Community Mental Health Affiliates, Inc.
New Britain, CT – Cohort II

"If I Knew then What I Know Now…"

CMHA
Community Mental Health Affiliates

Options to Health (O2H) Mission

To improve the quality of life of CMHA adult patients with serious mental health or substance use disorders who do not have a physician in the community through access to primary medical care, wellness programs, and the integration of medical and psychiatric treatment.

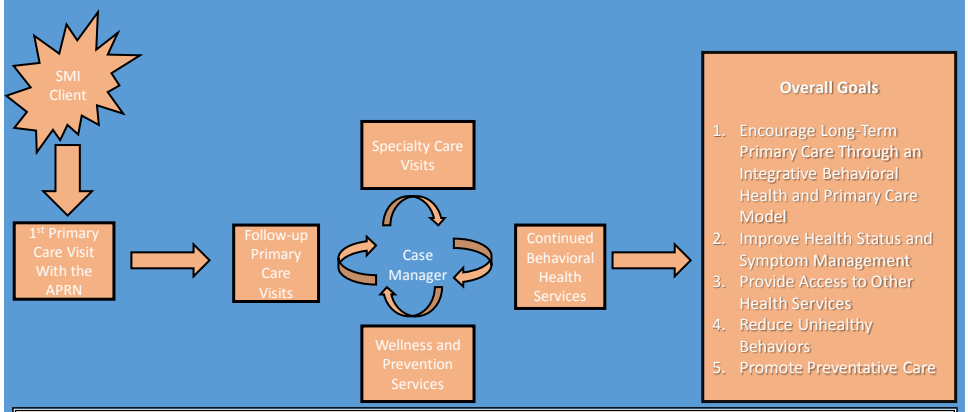
O2H Integrated Primary Care and Behavioral Health Team

The Hospital of Central Connecticut (THOCC)
- Primary Care Clinic Staff:
  - Physician Supervisor – William Rabitaille
  - APRN – Lauren McTeague

Community Mental Health Affiliates, Inc. (CMHA)
- Integrated Care Staff:
  - Project Director – Linda Filipetti
  - Project Manager – Marie Mormile-Mehler
  - Program Coordinator – Fran Cerasuolo
  - Performance Improvement Coordinator – Lisa Daley
  - Medical Case Manager
  - Medical Assistant

University of Connecticut Health Center
- Evaluator – Jane Ungemack

Options to Health Integrative Program



Primary Care: All care will be provided by an Advanced Practice Registered Nurse (APRN) with experience working with mentally ill population with the physician supervision.
Integration of Care: A case manager will work with patients to maintain appointments and communicate regularly with all medical services to ensure integrated care.
Services offered: Besides behavioral health and primary care services, the program will link participants to medical services that promote wellness, prevention and illness management. Examples of these medical services are referrals to dietitians, dentists, smoking cessation counselor, drug rehabilitation and other wellness services.
Eligibility: All seriously mentally ill (SMI) clients who either do not have a primary care provider or who are not regularly seeing primary care services.
Overall Goal: Improve access to primary care, empower and educate consumers, improve health status, and reduce unnecessary hospital utilization.

O2H: Disease Prevention & Health Promotion Programs

- ***Healthy Eating and Lifestyle***
- ***Smoking Cessation***
- ***Exercise Classes***
- ***Shopping for Healthy Food on a Fixed Income***
- ***Heart Health Tips of the Week***
- ***Diabetes: Recognizing the Signs***
- ***Wellness Week***
- ***Care Coordination***

O2H Accomplishments & Successes

- Unique partnership with THOCC, a community-based hospital; most PBHCI behavioral health grantees partnered with FQHCs
- Strong support from THOCC and CMHA leadership, clinical and administrative staff for integrated care model
- Intake data showed that one-in-three CMHA patients did not have a PCP
- CMHA changed its intake process to incorporate standardized health screening of all patients
- All clients had opportunity to enroll in O2H, although the O2H target population was patients without a PCP
- 375 clients were enrolled and received O2H services
- Increased client access to health care, including specialists, x-ray and lab services (one-stop shopping) through Primary Care Clinic site at THOCC

O2H Accomplishments & Successes

- Developed Health and Wellness Service System open to all agency clients.
- Annual Health Fairs attended by 100-200 clients and staff featuring:
  - Blood pressure, blood sugar and cholesterol screenings
  - Cooking demonstrations
  - Talks on health, nutrition and tobacco cessation
- Wellness “Walk in the Park” for 170 staff and patients
- CMHA obtained Accent TVs (Health Info) in client waiting rooms
- CMHA adopted Smoke Free Campus policy in January 2013 and a system-wide effort to promote tobacco cessation among patients and staff
- $175,000 grant from the CT Department of Public Health to provide Tobacco Cessation Services to SMI population
- SAMHSA HIT Grant of $200,000 for electronic medical record enhancements, including shared records and CCD

O2H Accomplishments & Successes

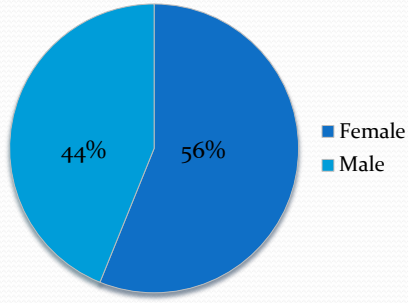
- CMHA prescribers and nurses gained access to THOCC EMR to better coordinate medical and psychiatric care
- CMHA adopted an integrated care model, breaking away from the traditional silo approach
- CMHA's experience with PBHCI led to its participation on the state Planning Committee for Behavioral Health Homes and positioned CMHA for changes in the health care system
- CMHA selected as one of Connecticut's first Behavioral Health Homes in July 2014
- Model selected for a special site study by RAND

O2H Accomplishments & Successes

- Accessed and linked THOCC data to O2H NOMS data to investigate O2H program impact on hospital services utilization, including ED, inpatient medical and inpatient psychiatric services
- Data analyses showed lower ED utilization from one year before enrollment in O2H to one year after enrollment in O2H
- Increased THOCC Outpatient Clinic staff's acceptance of treating patients with SMI
- O2H medical staff recognized by THOCC medical staff as the "go to" consultants regarding patients with SMI
- THOCC obtains direct connection with mental health treatment resources; CMHA obtains a direct connection with primary care resources for patients
- THOCC gains resource for dealing with patients with psycho-somatoform disorders
- More comprehensive, integrated care provided to patients

Demographic Characteristics of O2H Clients

Sex



Race/Ethnicity

Race	Number of Patients	Percent
White	192	55%
Black	51	15%
Hispanic	103	30%
Native American	15	4%
Asian	3	1%
Hawaiian	4	1%
Alaskan	1	<1%

Total Patients Recruited: 374 Clients

Percent of O2H Clients with Improved Health Indicators from Baseline to Most Recent Assessment

National Outcomes Measures	No Longer At-risk	Outcome Improved
Blood pressure - Systolic	16.3%	17.9%
Blood pressure - Diastolic	14.6%	4.1%
Blood pressure - Combined	17.1%	16.3%
BMI	5.0%	43.8%
Waist Circumference	3.3%	23.3%
Breath CO	6.3%	50.0%
Plasma Glucose (fasting)	13.3%	33.3%
HDL Cholesterol	0.0%	15.8%
LDL Cholesterol	0.0%	5.6%
Triglycerides	0.0%	21.1%

Percent of O2H Clients with Improved Outcomes from Baseline to Most Recent Assessment

National Outcomes Measures	Positive at 2nd Interview	Outcome Improved
Healthy overall	48.7%	15.4%
Functioning in everyday life	40.6%	45.3%
No serious psychological distress	57.8%	7.0%
Never using illegal substances	81.0%	10.2%
Not using tobacco products	28.1%	3.1%
Not binge drinking	89.9%	6.7%
Retained in the community	91.3%	12.7%
Had a stable place to live in the community	62.2%	11.0%
Attending school regularly/employed/retired	12.2%	6.5%
No involvement with criminal justice system	98.4%	2.4%
Were socially connected	59.0%	6.7%

O2H Accomplishments & Successes

- Ramon, a latino male with undiagnosed heart disease, referred by CMHA outpatient clinician to O2H 3 years ago; saw O2H APRN and got medication for cholesterol and high blood pressure. He attended nutrition, exercise, smoking cessation and behavioral health groups regularly, lost weight and had his cholesterol and blood pressure under control. He was incarcerated for a year and recently returned to CMHA and O2H.

Number of Hospital Visits Before and After Patient Enrollment in O2H

Type of Hospital Visit	In Year Before O2H Enrollment	In Year After O2H Enrollment	*P-value*
Emergency Department	821	645	0.01
Inpatient Medicine	23	32	0.20
Inpatient Psychiatric	47	40	0.49

Inpatient Days and Length of Stay Before and After O2H Enrollment

Type of Visit	Inpatient Days Before O2H Enrollment	Inpatient Days After O2H Enrollment	Average Change in Inpatient Days
Inpatient Medicine	76 Days 23 Visits **3.3 days/visit**	103 Days 32 Visits **3.2 days/visit**	0.1 days/visit
Inpatient Psychiatry	677 Days 47 Visits 14.4 days/visit	458 Days 40 Visits 11.5 days/visit	2.9 days/visit

O2H Challenges & Outcomes

- Difficulties in hiring and retaining medical staff, especially APRNs, who understand and have experience with SMI population
- Limited training for medical staff in working with SMI population
- Difficulty in engaging clients in wellness programs, particularly smoking cessation groups
- High no show rate in the primary care clinic, fluctuating between 30-50%
- Follow-up NOMS rate fluctuated between 40-60% due to difficulties in reaching clients for reassessments

O2H Challenges & Outcomes

- Difficulty getting buy-in from behavioral health care clinicians to providing integrated care model
- Overcoming social stigma from general primary care clinic staff towards SMI clients
- Accessing specialists for services, despite the project coordinator's numerous connections with them
- Chaotic hospital waiting room environment often caused patients to become agitated
- Even with additional supports, some patients had difficulties following through with health care recommendations

O2H Challenges & Outcomes

- Coordinating separate medical record systems; primary care provider using a paper record and CMHA using EMR which has own E-prescribe program.
- 2-year delay with vendor in import of CCD file from THOCC
- The NOMS mental health outcome measures and one-group study design could not discriminate between behavioral health and integrated care effects

Moving Forward

- CT Departments of Social Services and Mental Health and Addiction have designated CMHA as a "Behavioral Health Home" for 450 SMI clients annually
- The O2H project will morph into a Behavioral Health Home
- CMHA will receive BHH funding for Care Management (Nurse Care Managers) and Care Coordination under the Behavioral Health Home
- THOCC will sustain APRN services for the O2H population

Words of Wisdom: What We Wish We'd Done Differently

- Educate and obtain buy-in from your behavioral health clinicians on the value and importance of integrated care
- Enlist your medical director as a project champion
- Hire APRN staff who are experienced with and committed to the population
- Consider hiring a Nurse Care Manager (RN) vs. Medical Case Manager (BA level staff) to manage medical aspects of clients' care plans
- Add incentives for individual and group participation in wellness programs
- Make free Nicotine Replacement Therapy part of the tobacco cessation program