demonstrate competency to identify and treat behavioral health concerns, such as mental illness and substance use disorders/addictions, and recognize general medical or physical concerns.
- Care is coordinated across persons, functions, activities, and sites over time to maximize the value of services delivered to persons served.

WellConnect: an Integrated Care Solution at Centerstone

SAMHSA PBHCI Health Home Grant Nashville, TN Funded Sept. 2012 – March 2017

- Enroll **600** individuals in Health Home who receive services at three Davidson County Centerstone clinics

SAMHSA PBHCI Health Home Grant Clarksville, TN Funded Sept. 2015 – Sept. 2019

- Enroll **958** individuals in Health Home who receive services at Montgomery County Centerstone clinic
  - Current enrollment: **225**

Centerstone Funded Health Home Pilot October 2015

- Enroll **250** individuals in Health Home who receive services at the remaining 15 Centerstone clinics across TN

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Primary and Behavioral Healthcare Integration

- Integrated primary care and behavioral healthcare services at four locations:
  - Antioch
  - Clarksville
  - Madison
  - Nashville

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UNITY MEDICAL CLINIC

- Primary care and behavioral healthcare collaboration throughout all counties in TN.

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CARF - Commission on Accreditation of Rehabilitation Facilities: Health Home

- Received 1 year supplemental CARF Health Home Accreditation in May 2015 at 4 outpatient clinics.
- Received 3 year full CARF Health Home Accreditation in May 2016 at 19 outpatient clinics.

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WellConnect Health Home Goals

- To improve participants' experience of care as evidenced by participant self-report
- To improve self-management of health conditions by teaching skills to participants based on evidence-based prevention and wellness interventions as indicated by a reduction BMI, cholesterol levels, blood pressure, and A1c
- To improve the health status and outcomes for participants enrolled in the Health Home as indicated by a reduction in hospitalizations
- To improve participant understanding of appropriate hospital emergency room utilization as indicated by a reduction in emergency room visits

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WellConnect Health Home Activities

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Transitional Care
- Patient and Family Support
- Referral to social supports

Provided by Care Coordinators and Wellness Coaches

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Comprehensive Care Management

- **Comprehensive care management** includes a comprehensive Health Assessment of the client's behavioral and physical health needs at enrollment.
- The Health Assessment is reviewed by a Registered Nurse and conducted annually there after.
- Creating and monitoring a comprehensive person-centered care plan that includes physical and behavioral health needs.

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Care Coordination

- **Care coordination** involves strategies to help providers working with the same consumer to communicate with each other to improve the quality of care.
- Proactive outreach and follow up with primary care and behavioral health providers
- Assisting consumer in closing gaps in care

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Health Promotion

- **Health promotion** - providing education to client and family members.
- Educating consumers on how to self-manage medical and behavioral health conditions, disease prevention, and importance of annual screenings.
- Educating the consumer and family members on independent living skills.

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Transitional Care

- **Transitional care** focuses specifically on care coordination for consumers moving between care settings (e.g., inpatient to outpatient)
- Assisting with keeping follow-up appointments within 7 days of emergency room and hospital discharge (medical and psychiatric) to prevent readmissions.
- Provide education on appropriate emergency room usage .

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Patient and Family Support

- **Patient and family support** provides individual and caregiver coaching to help the individual improve function, obtain information about the individual's disability or conditions, and navigation of the service system.
- Check-ins with patient via phone and face to face to support treatment adherence.
- Identify resources to assist individuals and family supporters in acquiring, retaining, and improving self-help, socialization and adaptive skills.

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Referral to Social Supports

- **Referral to social supports** such as food, shelter, clothing, employment, legal, entitlements, and all other resources that would reduce barriers to help individuals in achieving their highest level of function and independence.
- Provide information and assistance in accessing services such as: self-help services, peer support services; and respite services.

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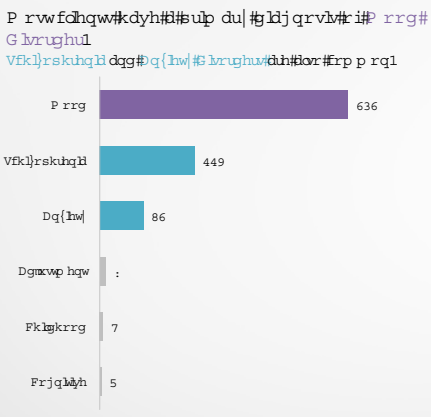
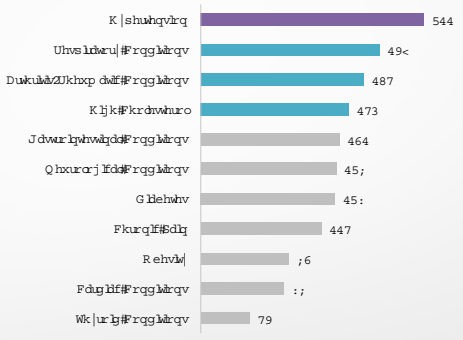
Diagnoses – Adult enrollees



The most frequently diagnosed primary psychological conditions are Mood Disorders (62%), Schizophrenia (24%), and Anxiety Disorders (11%).



The most prevalent chronic physical health conditions reported are: Hypertension (44%), Respiratory Conditions (*e.g., asthma, COPD, sleep apnea*)(35%), Arthritis/Rheumatic Conditions (32%), and High Cholesterol (29%).

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Small Changes Make a **BIG** Difference

- Blood cholesterol
  - 10% ⬇ = 30% ⬇ in Cardiovascular Disease (CVD)
- High blood pressure
  - ~ 6 mm Hg ⬇ = 16% ⬇ in CVD; 42% ⬇ in strokes
- Diabetes
  - 1% point ⬇ HbA1c = 21% ⬇ in Diabetic related deaths, 14% ⬇ in Heart Attacks

* 2014 PBHCI Presentation by Dr. Joe Parks
- Stratton, et al, BMJ 2000
- HennekensCH. *Circulation* 1998;97:1095-1102.
- Rich-Edwards JW, et al. *N Engl J* Med 1995;332:1758-1766.
- BassukSS, Manson JE. *J Appl Physiol* 2005;99:1193-1204

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Davidson Grant Outcomes: BMI and BP

Baseline BMI (n=162)	**Lost 5+ lbs.** at 12 Months
Overweight (BMI = 25.0-29.9)	16%
Obese (BMI = 30-39.9)	31%
Extremely Obese (BMI = 40+)	35%

Baseline Blood Pressure (n=164)	**Improved** BP by **6+ points** at 12 months
Prehypertension (129-139/80-89 mmHg)	50%
Hypertension (140+/90+ mmHg)	84%

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Davidson County Outcomes: Lipids & A1C

Baseline Lipids	**Improved** at 12 Months
Triglycerides (n=109) **at risk** (≥150 mg/dL)	41%
HDL (n=106) **at risk** (<40 mg/dL)	52%
LDL (n=87) **at risk** (≥130 mg/dL)	67%

Baseline A1c (n=83)	**Improved** A1c at 12 Months
Pre-diabetic (A1c = 5.7-6.4)	42%
Diabetic (A1c > 6.4)	37%

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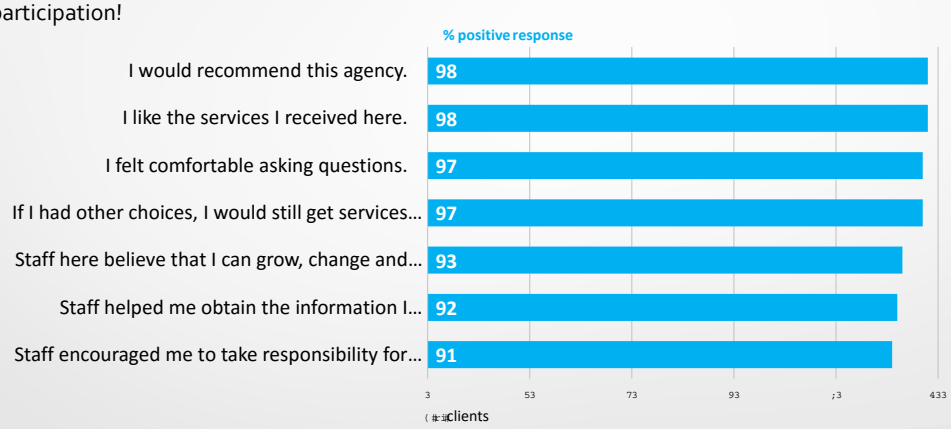
Davidson County: Consumer Satisfaction Outcomes

Clients are **overwhelmingly satisfied** with the Health Home services after 12 months of participation!



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New clinical model

Analytics

Targets the 5% (3+ hosp/ED use)

Wellness coaching with RN support

Technology-enabled care

Flexible funds

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Centerstone High Utilizer Care Results

87 enrollees, **2** states (TN and IN)

3 month intensive program

Hospital Days: 61% ↓

ED Visits: 43% ↓

$577,941 in estimated savings for reduced ER visits and hospital admissions

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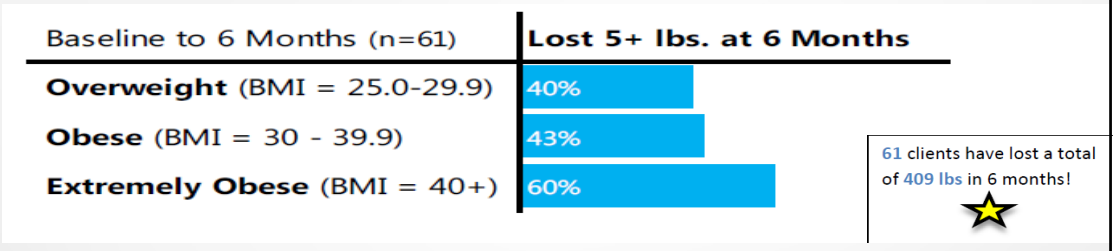
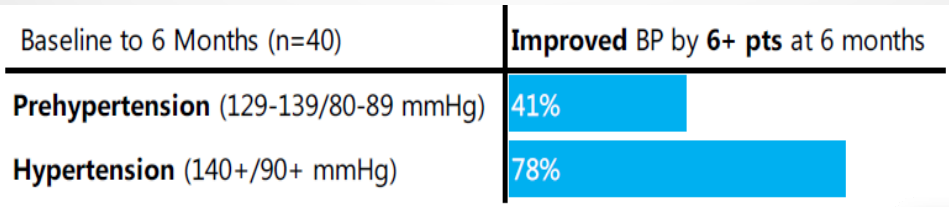
Montgomery County Outcomes: BMI & BP



61 clients have lost a total of 409 lbs in 6 months!



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Lessons Learned

- Engagement of Staff is **KEY** to Succeeding
- Don't Wait until You Think you Know Everything

  (That Never Happens)
- Just because you offer primary care does not mean they will come… **Must Continuously Engage Consumers**

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Centerstone Health Link

- Providing Whole-Person Coordinated Healthcare
- Centerstone Health Link Team
  - Health Link Administrator-MSN, RN
  - Lead Care Coordinators-RN
  - Care Coordinators
  - Wellness Coaches (Previously Known As Case Managers)
  - Mental Heath Providers
  - Primary Care Providers
- Delivering Care that Changes People's Lives

Health Link Information 877.834.9848
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centerstone.org/healthlink

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