Primary Care in Mental Health Settings

Anna Ratzliff, MD, PhD
Jürgen Unützer, MD, MPH, MA

With contributions from:
Wayne Katon MD, Benjamin Druss, MD, MPH,
Lori Raney, MD, John Kern, MD

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The SAMHSA/HRSA Center for Integrated Health Solutions

Providing information, experts, and resources dedicated to behavioral health and primary care integration

Online: www.CenterforIntegratedHealthSolutions.org
Phone: 202-684-7457
Email: Integration@thenationalcouncil.org
Why primary care service to mental health populations?

• High rates of physical illness in mentally ill
• Premature mortality
• Low quality of medical care to patients with mental illness
• High expense of physically ill with mental illness
• Access problems
Comorbidity of Mental Disorders and Medical Conditions

People with mental disorders: 25% of adult population

People with medical conditions: 58% of adult population

68% of adults with mental disorders have medical conditions

29% of adults with medical conditions have mental disorders

Mental Disorders and Medical Comorbidity by Druss BG and Reisinger Walker E:
(http://www.rwjf.org/pr/product.jsp?id=71883)
Original data from National Comorbidity Survey Replication, 2001-2003
Monthly Expenditures for Chronic Conditions With and Without Comorbid Mental Illnesses

Mental Disorders and Medical Comorbidity by Druss BG and Reisinger Walker E:(http://www.rwjf.org/pr/product.jsp?id=71883)
Original data from Adapted from Melek and Norris (2005 Marketscan data)
Mortality Burden of Mental Disorders

Mental Disorders and Medical Comorbidity by Druss BG and Reisinger Walker E: [http://www.rwjf.org/pr/product.jsp?id=71883](http://www.rwjf.org/pr/product.jsp?id=71883)
Original data from Adapted from Eaton et al., 2008 (literature review)

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Increased Mortality

• It is well established that persons with mental illness experience excess mortality compared with the general population
  
  • Compared to the general population, persons with major mental illness typically lose more than 25 years of normal life span. (Lutterman, 2003)
  
  • In Finland, the difference in life expectancy was 25 years less than that of a person in the general population (32.5 years vs. 57.5 years, respectively. (Tiihonen, 2009)
  
  • Persons with mental disorder die on average of 8.2 years earlier than the rest of the population (Druss, 2011)

• 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. (Parks, 2006)
Proposed Causes of Increased Mortality

Modifiable Risk Factors: Smoking, Weight and Inactivity

Social isolation

Unemployment/Poverty

Lack of access to care

Medications/Polypharmacy

Separation of medical and mental health
Non-Treatment of Medical Comorbidity: CATIE data

<table>
<thead>
<tr>
<th>Condition</th>
<th>Non-Treatment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>30.2%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>62.4%</td>
</tr>
<tr>
<td>Dyslipidemia</td>
<td>88.0%</td>
</tr>
</tbody>
</table>

Nasrallah HA et al, 2006
Changing Approach to Medical Care:

everyone wants better.

no one wants change.
Barriers to Providing Primary Health Care to Psychiatric Populations

Cultural
- Mental health staff and patients not used to incorporating primary care as part of job.

Financial
- Very rarely funded.
- Billing medical services challenging.

Motivational
- Population health issues not of interest to individual patients.
- Specialists do not cross boundaries

Organizational
- Devoting space, time, and money.

Physical
- Proximity is crucial.
- Arm’s length is best.
Mental Disorders are Rarely the Only Health Problem

- Chronic Physical Pain: 25-50%
- Smoking, Obesity, Physical Inactivity: 40-70%
- Heart Disease: 10-30%
- Cancer: 10-20%
- Diabetes: 10-30%
- Neurologic Disorders: 10-20%

Patient-centered care?
So, what do we do now?
Working Together: Many Possibilities!

Site of Care Delivery

- Primary Care Setting
- Mental Health Setting
- Co-location

How Care Delivered

- Facilitated referral from mental health center
- On-site primary care provider
- Primary care by psychiatrists
Working Together:
A Team Approach

PCP
Psychiatrist
Care Manager
Case Manager
Patient

Other Behavioral Health Clinicians
Substance Treatment
Vocational Rehabilitation
Other Community Resources

Core Team
Other Resources
### Roles for the Psychiatrist

<table>
<thead>
<tr>
<th>Co-Management</th>
<th>Manage with Primary Care Consult</th>
<th>Comprehensive Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each provider has their own caseload</td>
<td>Psychiatrist works with a care manager</td>
<td>Typically dually trained psychiatrist</td>
</tr>
<tr>
<td>PCP manages all medical problems</td>
<td>Manages a caseload of patients for BOTH mental health and basic medical health concerns using protocols from PCP</td>
<td>Provider manages both medical and mental health problems</td>
</tr>
<tr>
<td>Psychiatrist manages all mental health problems</td>
<td>PCP available for consultation and stepped care as needed</td>
<td>Limited number of providers have this expertise</td>
</tr>
<tr>
<td>Work together to re-enforce treatment plans</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All psychiatrists are responsible for “not making people sicker”.

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Experimenting: Some models developed so far

- PCARE study (Druss et al, 2010)
- Inpatient team with internist (Rubin et al, 2005)
- Facilitated referral to primary care (Griswold et al, 2010)
- Care Management - “Hot Spotters”
- TEAMcare (Katon et al, 2010)
- Missouri Medicaid Health Homes – PC and CMHC’s
- VA Programs - Three Efforts: enhanced care coordination, care manager to SMI patients and PC presence within SMI
Experimenting: Some models developed so far

• PCARE study Nurse care managers provided communication and advocacy to overcome barriers to primary medical care. (Druss, 2010)
  • Intervention group received more recommended preventive services, higher proportion of evidence-based services for cardiometabolic conditions, more likely to have a primary care provider (71.2% versus 51.9%).

• Inpatient program randomized patients to care with traditional psychiatric team vs team with internist (Rubin et al, 2005)
  • Inclusion of internist resulted in improved process and health maintenance care

• Facilitated referral to primary care randomly assigned patients to a navigator for referrals versus usual care (Griswold et al 2010)
  • Intervention group was statistically more likely to access care, versus controls
Other Program Examples and Ideas

- **TEAMcare (Katon et al, 2010)**
  - A Program for Managing Depression, Diabetes and Coronary Heart Disease in Primary Care.
  - Covers SMI to the extent that they are seen in primary care setting.

- **Missouri Medicaid Health Homes – PC and CMHC’s**
  - Per member per month payment to support Nurse care manager, admin support, health home director, physician consultant, BHC.
  - PC’s required to use BHC model and SBIRT.

- **VA Programs: Three Efforts**
  - Assigning SMI patients to a general primary care team with enhanced coordination of care with MH.
  - Assigning a care manager to SMI patients to ensure that the patients receive appropriate services.
  - Creating a full service PC presence within SMI programs. VA is implementing the medical home now and but tough to orchestrate all need services!
Primary Behavioral Health Care Initiative

- Primary Behavioral Health Care Initiative
  - SAMHSA grant – demonstration projects to improve physical health status in SMI; 64 grantees, beginning 2009.
  - Target audience Quadrant 4: Both high physical and high mental health risk.

- Better coordinate and integrate primary and behavioral health care resulting in:
  - Improved access to primary care services
  - Improved prevention, early identification and intervention to reduce the incidence of serious physical illnesses, including chronic disease

- Intervention to reduce the incidence of serious physical illnesses, including chronic disease
  - Increased availability of integrated, holistic care for physical and behavioral disorders
  - Better overall health status of clients
PBHCl: Models developed so far

None of these more than 2 years old:

• Doc on site
• Care management / coordination with primary care – like ACT.
• Use of registry [not widespread use of computerized registry]
• Wellness activities training
• Behavior change!
Principles of Integrated Care for Seriously Mentally Ill

Find Patients:
Screening, identification and determination of medical diagnoses

Track Patients:
Systematic follow-up and use of registry

Treat Patients:
- Evidence based treatment of medical and mental health conditions
- Health behavior change
- Timely treatment adjustment

Program Oversight and Quality Improvement:
Regularly review outcomes and make adjustments to program
Nuts and Bolts
Working Together: Floor plan of the future

Cortez Integrated Healthcare: Floor Plan

- Integrated Primary Care Rooms
- Integrated Provider Offices
- Integrated Behavioral Health Care Rooms
- Communal Meeting Spaces
Finding Patients

- Routine screening (Who?, Where?)
- Self referral
- Psychiatrist monitoring and referral in community mental health centers

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>4 wks</th>
<th>8 wks</th>
<th>12 wks</th>
<th>Annually</th>
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<tbody>
<tr>
<td>Review Personal / Family history of illness</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
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<tr>
<td>Weight [BMI]</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Waist Circumference</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Fasting Plasma Glucose</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Fasting Lipid Profile</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

But remember…
screening is just the start.

You cannot fatten a cow by weighing it.

~ Chinese Proverb

Who owns the information and what will you do with it?
Tracking Patients: Use of computerized registry

• This has been slow to evolve in PBHCI
• But here is an example of its use in a BHC program:
  • Track outcome data
  • Prevent falling through cracks
  • Treat to target
### Caseload Statistics

<table>
<thead>
<tr>
<th>CARE MANAGER</th>
<th># of Pt.</th>
<th>INITIAL ASSESSMENT</th>
<th>FOLLOW UP</th>
<th>LAST AVAILABLE</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>MEAN PhQ</td>
<td>MEAN HbA1c</td>
<td># of Pt.</td>
</tr>
<tr>
<td>6</td>
<td>5</td>
<td>13.8</td>
<td>8.0 (n=5)</td>
<td>5</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>15</td>
<td>5.8 (n=1)</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>5</td>
<td>18.4</td>
<td>7.2 (n=3)</td>
<td>4</td>
</tr>
<tr>
<td>0</td>
<td>-</td>
<td>-</td>
<td>- (n=0)</td>
<td>-</td>
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<tr>
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<td>4.7 (n=3)</td>
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</tr>
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<tr>
<td>8</td>
<td>8</td>
<td>15.8</td>
<td>37.5 (n=3)</td>
<td>4</td>
</tr>
<tr>
<td>0</td>
<td>-</td>
<td>-</td>
<td>- (n=0)</td>
<td>-</td>
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<tr>
<td>0</td>
<td>-</td>
<td>-</td>
<td>- (n=0)</td>
<td>-</td>
</tr>
</tbody>
</table>

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Track measurements over time, snapshot of medications and can graph outcomes.
Another view of health measurements and due dates for next measurements.
Treatments

Medical Treatments Targets
- Glucose control
- Blood pressure
- Cardiac risk reduction

Health Behavior Change Targets
- Inactivity
- Smoking cessation
- Improving dietary habits
Care Manager

• Facilitates patient engagement and education
• Manages a caseload of patients and systematically tracks treatment response
• Works closely with both primary care and mental health providers
• Supports medication management
• Provides brief, evidence-based counseling or refers to other providers for counseling services
• Reviews challenging patients with appropriate provider
• Facilitates referrals to other services (e.g., substance abuse treatment, specialty care and community resources) as needed
Working with Care Managers

Who are the care managers?

- RN, MA, ARNP, Case Managers?

What makes a good care manager?

- Organization
- Persistence
- Creativity and flexibility
- Enthusiasm for learning
- Strong patient advocate
- Willingness to be interrupted
- Ability to work in a team
# Sample Medical Treatment Protocol

<table>
<thead>
<tr>
<th>Target</th>
<th>Goal</th>
<th>Medications</th>
</tr>
</thead>
</table>
| Glucose Control      | FBG 80-120 HbA1C < 6.5    | 1) Metformin (250mg/day with dinner X 2 days, then 250mg BID for 2-3 days then 500mg BID)  
2) Insulin as needed by protocol |
| Blood Pressure       | BP < 130/80 mmHg          | 1) Home blood pressure monitoring  
2) Protocol for starting anti-hypertensive  
1) Prinzide (10mg lisinopril/12.5 HCTZ) OR  
2) Atentolol 25mg |
| Cardiac Risk Reduction | LDLc < 100                | 1) Lisinopril 10mg X 2 days then 20mg Qday  
2) Lovastatin as needed  
3) ASA enteric coated 81 or 325 mg/day unless contraindicated |

TEAMCare, Katon et al 2010
Health Behavior Change

40% of deaths in US from behavioral causes.
Rates of smoking, obesity higher in poor, SMI.

Figure 2. Numbers of U.S. Deaths from Behavioral Causes, 2000.
Among the deaths from smoking, the horizontal bar indicates the approximately 200,000 people who had mental illness or a problem with substance abuse. Adapted from Mokdad et al.\textsuperscript{12}
<table>
<thead>
<tr>
<th>Target</th>
<th>Goal</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking Cessation</td>
<td>Quit</td>
<td>Behavioral activation and smoking cessation strategies OR smoking cessation program</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Maintain Weight or 5% Weight Loss</td>
<td>DASH diet, ADA, AHA Mediterranean diet, Weight Watchers or other “healthy plan”</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>Increase current activity as able to 30 min walking/day</td>
<td>Assess past activity and brainstorm options to increase physical activity</td>
</tr>
</tbody>
</table>

TEAMCare, Katon et al 2010
Inactivity

• **IN SHAPE Health Promotion Program**
  - Manualized Intervention with Multiple Replications
  - Individualized fitness and healthy lifestyle assessment
  - Individual Meetings with a “Health Mentor”
  - Membership Vouchers to Local Fitness Centers
  - Group Health Education/Motivational “Celebrations”
  - Nurse Evaluation and Consultation

• Participants spend time each week with personal mentors working out, taking walks, in classes or working on nutrition plans.
• Mentors help participants to track their progress, set goals and stay motivated.

*Promoting Health and Functioning in Persons with SMI: CDC - R01 DD000140 (PI: Bartels)*

*Health Promotion and Fitness for Younger and Older Adults With SMI: R01 MH078052-01 (PI: Bartels)*
In SHAPE Outcomes

• Benefits for participants:
  • Increased participation in regular exercise
  • Reduced waist circumference
  • Improved satisfaction with fitness
  • Improvement in mental health functioning and negative symptoms

• Role of Meds? Role of Dietary Component?

PAR-Q & YOU

(A Questionnaire for People Aged 15 to 69)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 65 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: check YES or NO.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
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</tbody>
</table>

1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
2. Do you feel pain in your chest when you do physical activity?
3. In the past month, have you had chest pain when you were not doing physical activity?
4. Do you lose your balance because of dizziness or do you ever lose consciousness?
5. Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?
6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
7. Do you know of any other reason why you should not do physical activity?

If you answered YES to one or more questions

Yes to a FIT program

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

• You may be able to do any activity you want — as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
• Find out which community programs are safe and helpful for you.

No to all questions

If you answered NO honestly to all PAR-Q questions, you can be reasonably sure that you can:
• start becoming much more physically active — begin slowly and build up gradually. This is the safest and easiest way to go.
• take part in a fitness appraisal — this is an excellent way to determine your basic fitness so that you can plan the best way for you to be active. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

PLEASE NOTE: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional.

Ask whether you should change your physical activity plan.

© Canadian Society for Exercise Physiology
healthcanada.gc.ca

No changes permitted. You are encouraged to photocopy the PAR-Q but only if you use the entire form.

Smoking Cessation

- Interventions are worthwhile, don’t have to be complicated:
  - Unassisted quit attempt: 4-7% stop smoking. [2008 guideline]
  - Physician advice: 10.2% [2008 guideline]
  - >10 min counseling: 22% [Cochrane review]
- Nicotine Replacement Therapy increases chances of stopping smoking by 50-70% [Cochrane]
- Community interventions[smoke-free workplaces] - “limited evidence” for impact [Cochrane]
- Telephone support ( e.g., 1-800-QUIT-NOW ) effective as compared with no counseling.
- Counseling: Motivational Interviewing, CBT both effective.
- Self-help: weak effects [Cochrane and 2008 Guideline]


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Smoking Cessation Brief Intervention

• Free online programs and information:
  • [http://www.becomeanex.org/](http://www.becomeanex.org/)
  • [http://www.smokefree.gov/](http://www.smokefree.gov/)

• Quit Line
  • 1-800-QUIT-NOW
Improving Dietary Habits

• An initial weight loss goal of 5 to 7 percent of body weight is realistic for most individuals.

• Many types of diets produce modest weight loss.
  • Options include: balanced low-calorie, low-fat low-calorie, moderate-fat low calorie, low-carbohydrate diets, and the Mediterranean diet.

• Encourage a diet that reduces energy intake below energy expenditure to individual patient preferences, rather than focusing on the macronutrient composition of the diet.

• Explore community resources:
  • Example: Purdue Extension Service – absolutely free 6-8 sessions of in-home [or in, say, group home] instruction AND they cook with the patient!
How to Find Real Food at the Supermarket

1. Does it have a label? Yes/No
   - Yes: Does it make health claims? Yes/No
     - Yes: You're probably in the home improvement aisle
     - No: Was it ever alive? Yes/No
       - Yes: Does it have nutrition info? Yes/No
         - Yes: Might it contain bacon anyway? Yes/No
           - Yes: It's either a hair or household product
           - No: Are any ingredients in Latin or Sciencese? Yes/No
             - Yes: Are there more than 5 ingredients? Yes/No
               - Yes: Probably dog food
               - No: It's a dairy product? Yes/No
                 - Yes: It's food
                 - No: Run each ingredient through flowchart
         - No: Grab light bulbs for the garage
           - Do not eat
     - No: Well done, you're at the produce aisle or meat counter
         - Yes: Was it ever alive? Yes/No
           - Yes: Does it have nutrition info? Yes/No
             - Yes: Might it contain bacon anyway? Yes/No
               - Yes: It's either a hair or household product
               - No: Are there more than 5 ingredients? Yes/No
                 - Yes: Probably dog food
                 - No: It's a dairy product? Yes/No
                   - Yes: It's food
                   - No: Run each ingredient through flowchart
         - No: Grab light bulbs for the garage
           - Do not eat

2. Eat at own risk

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AIMS CENTER | Advancing Integrated Mental Health Solutions
Health Behavior Change

Many opportunities in mental health settings!

• A huge body of knowledge and expertise in behavior change is basically unknown to psychiatrists.
• A few examples of health behavior change models:
  • Health Belief/Health Action Model
  • Relapse Prevention Model
  • Health Action Process Approach
  • Motivational Interviewing
Simple Behavior Change Plan

STEP ONE:
Choose a tiny step.
(Walk one block.)

STEP TWO:
Find a spot.
(Every morning on my way to work.)

STEP THREE:
Train the cycle.
(Do it every day.)

STEP FOUR:
Assess Outcomes.
(Did it change? Any changes?)
Motivational Interviewing for Health Behavior Change

Definition

• “client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence” (Miller and Rollnick, 2002)

Evidence

• Demonstrated intervention for health behavior change:
  • Substance Use/Abuse
  • Dual Diagnosis
  • Eating Disorders/Obesity
  • Medical Co-morbidity (Cardiovascular health, Diabetes, Asthma, HIV treatment and more)
  • Health Promotion/Exercise Fitness
  • Medical Adherence
  • Depression and Anxiety
  • Smoking Cessation
  • Pain

Adapted from slides from Kari Stephens, PhD
“Of course we can’t make you do anything you don’t want to do... But we’re all headed to Dodge City and we’d like you to join us.”

Adapted from slides from Kari Stephens, PhD
Getting Started
If you build it, they will not necessarily come...

North Shore put a nurse practitioner in place → Very little business!

Why not?

- Separate FQHC registration a significant barrier.
- It turns out staff are needed to shepherd the transition, even in the same office suite.
- All CMHC staff didn’t have message repeated and repeated and repeated...
- What seems like a lot of CMHC patients is a trickle for the FQHC!
Tasks Prior to Setting Up a Program

• Financial arrangements
• Agreements with primary care providers
  • If you don’t have pre-existing relationship, they may not be that interested
  • Plan protocols and workflow
• Plan for evaluation
• Promotion, Promotion, Promotion!
Promoting the program

- PR, PR, PR
  - To Organizations
  - To Providers
  - To Patients

- Get your story straight!
  - Why should anyone care or want integration?
  - Why should anyone care about population health?
  - Need to develop tag line
    - “We need this to improve health outcomes!”
Weekly Wellness Schedule

**Monday**
12 - 12:30 p.m. Gym Exercise Group

**Tuesday**
12 - 12:30 p.m. Gym Exercise Group
1 - 2 p.m. Gym Yoga

**Wednesday**
12 - 12:30 p.m. Gym Exercise Group
3-4 p.m. D102 Relaxation Training

**Thursday**
9 - 10 a.m. Gym Yoga

**Friday**
12 - 12:30 p.m. Gym Exercise Group

For more information, contact Olga Felton, nurse care manager; Brian Fesko, peer support specialist; or Jamie Sponaugle, case manager, at 736-7297.
Regional Primary Care Initiative

Persons with mental illness die up to **25 years too soon** due to preventable health conditions.

**Regional Primary Care Initiative** now offers a nationally recognized program to bring needed primary medical services to our clients, right in our Merrillville and East Chicago centers.

- General medical care at the Regional office.
- Assistance for consumers in:
  - Medication management,
  - Healthy eating,
  - Stress management,
  - Healthy activities,
  - Stopping smoking,
  - Help negotiating the medical system.

**Talk** to your clients and peers about engaging in this program to live longer and healthier!

**Sign up today** by calling Olga at 219-99999

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The Regional Primary Care Initiative has 3 parts:

1. Provision of primary medical services directly at our Merrillville and East Chicago main centers, by our partners, the NorthShore and East Chicago Health Centers. This will make it much easier for us to coordinate our efforts.

2. Care Management:
   - Regular health screenings and monitoring by our Regional Primary Care Initiative staff, to ensure that commonly occurring conditions like diabetes or high blood pressure are treated in a timely, preventative fashion and EFFECTIVELY.
   - Assistance with negotiating the complex health care systems, to assure the best medical care is available.

3. Wellness activities: Support and training for clients to help develop skills and habits that foster good health for a lifetime.

**Talk**—obviously this should be "3", but I couldn't make it fit right.

A 4-year grant from the Substance Abuse and Mental Health Services Administration is supporting the development of this program. We are encouraged to develop original ideas to help meet our goal of better wellness for the people we serve.

This kind of case management program represents the state of the art in bringing medical care to our behavioral care.

If these programs are successful, they will lead to changes around the country in the way medical services are provided, and form an important part of health care reform—for the better! We are excited to have this opportunity; we have lots of resources to use to offer all these services, and we are eager to have our clients involved.

Any Regional client is welcome to participate in ANY PART OF THE PROGRAM, even if they do not wish to use the primary care services offered here, and want to continue with their present primary care provider.

We urge our clients and families to join with us in developing a new kind of care to make a difference here and all over the country.

**Call us, come in, we want to work together with you!**
Improve Care for Comorbid Conditions Under Health Reform

- **Financing and insurance**
  - Ensure a core health benefits package that covers care management and other evidence-based services.
  - Use Accountable Care Organizations to allow vertical integration with other components of the health care system.

- **Care delivery redesign**
  - Ensure that mental health has a room in the medical home.
  - Help mental health providers develop IT infrastructure and participate in health exchanges.

- **Fostering prevention and promotion**
Until All This Happens...

Focus on principles of care!

Find Patients:
Screening, identification and determination of medical diagnoses

Track Patients:
Systematic follow-up and use of registry

Treat Patients:
- Evidence based treatment of medical and mental health conditions
- Health behavior change
- Timely treatment adjustment

Program Oversight and Quality Improvement:
Regularly review outcomes and make adjustments to program

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Get Creative!

• Find natural primary care partner
  • A local FQHC may be thrilled with your Medicaid population.

• Other solutions by PBHCI grantees:
  • Hire own doc
  • Partner with a provider, maybe by starting BHC program, offering other consultation / support services.
  • Academic partners may be looking for someone just like you!
  • State grants – e.g., Michigan Primary Care ACT.

• Capitalize on MH case management expertise.
## Commit to Targets

<table>
<thead>
<tr>
<th>Goal</th>
<th>Target</th>
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<tbody>
<tr>
<td>Improve tracking of health outcomes</td>
<td>90% of eligible clients will have documented BMI, Hgb A1c, LDLc, and blood pressure in the last 6 months.</td>
</tr>
<tr>
<td>Improve health outcomes</td>
<td>Reduce by 25% the number and % of eligible clients with a Hgb A1c &gt; 7, a blood pressure &gt; 140/90, or LDLc &gt; 100.</td>
</tr>
<tr>
<td>Improve health behaviors</td>
<td>Reduce by 25% the number and % of clients who are smoking.</td>
</tr>
<tr>
<td></td>
<td>Increase by 25% the number and % of clients who are physically active (30 minutes or more of aerobic activity such as walking at least 4 times/ week)</td>
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Spectrum of Patient Centered Collaborative Care

- Mental Health in Primary Care Settings
- Primary Care in Mental Health Settings
Resources

For consulting psychiatrists:

- AIMS Center: http://uwaims.org
- Registry links

Resources to provide to your team:

- TEAMCare: http://www.teamcarehealth.org/
- InSHAPE
  - http://www.nytimes.com/2005/12/08/fashion/thursdaystyles/08Fitness.html?adxnnl=1&adxnnlx=1329165399-vPYyZI1j7wfft0t5lTGmlg
Primary Care in Mental Health

Settings References - I


