Integrated Health Care: Planning for, Training Staff and Making it a Reality at your CMH/PIHP

Cynthia Blair
231-724-3699  blair@cmhs.com.muskegon.mi.us

Suzanne Beckeman
231-724-3699  beckeman@cmhs.co.muskegon.mi.us

Objectives:

1. Identify advances in clinical assessment and management of selected healthcare issues related to persons with developmental disabilities

2. Cultivate a shared vision for Integrated Health amongst staff, partners, and community

Notes:
Cyndi Blair, RN-C
Director of Clinical Services
Community Mental Health of Muskegon County

Suzanne Beckerman, RN
Integrated Health Coordinator
Community Mental Health of Muskegon County

Taking Health Integration Full Scale:
Fully Engaging Staff and Consumers in a Culture of Wellness

Chronic Illness:
Unsolved Burden in US Healthcare

• 45% of non-institutionalized Americans have one or more chronic illness.
• Chronic illness accounts for 78% of the cost of healthcare in the US.
• Our medical system is primarily set up to treat acute illness.


County Health Rankings

Muskegon ranks last (82nd out of 82 counties) in Michigan when compared to other counties in the state in healthy behaviors.

County Health Rankings & Roadmaps, Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute, updated 2012
“Muskegon County, Michigan is one of the most obese counties in the state of Michigan, which happens to be one of the most obese states in the nation”

CMH of Muskegon County
Fiscal year 2012

We served:

• 2,938 Adults with SMI
• 771 Adults with developmental disabilities
• 795 Children with serious emotional disturbance
• 191 Children with developmental disabilities
• 265 are un-insured
• 185 have no primary care physician

Most Frequently Occurring Physical Health Diagnoses for People Served at CMH

• Obesity
• Diabetes
• Hypertension
• Asthma
• Hyperlipidemia
• At least one-third smoke cigarettes
Illness & Death in People with Serious Mental Illness

- People with serious mental illness (SMI) are dying 25 years earlier than the general population.
- While suicide and injury account for about 30-40% of excess mortality, 60+% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary and infectious diseases.

How Are the “25 years” Lost?

- People with SMI have more chronic illnesses than matched populations of Medicaid recipients.
- These lead to largely preventable poor outcomes.
- List includes: diabetes, metabolic syndrome, lung and liver diseases, high blood pressure, cardiovascular diseases, infectious diseases and dental disorders.
- Individuals with severe disabilities tend to have shorter life expectancy due to increased medical complications.

Barriers of Health Care Access

- Lack of information about services
- Shortage of appropriately trained health providers
- Transportation and access problems
- Lack of adequate health insurance coverage
- Cultural and language barriers
- Limited patient education materials
- Lack of health care standards/guidelines
Chronic Conditions with a Behavioral Health Component in Standard of Care Protocols

- Asthma
- Diabetes
- Cardiovascular Disease
- Irritable Bowel Syndrome
- Obesity
- Unhealthy Substance Use
- Depression

Depression with Chronic Illnesses

Increased rates of depression in patients with:
- Congestive Heart Failure
- Diabetes
- COPD
- Patients with chronic illness and depression: 2.5x the healthcare cost of patients with chronic illness alone
- Depression is the common factor in patients disabled (compared with patients equally sick but not disabled) by hypertension, asthma, arthritis, ulcers.

National Diabetes Fact Sheet

According to the 2011 National Diabetes Fact Sheet...

25.8 million children and adults in the United States --- 8.3% of the population --- have diabetes.
Higher Rates of Diabetes for SMI

- 15% for those with Major Depression
- 16-25% for those with Schizophrenia
- 25% for those with Bi-polar Disorder
- 50% for those with Schizoaffective Disorder

Bazelon Center for Mental Health Law (2006)

Diabetes Prevalence Among People with and without Cognitive Limitations

<table>
<thead>
<tr>
<th>Disability Status</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Disability</td>
<td>3.7%</td>
</tr>
<tr>
<td>Cognitive Limitation</td>
<td>18.5%</td>
</tr>
</tbody>
</table>

Diabetic Care

The majority of Medicaid-supported diabetic individuals with cognitive limitations did not receive their yearly foot check, HbA1c check, eye check, or cholesterol check.

www.rtcil.org/micl
Diabetes Summary Report for Integrated Health Center

• One provider at the IHC: 25% of her patients have diabetes. All people served at the IHC received CMH services and have Chronic Disease concerns.

• Fifteen providers at HCCC (FQHC): The percentage of patients with diabetes per provider at HCCC range from 5%-17%.
Major Chronic Conditions

Those with cognitive limitations and diabetes had a higher prevalence rate for six major chronic conditions (asthma, arthritis, heart disease, high cholesterol, high blood pressure, and stroke) than people who had diabetes but no disability.

Integrated Health Clinic

“Improve the quality of life for persons with serious mental illness through holistic, integrated, coordinated health care”
Collaborative Setting

“Treatment compliance for medical problems is increased when delivered in a collaborative setting”

Integrated Health Clinic

- Currently in operation 2 days per week
- Part-time Physician’s Assistance (from FQHC)
- Part-time Registered Nurse (CMH)
- Full-time Clerical Support (CMH)
- Integrated Health Care Coordinator (CMH RN)
- Director Medical Services (CMH RN-BC)
- Supervision provided by FQHC Medical Director
- On-site laboratory
- On-site pharmacy in development

IHC Patient/Visit Data

1198 Visits * 183 Patients

<table>
<thead>
<tr>
<th>Chronic Disease</th>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>48</td>
</tr>
<tr>
<td>Hypertension</td>
<td>73</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>72</td>
</tr>
<tr>
<td>Asthma</td>
<td>26</td>
</tr>
<tr>
<td>COPD</td>
<td>12</td>
</tr>
</tbody>
</table>
Case Study – “Jamie”

“Jamie” is a 36 year-old male with the following diagnoses:
- Mild Mental Retardation
- Mixed Hyperlipidemia
- Diabetes Mellitus, Type 2
- Bi-polar Disorder
- Impulse Control Disorder
He lives independently with the assistance of a Community Living Support Worker.

Case Study – “Jamie”

- Seen 16 times at the IHC in the last 12 months.
- Seen only 8 times in the previous 12 months at his previous PCP office.
- A1C upon referral to IHC 3/2012 was 10.5
- A1C 6/2012 down to 7.8
- A1C increased to 9.0 in 10/2012 (frequency of appts decreased because he was doing well).
- A1C is now down to 8.0 as of 4/18/2013
- We learned that “Jamie” needs more frequent appointments to remain engaged in his treatment.
Case Study

“Tammy” is a 47 year-old female with the following diagnosis:

- Hypertension
- Obesity
- Depression
- Mental Retardation
- Hyperlipidemia
- Diabetes Mellitus Type 2

Case Study

- “Tammy” has a full-scale IQ of 56.
- She reads at a 4th grade level
- Attended special-education classes
- Quit school in the 8th grade

Case Study

- Tammy uses a wheel-chair
- Was going to a PCP in the community but often missed appointments due to lack of transportation
- Resides one-block from the IHC at CMH
- Was seeing endocrinologist who provided the following insulin order. She was discharged from that practice for being non-adherent.
Insulin Instructions

Reduction of ER Visits

- "Maria" is a 29-year old female who had her initial visit to the IHC on 5/16/2012
- She has 9 ER visits from 3/29/2011 to 3/11/2012
- She has had 3 ER visits from 10/13/2012 to 4/19/2013
- The number of ER visits was reduced by 2/3 after coming to the IHC.

Reduction in ER Visits

- "Larry" is a 50-year old male who had his initial visit at the IHC on 3/22/2012
- He had 14 ER visits from 3/15/2011 to 3/15/2012
- He had only 7 ER visits from 3/25/2012 – present.
- The number of times he went to the ER was reduced in half after coming to the IHC.
What Makes it Work?

• Team work
• Using Evidence-Based Practices
• Providing additional training to staff
• Convenience of Integrated Care under one roof
• Collaboration with community partners
• Support of administration
• Rapid response to behavioral health/medical concerns
• Having the right team members (IT, Finance, Clerical, etc.)
• Flexibility – “Thinking outside the box”
• Activity of advocacy

What Makes it Work for Individuals with a Developmental Disability?

• There is no health-disparity for the diverse population served in the Integrated Health Clinic.

• 30 minute appointments instead of standard 15 minute appointments.

• Health promotion programs

• Support provided to individuals with DD, their families, and other caregiver in self-care and wellness.

• Collaboration between the developmental disability network and the health network.
Two-Year Follow-up

Integrated Care group patients reported:
• Better social functioning
• Consumer satisfaction

Physicians reported:
• Better communication between practitioners
• Less stigma for patients
• Better coordinated care
• Overall better patient outcomes

Laboratory Services

• On-site Laboratory services
• Point-of-care testing (A1C, Hgb, Glucose, UA, PT, Strep Screen, Pregnancy Test)
• CLIA Certified (Certificate of waiver from the Centers of Medicare and Medicaid for Laboratory Improvement Amendments)
• Additional testing is done via obtaining specimens on-site by medical staff and send them for off-site testing (Quest Laboratory).
• Results for off-site testing are available for most tests by 7:00 a.m. the following business day.

Benefits of an On-site Pharmacy

• We have established “working relationships” with local pharmacies.
• Moving a pharmacy on-site would be another link to providing care in an integrated manner.
• Consumer leaves appointment with medications in hand, increasing adherence.
• Full service pharmacy: all meds and all scripts can be filled.
• Pharmacist is part of the “care team”.
• Less stress for consumers and less workload for staff.
Achievements to Date

- Remodeling of a wing of CMH to accommodate primary care
- Establishment of two exam rooms equipped to provide primary care
- Development of primary care assessment forms and data collection tools
- Memorandum of Understanding with Hackley Community Care (FQHC)
- Recruitment of a certified Physician's Assistant (PA-C)
- Contract with a primary care physician to supervise on-site PA-C
- Established billing processes
- Primary care services provided on-site to individuals
- Trained 17 CMH RNs and 5 FQHC RNs to Certified Nurse Care Managers

Future Plans

- Increase hours of operation from 16 to 40 hours per week
- Modify space in current clinic to accommodate 4 additional exam rooms
- Further develop and implement protocols for care coordination (especially those with 2 or more chronic diseases)

The Big Picture

- We learned that Integrated Health is much more than Integrating Primary Care and Behavioral Health.
- It includes helping our staff understand their own health care needs before they can assist to address the health care needs of consumers.
- It is about promoting a healthy community.
- Ultimately it is about the collaboration of partnering agencies addressing Integrated Health Care in the community at large.
Identified Challenges

In spite of the many achievements of the integrated health clinic, we continue to struggle with successful integration of physical and mental health:

- Only 10% of our clients are currently patients at the integrated health clinic
- Muskegon ranks last (82nd out of 82 counties) in Michigan when compared to other counties in the state in healthy behaviors
- Staff are uncomfortable addressing physical health issues with clients; often defer to nursing staff
- Staff health habits are poor and many struggle with chronic health issues
- Staff lack knowledge to reinforce healthy behaviors
- There is a lack of time, resources and opportunities for staff and individuals receiving services to focus on physical health

In response, we've developed a new program...

Let's Get...
Better Together
So much more than the average wellness program

Program Overview

- "Better Together" is funded by a Block Grant from the Michigan Department of Community Health
- Partners include:
  - Community Mental Health Services of Muskegon and Ottawa Counties
  - Public Health Muskegon County
  - Access Health
  - Hackley Health
  - Local Businesses
- Guiding Philosophy: In order to get healthier, we all need knowledge, tools, and support. We believe our staff and clients will have positive outcomes if we work together.
- Staff get trained to be health coaches and then are paired with an individual receiving services. Pairs work together and support each other to reach their health goals.
Healthy Menu of Choices

<table>
<thead>
<tr>
<th>Weight Loss &amp; Fitness</th>
<th>Mind &amp; Body Wellness</th>
<th>Smoking Cessation</th>
<th>Chronic Diseases Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Cooking Matters&quot; classes with the Health Department (includes free groceries!)</td>
<td>Stress Relief through Meditation and Mindfulness classes (Jim Johnson at Muskegon CMH)</td>
<td>Quit smoking classes available at Health Department</td>
<td>Stress Relief through Meditation and Mindfulness classes (Jim Johnson at Muskegon CMH)</td>
</tr>
<tr>
<td>Weight Loss through Hypnosis with the Health Department</td>
<td>Stress Management 101 QI for health and harmony</td>
<td>Smoking Cessation (Hackley Community Care)</td>
<td>Smoking Cessation (Muskegon CMH)</td>
</tr>
<tr>
<td>Train for your Health class</td>
<td>Dance Classes (jazz, hip hop and ballet)</td>
<td>Smoking Cessation Series (Hackley Community Care)</td>
<td>Stress Management 101 QI for Health and Harmony</td>
</tr>
<tr>
<td>Stretch for Health class</td>
<td></td>
<td>Smoking Cessation (Muskegon CMH)</td>
<td>Chronic Disease courses through Access Health</td>
</tr>
</tbody>
</table>
| Making healthy lifestyle changes classes | Plus: All participants may select a 3-6 month Curves, YMCA, Snap Fitness, Planet Fitness, Weight Watchers, or Aquatic Center Membership | Smoking Cessation through Hypnosis (Health Department) | No more side lines!

Program timeline and requirements

1. Staff participants turn in paperwork and complete 30-minute health screen with their Access Health Coach; set health goals
2. Staff begin working towards their goals and complete (2) 2 hour Health Coach trainings in early May
3. Individuals receiving services sign up and are paired with their staff Health Coach partner by early May
4. Partners have a minimum of one meaningful contact per week between May and September
5. All participants turn in "mid-point" data by June 21
6. All participants turn in "post" data by September 20
7. All participants must attend 2 Access Health trainings, one of which must be the "Health Talk"

Baseline Data

- 150 participants from Muskegon & Ottawa CMH and Hackley Community Care (75 staff and 75 people receiving services)

- Measures of success:
  - 50% of participants will have a 5% improvement in one or more of the following health measures: BMI, weight, Blood Pressure, HgbA1C, Lipids
  - 90% of all participants will have a self-management goal to improve overall health reflected in their Person Centered Plan within the 1st year
Baseline Data: Staff

- Average BMI of staff: 31.4 (obese)
- 85% of staff are overweight or obese
- Average Weight: 189.09 lbs
- Average waist circumference: 38.9 in.

Baseline Data: Consumers*

- Average BMI of staff: 34.6 (obese)
- 87% of consumers are overweight or obese
- Average Weight: 215.47 lbs

*N=39; some data missing

Quick Health Fact!

Did you know...?
Literacy skills are a stronger predictor of an individual’s health status than age, income, employment status, education level, or racial/ethnic group