Tuesday, 12:30 – 2:00, B7

Washtenaw Community Health Organization Disease Management Program

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Objectives:

1. Identify effective methods for the practical application of concepts related to improving the delivery of services for persons with developmental disabilities
2. Identify advances in clinical assessment and management of selected healthcare issues related to persons with developmental disabilities

Notes:

Washtenaw Community Health Organization (WCHO) Disease Management Program

Trish Cortes
Tim Florence
Mike Harding
Brandie Hagaman

29th Annual Developmental Disabilities Conference
April 23, 2013

Goals of Presentation

- 1.Identify the purpose of the WCHO pilot disease management program
- 2. Understand the stratification and health conditions of populations (MI, DD, Dual Eligible, Non-Dual Eligible)
- 3. List 4 intervention strategies for Disease Management Consumers
- 4. Understand outcomes for 4 Case Studies and the disease management interventions
- 5.Cross reference difference for BMI for three subgroups
- 6. Ongoing infrastructure efforts

What We Know About Morbidity and Mortality?

Individuals with serious mental illness served by our public mental health systems die, on average, 25 years earlier than the general population.

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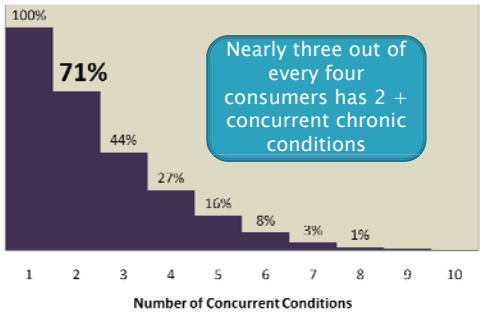
NASMHPD 2006

Frequency of Multimorbidity, WCHO Consumers



Mental Illness, Developmental Disabilities, Substance Use Disorder, Asthma, Emphysema, Bronchitis, Heart Disease, Diabetes, Hepatitis, Hypertension, Cholesterol, Chronic Pain.

WCHO Experience With Integrated Health

- Began Integrated Health efforts in 2004
- Goal: improve physical health of CMH consumers by creation of medical home in primary care sites
- 5 primary care clinics
- Results based on data from 2007- 2009:
  - 64 consumers discharged to primary care
  - ~15% readmitted to CMH

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Pilot Disease Management Program

Purpose:

To improve physical health outcomes for individuals with SMI/SUD/DD through a set of interventions directed towards improved management of particular core diseases, conditions and co-morbidity clusters.

Target Populations: ~ 1100 fee-for-service individuals (i.e. spend down and dual eligibles)

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Initial Infrastructure Achievements

- Creation of disease registries through use of an annual Personal Health Review
- Creation of central data warehouse through health information exchange with MSA
- Evaluation of self report/self rated health status (from PHR) based on claims in data warehouse for CMH consumers
- Creation of labs module in EMR (HbA1c, cholesterol, triglycerides, glucose)

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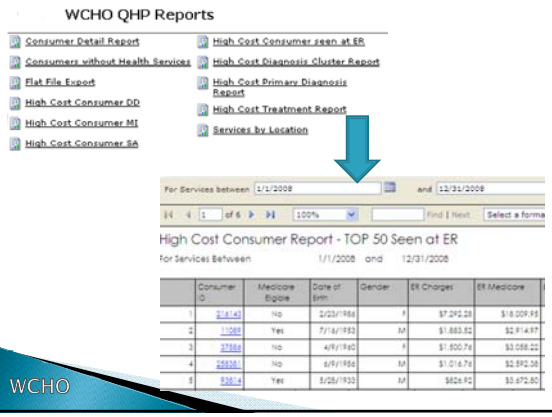

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Variables Used for Stratification of Target Population

- Consumer self rated health as "poor" or "fair"
- Presence of disease or clusters of conditions (diabetes, hypertension, cardiovascular disease, asthma/ COPD)
- Utilization of medical hospitalization and ER in last year
- Presence of certain ambulatory sensitive conditions (heart disease symptoms)
- Tobacco use
- Disease management team ended up providing services for ~450 consumers

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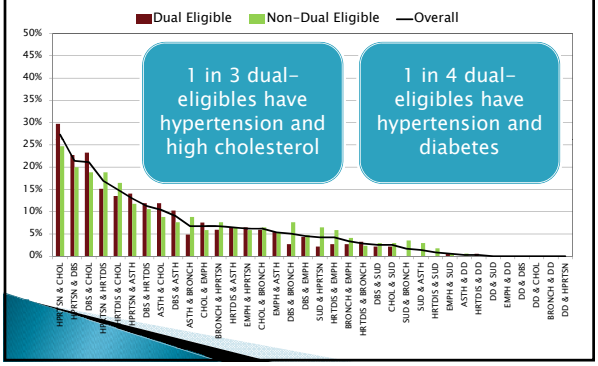
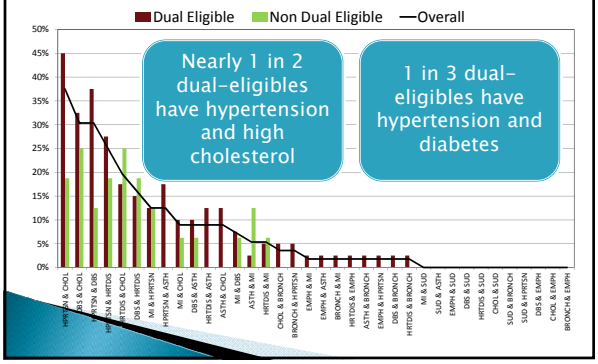
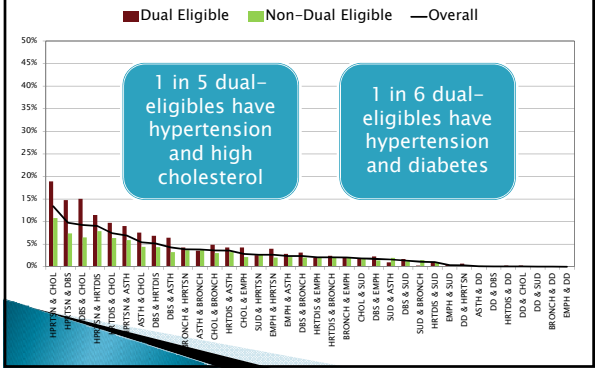
WCHO Disease Mgt Consumers with Mental Illnesses (MI)



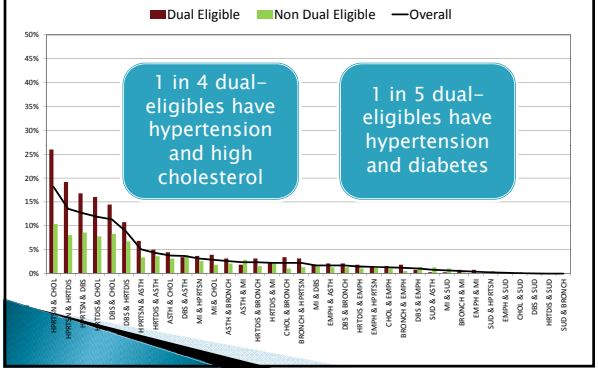
WCHO Disease Mgt Consumers with Developmental Disabilities (DD)



All WCHO MI Consumers



All WCHO DD Consumers



Interventions

Intervention Strategies

- Use of Comprehensive Care Coordination Team Approach
- Supports Coordination with Social Supports
- Use of "High Touch" Approach
- Health Promotion/ Self Management

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Intervention Strategies

Creation and Expansion of Disease Management Team

- 5 care coordinator RNs
- 3 full time certified peer support specialist
- 1 registered dietician/health educator
- 1 half-time family nurse practitioner

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Intervention Strategies

Use of Comprehensive Care Coordination Team Approach

- Person centered
- Disease Management Team care coordinator is the "go-to"
- Other team members may include:
  - primary care physician
  - on-site family nurse practitioner
  - behavioral health professionals (social worker, job coach, mental health RN, psychiatrist, behavioral psychologist, therapist)
  - independent living support staff
  - medical specialist (cardiologist, endocrinologist, etc)
  - pharmacist

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Intervention Strategies

Supports Coordination with Social Supports

Linking and coordinating with community partners in the following life domains

- Housing
- Employment
- Natural supports
- Transportation
- Education
- Recreation
- Public safety
- Spirituality

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LIFE DOMAIN	COMMUNITY RESOURCES	FUNDERS	OTHER SERVICE PROVIDERS	COUNTY DEPARTMENTS	ASSOCIATIONS/ ALLIANCES	PUBLIC OFFICALS	COMMUNITY OF INTEREST
Housing	Landlords Utility Companies	Section 8 HUD Entitlements Mortgage lenders Habitat Community Foundation County CDBG MSHDA Barrier Busters Consumer Loan Fund	Housing Commissions Avalon CHA Shelter Adult Foster Care Assisted Living Group Homes SSIS Housing Bureau for Seniors Depaul	Planning Public Health County extension ECTS Treasurer's Office	Continuum of Care Housing Alliance CSH Consortium AA Community Development Ypsi Community Development HSCC	Public Housing Boards City Council BSC Social Soc Admin	Homelessness and Housing
Work **Paid or volunteer**	Employers Skill Bank Volunteer Organizations	WRS WCHO Ticket to Work CIL Talent Exchange ECTS	Fresh Start SE Providers WISD	Support Services ECTS	SE Exec Committee SE Network HSCC Ad Hoc Committee	State Legislature Congress	HBH Support Services
Family/Friends	Faith Organizations	FIA – Home Help WCHO-Respite WCHO – NAMI and ACA funding	Respite Wrap-Around Child Waiver FIA Schools	ECTS Children's services Public Health	NAMI Friends of the DD HSCC	BSC State Legis. DCH	Children's Well Being Homelessness and Housing Health
Recreation	City and County Parks Rec Centers Community at large (movies, malls, restaurants))	SLP Budgets Life Enhancement WCHO CIL (Talent Exchange)	Project Transition SLP Providers fresh Start Full Circle Therapeutic Riding Inc.	Parks and Rec.	Friends of the DD	Park Commission	Health?
Education	Head Start Public Schools Community Colleges Universities	Entitlement Scholarships Loans	WISD	Juvenile Detention Head Start County Extension	Transition Council HSCC	Boards of Ed Regents State and Fed Legislature	Children's Well Being
Spirituality	Local churches Synagogues, Mosques		Group homes and SLP providers assist with attendance		Parish Partnerships Interfaith Alliance HSCC		Children's Well Being Health
Transportation	Private market Public Transportation	FIA WCHO MRS	AATA Milan Transit Cab Companies CBDG funds?	Facilities	HSCC Supported Employment Ex Comm.	AATA Board	Homeless and Housing Health Planning
Public Safety	Police Departments Sheriff's Department		Jail Services WCHO Court Services Town Farms	Sheriff's Department Juvenile Detention	Affiliation JD workgroup Local Jail Diversion Workgroup Crisis Relief Task Force	BSC Sheriff Prosecutor Public Defender	Public Safety and Justice Health Homeless and Housing

Care Interventions

"High Touch" Approach

- Face to face contact is provided by Care Coordinator "where the consumer is at" figuratively and literally
- Expectation of an in home assessment upon enrollment
- Use of Peer Support Specialists
- Care Coordinators have opportunities for face to face interaction with primary care physicians and specialists
- Care Coordinators work as an integrated part of behavioral health team
- Certain Care Coordinators are assigned to primary care clinics serving high volume at risk populations (Packard health clinic, Ypsilanti Health Clinic, Neighborhood Family Health Clinic)
- Care Coordinators training in motivational interviewing

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Care Interventions

Health Promotion/ Self Management

- Self Management/ Wellness Classes
- Diabetes Management
- Health Bodies Healthy Minds
- Stress Management
- Tobacco Treatment
- Healthy Lifestyles Series
- Weight Loss Series
- Physical Activity
- Nutrition for Diabetes
- Music in Motion

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Care Interventions

Peer Support Specialist Assists With:

- Care coordination (phone calls, attending appointments, etc)
- Medical appointments
- Physical activity in community
- Health food choices in grocery store
- Creating daily schedules
- Accessing community resources
- Transportation needs
- Money Budgeting

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Outcomes

What we know about BMI/BP

- Estimate of body fat
- Risk for heart disease, hypertension, type II diabetes, gall stones, breathing problems, certain cancers
- Improvements in blood pressure can improve other health conditions

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Case Studies

The first 2 case study consumers all had (concurrently):

- Mild Intellectual Disability
- Hypertension
- High Cholesterol
- At risk for Heart Disease

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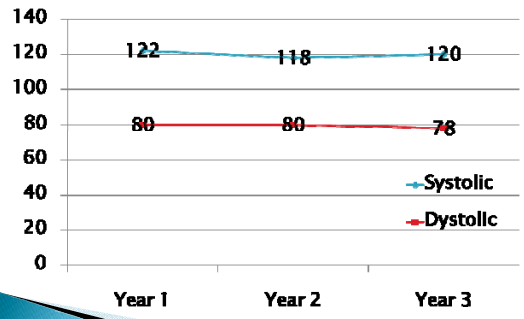
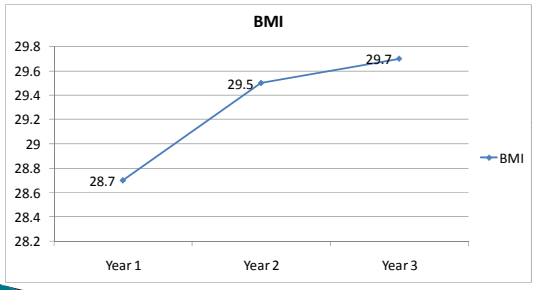
Consumer A

- 49 year old female
- Lives in private residence with family/spouse
- Dual Eligible
- Receives Supports Coordination
- Mental Health Nursing Services
- No SUD

Consumer A– Blood Pressure



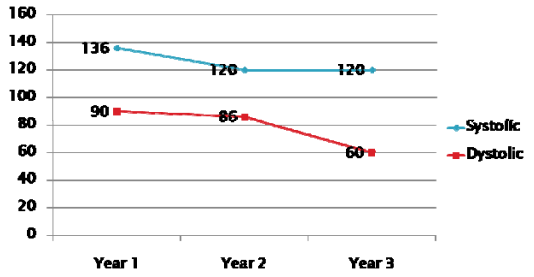
Consumer A– BMI



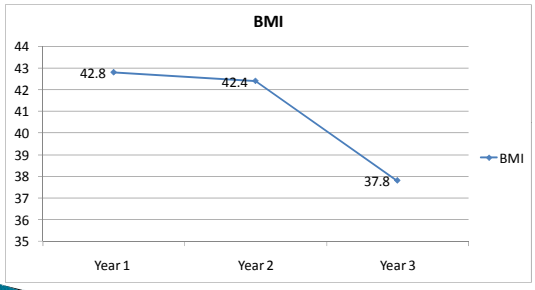
Consumer B

- 49 year old female
- Lives in private residence with family/spouse
- Dual Eligible
- Receives Supports Coordination
- Mental Health Nursing Services
- No SUD
- Receives Disease Managment services
  - Nursing
  - Peer
  - Wellness classes

Consumer B– Blood Pressure



Consumer B – BMI



Next 2 Case Studies

BMI ONLY

Actively Receiving RN Care Coordination:
Consumer has been assigned a care coordinator

No care coordination
Not part of Disease Management target population

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Case Studies

The next 2 case study consumers all had (concurrently):

- Schizoaffective disorder
- Uncontrolled Diabetes
- High Cholesterol
- Hypertension
- Prescribed at least one Atypical Antipsychotic

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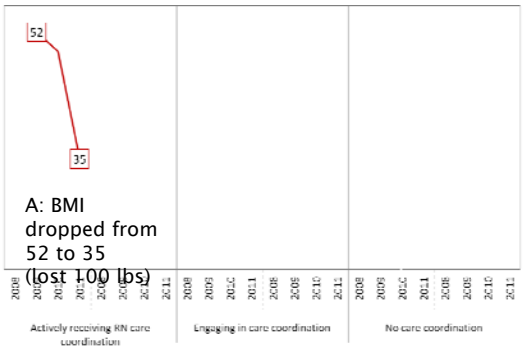
Actively Receiving RN Care Coordination

Consumer C

- 44 year old female
- Lives independently
- Supports Coordination
- Psychiatry services
- Mental health nursing services
- Dialectical Behavioral Therapy
- Disease Management Health Promotion and Self-Management groups
- Disease Management Care Coordination



A: BMI dropped from 52 to 35 (lost 100 lbs)

No Care Coordination

Consumer D
- 47 year old male
- Lives independently
- Supports coordination
- Psychiatry services
- Mental health nursing services

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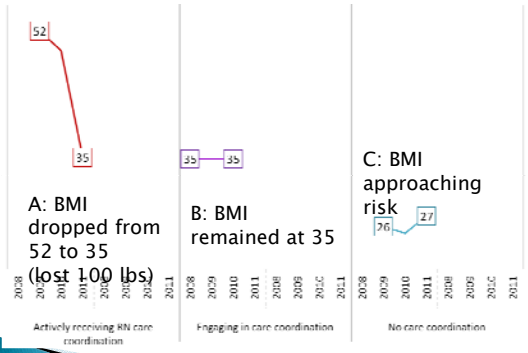
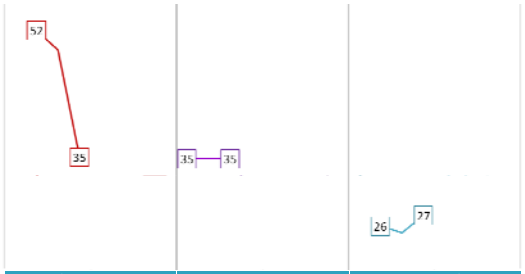


A: BMI dropped from 52 to 35 (lost 100 lbs)

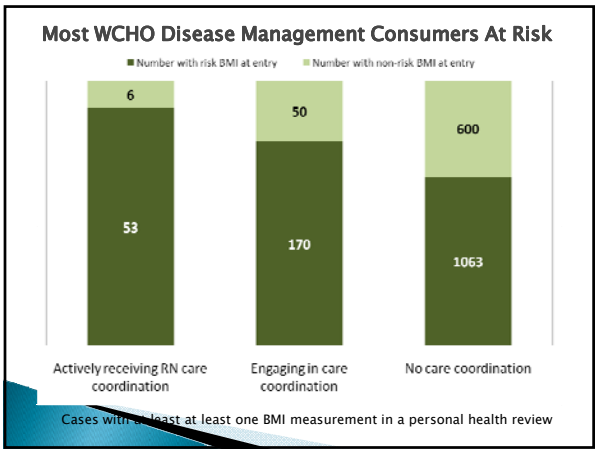
B: BMI remained at 35

C: BMI approaching risk

THIS PATTERN HOLDS FOR WCHO CONSUMERS



Actively receiving RN care coordination	Engaging in care coordination	No care coordination
1.45 BMI points LOST per year (p=0.0224)	No evidence of change (p=0.6390)	**0.28 BMI points GAINED** per year (p<0.0001)



Ongoing Infrastructure Efforts

- Deployment of mobile technology
- Development of fully integrated meaningful use certified EMR
  - Clinical decision support
  - Client Dashboard
  - Referral tracking
  - Patient education
  - E-Prescribing
  - Clinical Coordination Documents

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Ongoing Infrastructure Efforts

- Personal health record (CHER)
- Medical Wristbands
- Health Information Exchanges (HIE)
- Behavioral and physical health related outcomes


Questions