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# PBHCI Medical Staff Summit

Lori Raney MD
John Kern MD, Laurie Carrier MD

Grantee Meeting
August 13, 2014



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## Outline

### Morning

- How we got here
- PBHCI Requirements
- RAND Evaluations
- Recommendations
- Other Emerging Models
- Population Management
- Roles for Psychiatric Medical Teams
- Culture of Integration
- PCP – Psychiatric Provider Partnership

### Afternoon

Psychiatric – review common disorders with Laurie Carrier, MD

PCP – Review psychotropic medications with Lori Raney, MD

Group Discussion – Roles and EBPs

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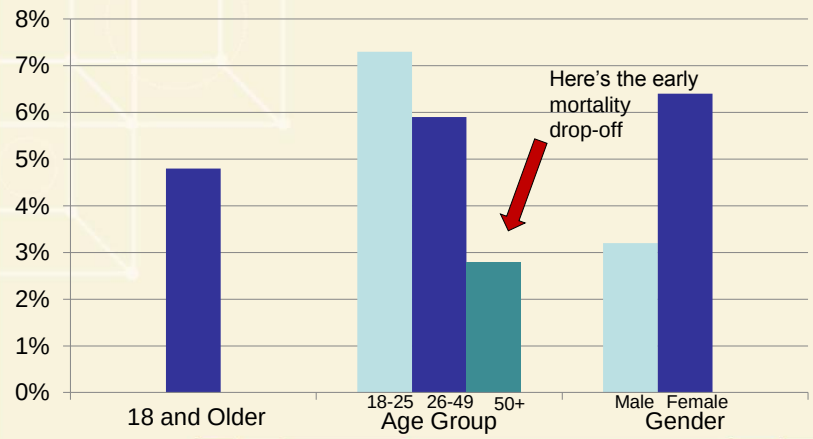
## Serious Mental Illness in the Past Year Among Adults, 18 and Over

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Data courtesy of SAMHSA
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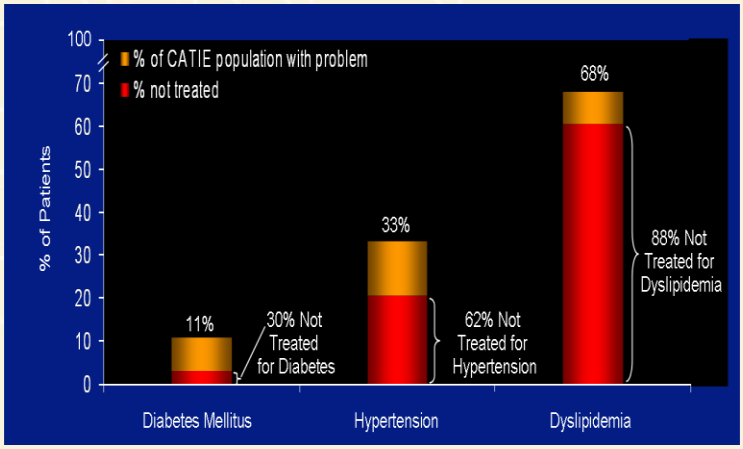
## Rates of Non-treatment




Nasrallah HA, Meyer JM, Goff DC, McEvov JP, Davis SM, Stroup TS, Lieberman JA: Schizophrenia Research 2006. 86(1-3):15-22

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## Programs Generally Contain 3 Major Components:

Primary Care Services

Care Management and Tracking

Health Behavior Change

Kern, in Integrated Care: Working at the Interface of Primary Care and Behavioral Health
Lori E. Raney, MD, editor. American Psychiatric Publishing, publication Sept 2014

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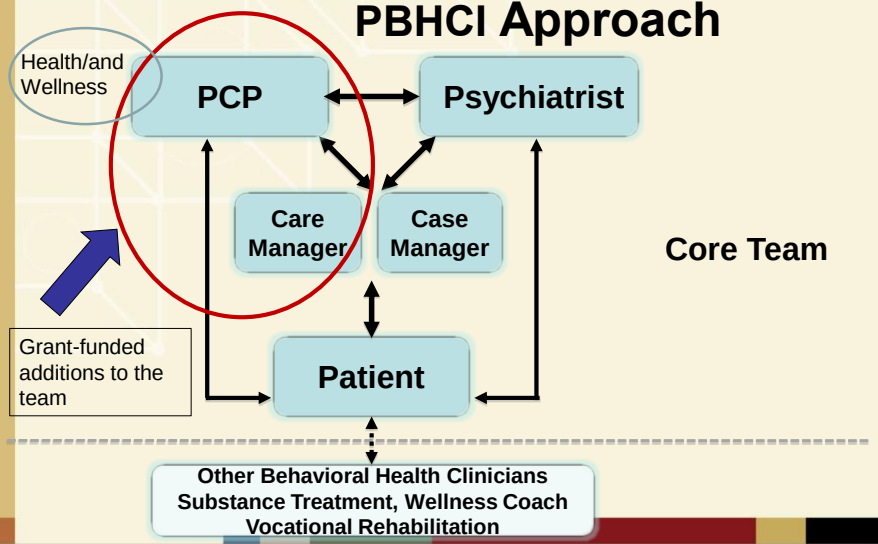
## PBHCI Approach

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## Four Core Features- Required

**Screening/referral for necessary** PC prevention and treatment, including screening/assessment/treatment and referral for hypertension, obesity, smoking, and substance abuse.

**Developing a registry/tracking** system for all PC needs and outcomes for consumers with SMI.

**Care management,** understood as individualized, person-centered planning and coordination to increase patient participation and follow-up with all PC screening, assessment, and treatment services

**Incorporation of prevention and wellness support services**, including nutrition consultation, health education and literacy, peer specialists, and self-help/management programs, into individualized wellness plans for each person receiving services through the grant.



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## Six "Optional Strategies"

**Undertake regular screening and registry tracking/outcome measurement at the time of psychiatric visits for all individuals receiving psychotropic medications**.

**Co-locate** medical nurse practitioners (NPs)/PC physicians in BH facilities whose charge is to provide routine PC services.

**Identify a PC supervising physician** within the full-scope health care home to provide consultation on complex health issues for the psychiatrist, medical NPs, and/or nurse care manager.

**Embed nurse care managers** within the PC team working in the BH setting to support specific individuals (i.e., those with significantly elevated levels of glucose, lipids, blood pressure (BP), and weight/body mass index [BMI]).

**Use evidence-based practices (EBPs**) in clinical preventive services developed to improve the health status of the general population, adapting these practices for use in the BH system.

**Create wellness programs that utilize proven methods/materials** developed for engaging individuals in managing their health conditions

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## Integrating Primary Care Into Community Behavioral Health Settings: Programs and Early Implementation Experiences

Deborah M. Scharf, Ph.D.
Nicole K. Eberhart, Ph.D.
Nicole Schmidt, M.A.
Christine A. Vaughan, Ph.D.
Trina Dutta, M.P.P., M.P.H.
Harold Alan Pincus, M.D.
M. Audrey Burnam, Ph.D.

- Registries not simple to construct – data gathering difficult
- Recruiting and retaining qualified staff -Primary care provider turnover
- Patient recruitment
- Space and licenses to do primary care

Sharf DM, et al. *Psychiatric Services.* 2013;64(7):660-665



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## PCPs who are a "good fit" for this work

- Flexible, sense of humor
- Adapts well to behavioral health environment
- Likes working with patients with mental illnesses – compassion and passion
- Enjoys being part of a team – no lone rangers
- Want to make a difference in a health disparity group
- Prefer to use data to drive care including utilizing a 'treat-to-target" approach to meet goals

*"My observations are that the key variable is a seasoned/experienced, confident provider who may not fully understand but isn't frightened or put off by issues of mental illness - we've had multiple folks fitting this description who have functioned very well in behavioral health-based primary care clinics."*

- ***PCP Curriculum soon available at CIHS***

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# Evaluation of the SAMHSA Primary and Behavioral Health Care Integration (PBHCI) Grant Program:

## Final Report

- Integrated systems of various kinds created
- Limited use of Evidence Based Practices for smoking, obesity in particular
- Not able to identify centers which functioned best
- Small clinical evaluation did not show significant effect on physical health.

Scharf, et al. 2013 Report to HHS. http://aspe.hhs.gov/daltcp/reports/2013/PBHCIfr.shtm



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## PBHCI Clinical Outcomes – N of 3, 12 months

**FIGURE 5.1. Change Trends in Case-Mix Adjusted Physical Health Indicators, Separately and Combined for Intervention/Control-Site Pairs**

| | Pair 1 | Pair 2 | Pair 3 | Combined |
|---|---|---|---|---|
| SBP | | | | |
| DBP | | | | |
| BMI | | | | |
| TC | | | | + |
| HDL-C | | | | + |
| LDL-C | | | | + |
| FPG | | | | |
| A1c | | | | |
| Trig | | | | |
| Smok | | | | |

**NOTES**: **Green** favors PBHCI, **Orange** shows no advantage for PBHCI or controls, and **Red** favors controls. A plus sign indicates a statistically significant difference ($p<0.05$) for analyses of the "at risk" sample.

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# RAND Recommendations

Needs Assessment - include systematic efforts to understand the types and extent of consumer physical health care needs, preferences, attitudes, and beliefs about integrated care; barriers anticipated, number of clients in need of care, etc

Improve Program performance through continuous quality improvement initiatives – use data to drive care, PDSA cycles

Use Evidence-based practices and measure fidelity to the practice if appropriate

Provide ongoing education to staff about the primary care services being offered to improve recruitment into the program

Hire staff that are a good fit for Integrated Care



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# Effects of Interventions to Reduce Risks of CVD – *Small* Changes Can Have Significant Impact

Blood cholesterol
- 10% ↓ = 30% ↓ in CVD (200-180)

High blood pressure (> 140 SBP or 90 DBP)
- ~ 6 mm Hg ↓ = 16% ↓ in CVD; 42% ↓ in stroke

Diabetes (HbA1c > 7)
- 1% point ↓ HbA1c = 21% decrease in DM related deaths, 14% decrease in MI, 37% decrease in microvascular complications

Cigarette smoking cessation
- ~ 50% ↓ in CVD

Maintenance of ideal body weight (BMI = 18.5-25)
- 35%-55% ↓ in CVD
- 5 – 10 % decrease can lead to "clinically significant" changes

Maintenance of active lifestyle (~30-min walk daily)
- 35%-55% ↓ in CVD

Stratton, et al, BMJ 2000
Hennekens CH. *Circulation* 1998;97:1095-1102.
Rich-Edwards JW, et al. *N Engl J Med* 1995;332:1758-1766.
Bassuk SS, Manson JE. *J Appl Physiol* 2005;99:1193-1204.

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## PCARE
## Primary Care Access, Referral and Evaluation

- PCARE study: Nurse *care managers* provided communication and advocacy to overcome barriers to primary medical care.
  - 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%).
  - *Reduction in Framingham Cardiovascular Risk Index score in intervention group:*

    *6.9% compared to usual care 9.8%*

Druss BG, et al. *Am J Psychiatry.* 2010;167(2):151-159



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## Care Management

- Facilitates patient engagement
- Identification and targeting of high-risk individuals
- Monitoring of health status and adherence – tracking outcomes in registries
- Staff and patient education
- Development of treatment guidelines
- Individualized planning with patients
- Tracks care transistions

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## Health Promotion Implementation Resource Guide: Implementation Ready Health Promotion Programs for Weight Loss

| Intervention | Author | Design | Duration | Report Clinical Signif | Results |
|---|---|---|---|---|---|
| RENEW | Brown (2011) | RCT | 6 months | | 4.4 lbs wt loss |
| SIMPLE | Jean-Baptiste (2007) | RCT | 16 weeks | ✓ | 6.4 lbs wt loss |
| In SHAPE | Bartels (In Press) | RCT | 12 months | ✓ | 49% ≥ 5% wt loss *or* clin significant fitness |
| Behavioral Therapy | Brar (2005) | RCT | 14 weeks | ✓ | 27% with ≥5% wt loss |
| HEALTH | Mangurian (2012) | Comp | 14 weeks | ✓ | 24% with ≥5% wt loss |
| Lifestyle Intervention | Wu et al (2008) | RCT | 12 weeks | | 3-10 lbs wt loss |
| DART | McKibbin (2006) | RCT | 24 weeks | | 5 lbs wt loss |
| Behavioral Wt-Loss Intervention | Daumit (2011) | Pre-Post | 6 months | | 4.5 lbs wt loss |
| Eli Lilly Solutions For Wellness | Industry Supported | 5 Pre-Post 3 RCTs | 12 weeks | | 0.1-8.7 lbs wt loss |

[1]Recovery Through Nutrition and Exercise for Wt Loss, [2]Simplified Intervention to Modify Physical Activity , [3]Lifestyle, Eating Behavior, Healthy Eating and Activity in Latinos Treated in the Heights

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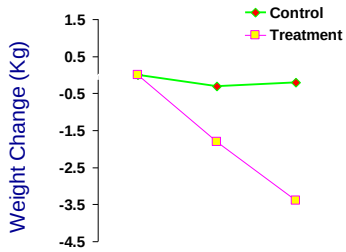
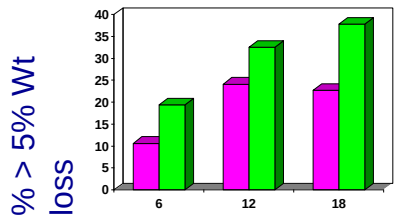
## Lifestyle Modification: ACHIEVE

- RCT (n= 291)
- SMI patients in rehab programs
- 18 months: individual + group exercise and nutrition
- 57% with schizophrenia; 82% on SGA
- Baseline BMI = 36.3
- 37.8% lost >5% IBW (compared to 22.7% of control, p = 0.0009)




*Daumit GL et al. N Engl J Med 2013; 368: 1594-1602*

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## Behavioral Weight Loss Interventions

Most likely to be effective:

- Longer duration (24 weeks)
- Manualized
- Combined education and physical activity
- Both nutrition and physical exercise
- Evidence-based (proven effective by RCTs)

Less likely to be successful:

- Briefer duration interventions
- General wellness or health promotion education only
- Non-intensive, unstructured, or non-manualized interventions

*Bartels S, et al. SAMHSA-HRSA Center for Integrated Health Solutions, 2012*

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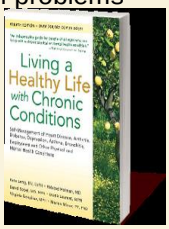
## Self Management

Programs designed to help people gain self-confidence in their ability to control their symptoms and explore how their health problems affect their lives

Stanford Self-Management Program

6 weeks, co-lead

Topics: dealing with emotions, exercise, nutrition medications, communication, decision making




Using Peers:

- HARP – Health and Recovery Peer Program – manualized, 6 session, peer led – improved activation
- WHAM – Whole Health Action Management www.samhsa.gov/health-wellness/wham (not EBP)

Schizophrenia Research Volume 118, Issues 1-3, Pgs 264-270 2010

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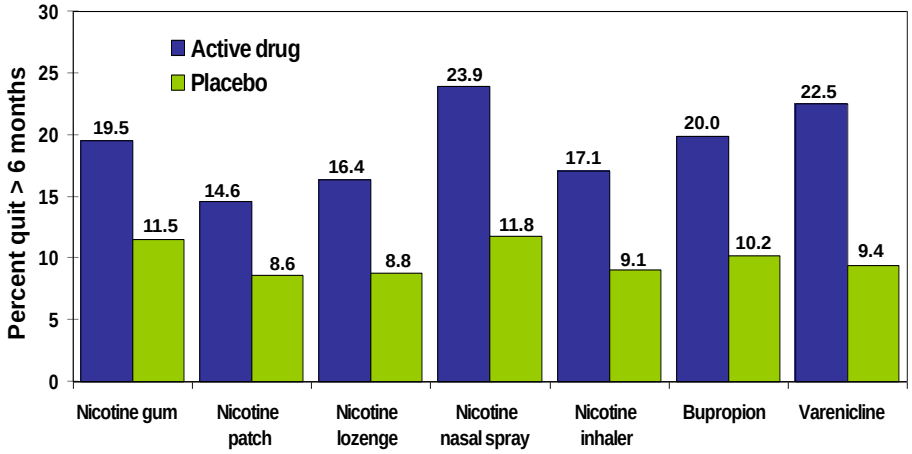
# **ASSIST:** Ready to Quit

## FDA Approved Pharmacotherapy
## LONG-TERM QUIT RATES




Silagy et al. (2004). *Cochrane Database Syst Rev;* Hughes et al., (2004). *Cochrane Database Syst Rev.;* Gonzales et al., (2006). *JAMA* and Jorenby et al., (2006). *JAMA*

# Management for specific SMI diagnoses

**Major Depression**

- NRT, Bupropion, Varenicline: Good evidence of long term abstinence

(Thomas 2013, Gierisch 2012, Hughes 2007)

**Schizophrenia**

- NRT — Insufficient data
- Bupropion — Good evidence of long term abstinence
- Varenicline — Early evidence for but unclear at 6 m

(Gibbons 2013, Tsoi 2013)

**Bipolar Disorder**

- NRT, Bupropion, Varenicline: Insufficient data
  - case reports of mania, 2 retrospective studies of smokers with mental illness (some with bipolar) showed safety

(Stapleton 2008, McClure 2010, George 2012)

# Nonfasting Labs

*Table 1*

Recommended screening guidelines and frequency for adults taking second-generation antipsychotics[a]

| Parameter[b] | Measurement Method | Abnormal cutoff | Measurement period: Baseline | 4 weeks | 8 weeks | 12 weeks | Every 3 months | Annually |
|---|---|---|---|---|---|---|---|---|
| Medical or family history | Interview | na | ✓ | | | | | ✓ |
| Weight (BMI) | Office | >7% weight gain over baseline OR ≥25 kg/m$^2$ | ✓ | ✓ | ✓ | ✓ | ✓ | |
| Waist circumference | Office | Men: 40 inches; women: 35 inches | ✓ | | | | | ✓ |
| Blood pressure[c] | Office | ≥140/90 mmHg | ✓ | | | ✓ | | ✓ |
| Nonfasting HBA1c or random plasma glucose[d,e] | Venipuncture | Diabetes, ≥6.5%; prediabetes, ≥5.7%; OR diabetes, ≥200 mg/dl; prediabetes, ≥140 mg/dl | ✓ | | | ✓ | | ✓ |
| Nonfasting TC and HDL (non-HDL=TC–HDL)[e,f] | Venipuncture | Non-HDL, ≥220 mg/dl; OR 10-year risk, ≥7.5%[g] | ✓ | | | ✓ | | ✓ |

[a] Unless noted, guidelines are unchanged from the 2004 screening guidelines issued jointly by the American Diabetes Association and the American Psychiatric Association.
[b] BMI, body mass index (kg/m$^2$); TC, total cholesterol; HDL, high-density lipoprotein
[c] Criteria for diagnosis require two measurements collected at least 1 week apart with the subject in an upright position measured over the brachial artery at the level of the heart.
[d] American Diabetes Association updated classification of diabetes diagnosis and screening (15). Criteria for diagnosis require two samples collected via venipuncture on separate days. HBA1C, glycated hemoglobin.
[e] Venipuncture is the preferred method of diagnosis. Finger-stick point-of-care testing has not been validated, and results should be interpreted with caution or verified with venipuncture.
[f] American College of Cardiology and American Heart Association updated guideline on screening and diagnosis of dyslipidemia (13)
[g] Risk calculators are available online (23).

Vanderlip, et al Nonfasting Screening for Cardiovascular Risk Among Individuals Taking Second Generation Antipsychotics. Psychiatric Services, Vol. 65 No. 5. 573 - 576

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## Daily Huddles

Plan for changes in the workflow, manage crises before they arise

Share details of care being provided by individual members so you have a more comprehensive picture of the patient

Who needs rescreening?

Who is not improving?

Decide if labs, reports, etc are available and who needs extra intervention

Check for openings - might be able to get someone in?

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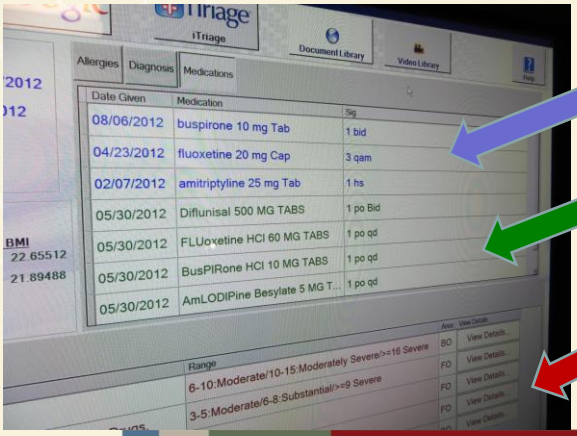
# Blending 3 Data Streams: Dashboard




Carelogic

Intergy "Sage"

Patient Tools

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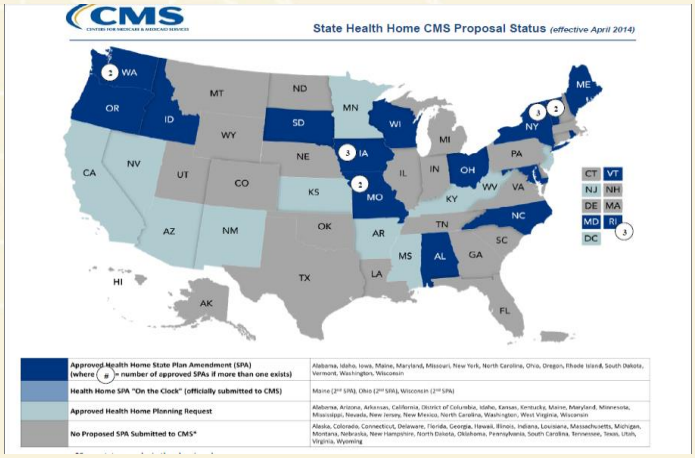
# 2703 Medicaid State Plan Amendments

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## Six Required Services (no Primary Care)

- Individual and Family Support
- Comprehensive Care Management
- Care Coordination
- Referral to Community and Social Support Services
- Health Promotion
- Comprehensive Transitional Care



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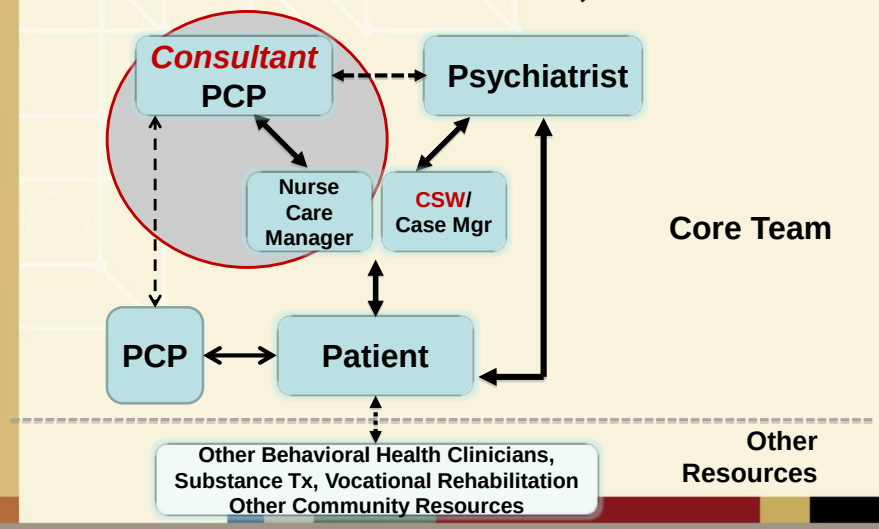
## Health Home Team – Missouri, Ohio



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## Consultant PCP Duties

1. Case Consultation – Care managers, psychiatric providers, etc
2. Collaboration with staff/outside providers
3. Population management
4. Education – medical and non-medical

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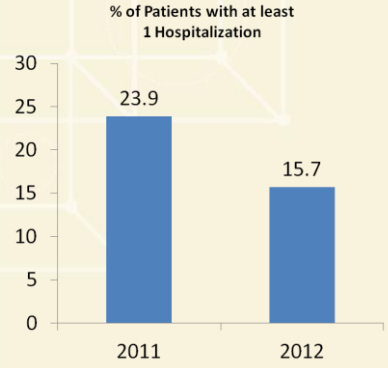
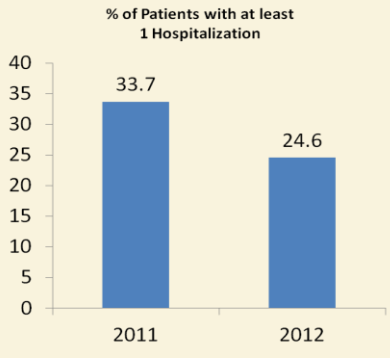
Outcomes

## Reducing Hospitalization




Primary Care Health Homes




CMHC Healthcare Homes

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## HOME (Health Outcomes Management and Evaluation) Study

- 300 patients with SMI and at least one chronic condition: DM, HTN, Dyslipidemia, Heart Disease
- Randomized usual care or intervention
- Partner with FQHC on site
- "Integrated Care Community" (ICC) will provide care for both the index cardiometabolic conditions and common acute and chronic comorbidities
- Medical outcomes and budget analysis

Druss, NIMH funded. http://clinicaltrials.gov/ct2/show/NCT01228032



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## Certified Community Behavioral Health Clinics (CBHC)

*Excellence in Mental Health Act – passed March 31, 2014*

Scope:

Screenings and Monitoring of Key Health Indicators and Risk

Care Management

Partnerships with FQHCs for physical health

Evidence-Based Practices

Robust evaluation of 8 pilots – Start date Sept 2015

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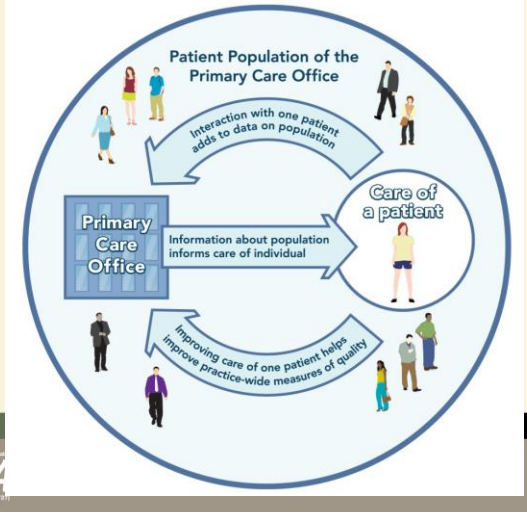
## Bidirectional connection: between the individual patient and practice population

- Interaction with one patient adds to data on a population
- Information about a population informs care of the individual patient.
- Improving care of one patient helps improve measures of quality and long- term patient outcomes across a practice's patient population

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## Population-based Care: Analyzing Aggregate Data

Identify high risk individuals in need of immediate attention

Select chronic disease, cohort of consumers and interventions most likely to have the greatest effect on improving the management of chronic disease

Choose the initiative most likely to have significant impact and use to focus educational efforts

(EMR, payment, pharmacy data, registries, etc)

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# Metrics – HEDIS

| CLID | Description | Flagged | OK | % Flagged | % OK | | Goal | Var |
|---|---|---|---|---|---|---|---|---|
| DM01 | Use of inhaled corticosteroid medications by persons with a history of COPD (chronic obstructive pulmonary disease) or Asthma. | 54 | 48 | 52.94 | 47.06 | 52.94 47.06 | 70 | -22.94 |
| DM02 | Use of ARB (angiotensin II receptor blockers) or ACEI (angiotensin converting enzyme inhibitors) medications by persons with a history of CHF (congestive heart failure). | 6 | 8 | 42.86 | 57.14 | 42.86 57.14 | 70 | -12.86 |
| DM03 | Use of beta-blocker medications by persons with a history of CHF (congestive heart failure). | 8 | 6 | 57.14 | 42.86 | 57.14 42.86 | 70 | -27.14 |
| DM04 | Use of statin medications by persons with a history of CAD (coronary artery disease). | 12 | 5 | 70.59 | 29.41 | 70.59 29.41 | 70 | -40.59 |
| DM05 | Use of H2A (histamine 2-receptor antagonists) or PPI (proton pump inhibitors) medications for no more than 8 weeks by persons with a history of GERD (gastro-esophageal reflux disease). | 73 | 81 | 47.40 | 52.60 | 47.4 52.6 | 50 | 2.60 |
| DM06 | Presence of a fasting lipid profile within the past 12 months for patients with CAD (coronary artery disease). | 12 | 5 | 70.59 | 29.41 | 70.59 29.41 | 70 | -40.59 |
| DM07 | Presence of a DRE (dilated retinal exam) within the past 12 months for patients with diabetes mellitus. | 75 | 51 | 59.52 | 40.48 | 59.52 40.48 | 70 | -29.52 |
| DM08 | Presence of a urinary microalbumin test within the past 12 months for patients with diabetes mellitus. | 103 | 23 | 81.75 | 18.25 | 81.75 18.25 | 70 | -51.75 |
| DM09 | Presence of at least 2 hemoglobin A1C tests within the past 12 months for patients with diabetes mellitus. | 81 | 45 | 64.29 | 35.71 | 64.29 35.71 | 70 | -34.29 |
| DM10 | Presence of a fasting lipid profile within past 12 months for patients with diabetes mellitus. | 80 | 46 | 63.49 | 36.51 | 63.49 36.51 | 70 | -33.49 |

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# Registry Example: Diabetes

Invert Layout | Graph | Print | Close

Flowsheet - Diabetic Flowsheet

| Date | 05/16/2012 | 04/27/2012 | 01/25/2012 | 10/24/2011 | 07/22/2011 | 05/20/2011 | 01/07/2011 | 12/01/2010 | 10/06/2010 |
|---|---|---|---|---|---|---|---|---|---|
| HEMOGLOBIN A1C | 6.4 | 6.5 | 6.3 | 6.4 | 6.4 | | | 5.8 | |
| Microalb/Creat Ratio | | 6.9 | | | 5.6 | | | | |
| Triglycerides | 172 | 182 | | | 111 | | 128 | | 185 |
| HDL Cholesterol | 27 | 26 | | | 31 | | 28 | | 28 |
| LDL Cholesterol Calc | 57 | 53 | | | 65 | | 46 | | 104 |
| Cholesterol, Total | 118 | 115 | | | 118 | | 100 | | 169 |
| LDL/HDL Ratio | 2.1 | 2.0 | | | 2.1 | | 1.6 | | 3.7 |
| VLDL Cholesterol Cal | 34 | 36 | | | 22 | | 26 | | 37 |
| Blood Pressure | 136/84 | 152/86 | 140/86; 13... | 122/78 | 130/78; 13... | 124/77 | | 122/70 | |
| Weight | 275.40 lbs | 275 lbs | 277.80 lbs | 278 lbs | 280.60 lbs | 279.60 lbs | | 286.60 lbs | |
| FOOT EXAM PERFORMED | | | | | | | | | |
| FLU VACCINE, (3yrs & older, Medicare) | | | | Performed:... | | | | Performed:... | |
| PNEUMOCOCCAL VACCINE | | | | | | Performed:... | | | |
| ZOSTER VACC, SC | | | | | | | | | |

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## DIABETES DATA

| | ALL PROVIDERS | Provider A | Provider B | Provider C | Provider D | Provider E | All providers Aug-08 |
|---|---|---|---|---|---|---|---|
| DM Pt's A1C <7.0, **GOAL 40%** | 48% | 51% | 41% | 43% | 61% | 0% | 47% |
| DM Pt's A1c <9.0, **GOAL 68%** | 75% | 80% | 72% | 78% | 70% | 100% | |
| DM Pt's, BP <130/80, **GOAL 25%** | 35% | 41% | 32% | 47% | 21% | 0% | |
| DM Pt's, LDL <100 mg/dl, **GOAL 36%** | 42% | 42% | 44% | 35% | 42% | 100% | 27% |
| DM Pt's Annual Dilated Eye exam, **GOAL 40%** | 7% | 9% | 3% | 4% | 9% | 100% | 0% |
| DM Pt's Annual Foot Exam, **GOAL 80%** | 96% | 93% | 95% | 100% | 91% | 100% | 24% |
| DM Pt's Annual Nephropathy, **GOAL 80%** | 95% | 93% | 92% | 100% | 94% | 100% | 24% |
| DM Pt's Smoking Status documented and/or advised Treatment, **GOAL 80%** | 93% | 96% | 92% | 96% | 94% | 100% | 55% |

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## Roles for Psychiatrists

### Co-Management

- Each provider has their own caseload
- PCP manages all medical problems
- Psychiatrist manages all mental health problems
- Work together to re-enforce treatment plans
- Psychiatrist screens for medical problems
- Same site or different
- Facilitated referral

### Manage with Primary Care Consult

- Psychiatrist works with a nurse care manager
- Manages a caseload of patients for BOTH mental health and basic medical problems
- Utilize protocols from PCP
- PCP available for consultation and stepped care as needed
- Outside PCP care continued

### Comprehensive Management

- Typically dually trained psychiatrist
- One provider manages both medical and mental health problems
- Limited number of providers have this expertise

**All psychiatrists are responsible for "not making people sicker"**

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## What can Psychiatrists Do to Improve the Heath Status of SMI population?

- Minimizing metabolic effects of psychotropic medications
- Screening for cardiometabolic risk factors – APA/ADA 2004 guidelines
- Counseling for lifestyle issues
- Treating some basic medical conditions?
- ***Attention to all medical conditions***

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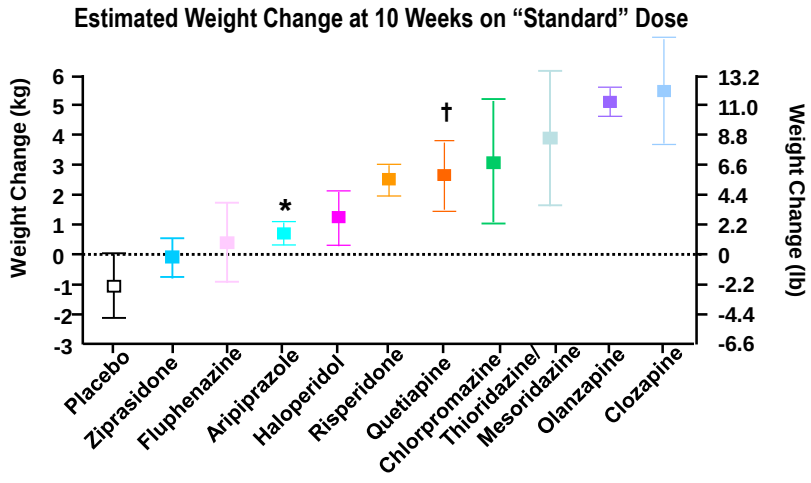
## Mean Weight Change With Antipsychotic Medications




*4–6 week pooled data (Marder SR et al. *Schizophr Res*. 2003;1;61:123-36; †6-week data adapted from Allison DB, Mentore JL, Heo M, et al. *Am J Psychiatry*. 1999;156:1686-1696; Jones AM et al. ACNP; 1999.

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## ADA/APA Screening Guidelines for Second Generation Antipsychotics

| | Baseline | 4 wks | 8 wks | 12 wks | Annually |
|---|---|---|---|---|---|
| Review Personal / Family history of illness | X | | | | X |
| Weight [BMI] | X | X | X | X | X |
| Waist Circumference | X | | | X | X |
| Blood Pressure | X | | | X | X |
| Fasting Plasma Glucose | X | | | X | X |
| Fasting Lipid Profile | X | | | X | X |

American Association of Clinical Endocrinologists, North American Association for the Study of Obesity: Consensus development conference on antipsychotic drugs and obesity and diabetes. Diabetes Care 2004; 27:596–601

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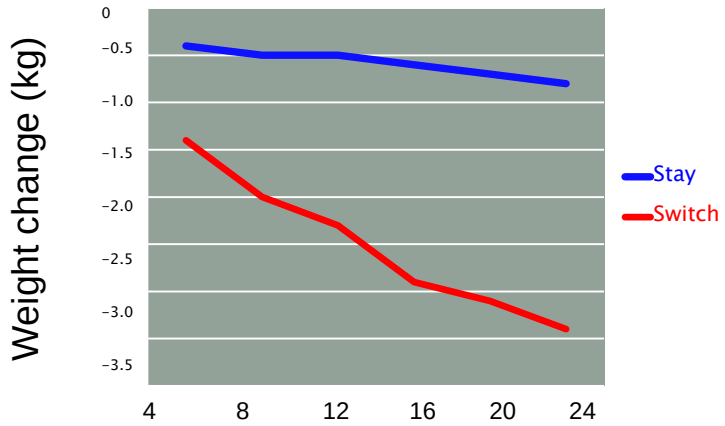
## Switch to Reduce Metabolic Risk (CAMP)




*Stroup TS, et al. Am J Psychiatry 2011; 168: 947-956*

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# Psychiatrists Prescribing SGAs

*Agents with higher cardiometabolic risk were prescribed to over 75% of individuals with cardiometabolic disorders*

- *Efficacy
- *Less sedation/more sedation
- *Patient preference
- Low incidence of extra pyramidal symptoms
- Low incidence of tardive dyskinesia
- Cannot tolerate alternatives

Hermes, et al. Prescription of Second Generation Antipsychotics: Responding to Treatment Risk in Real World Practice, Psychiatric Services Vol 64, No 3, 2013

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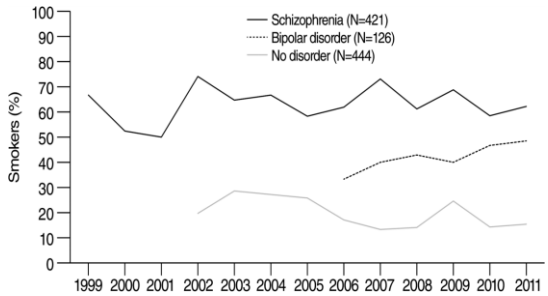
**From: Cigarette Smoking Among Persons With Schizophrenia or Bipolar Disorder in Routine Clinical Settings, 1999–2011**

Psychiatric Services. 2013;64(1):44-50. doi:10.1176/appi.ps.201200143



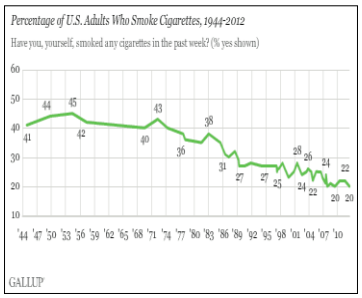




**Figure Legend:**

**Percentage of smokers by diagnostic group and year of enrollment[aa]Data are not shown for the bipolar disorder sample prior to 2007 or for the control group (no psychiatric illness) for 2004 because N<10 for each of these years for these groups. Number of persons in each of the other groups, by year, follows. For schizophrenia: 1999, 15; 2000, 21; 2001, 10; 2002, 27; 2003, 34; 2004, 15; 2005, 48; 2006, 21; 2007, 26; 2008, 49; 2009, 77; 2010, 41; 2011, 37. For bipolar disorder: 2007, 15; 2008, 14; 2009, 20; 2010, 30; 2011, 33. For the no-disorder control group: 2002, 71; 2003, 28; 2005, 66; 2006, 35; 2007, 45; 2008, 64; 2009, 61; 2010, 35; 2011, 39**



Dickerson, 2013

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## Tobacco Cessation and Psychiatrists

- Smoking contributes to half the deaths in SMI population, DSM V diagnosis
- Psychiatrists counsel patients less frequently regarding cessation – <15% vs 90% for PCPs
- Education issue? Reluctance? Belief not interested in quitting?

***Partnerships with PCPs could be helpful***

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## Treatment

Existing treatments are effective in patients with SMI, and do not worsen psychiatric symptoms

- Varenicline most effective
- Can mix patches and bupropion
- Can smoke with patches – FDA changed package insert 2013
- Initiate cessation inpatient
- Start NRT 2 weeks before quit date

**Previous**

*Drug Facts Labeling*

***Warnings***
**Do not use.**
- If you continue to smoke, chew tobacco, use snuff, or use a different NRT product or other nicotine-containing products

***Directions***
- Stop smoking completely when you begin using the NRT product
- It is important to complete treatment. Stop using the NRT product at the end of a specified number of weeks. If you still feel the need to use the NRT product, talk to your doctor

**Current**

*Drug Facts Labeling*

***Warnings***
**None.**
The "Do not use" statement has been removed.

***Directions***
- Begin using the NRT product on your quit day
- It is important to complete treatment. If you feel you need to use the NRT product for a longer period to keep from smoking, talk to your healthcare provider

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# Psychiatrists Treating Some Common Medical Conditions

- Joint APA/AMP Position Statement
- Courses
- Standards
- PCP Collaboration
- Prevention in Psychiatry – McCarron, et al Fall 2014




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# Anti- Hypertensive Dosing Guideline

| | | |
|---|---|---|
| **1st LINE: Thiazide Diuretics**<br><br>**Unless have CHF, DM, Chronic Kidney Dz** | **HCTZ 12. 5 mg, 25 mg, 50 mg (max)**<br><br>**Chlorthalidone 25 mg (max)** | **QD dosing, Check electrolytes 4-6 weeks, then q 3 mos, then annually**<br>**Add second agent if partial response**<br>**$ 4 list - both** |
| **2nd LINE: ACE Inhibitors**<br><br>1st line for above dx | Lisinopril 5mg, 10 mg<br><br>Enalapril 2.5mg, 5 mg, 10 mg, 20 mg | Start at 5-10 mg/day and titrate up to as much 40 mg per day.<br>Check electrolytes 8-10 weeks. Stop if CR > 2.5<br>Once a day, dry cough, elev CR, angiodema, facial swelling, do not use in pregnancy<br>$ 4 list |
| **3rd LINE: Calcium Channel Blockers** | Amlopidine 2.5 mg, 5 mg, 10 mg (max)<br>Nifedipine LA 30 mg, 60 mg, (max 90 mg ) | Very potent, if adding as 3rd agent call PCP first! can cause peripheral edema |
| **4th LINE: Beta Blockers** | Metoprolol succinate (XL) 25, 50, 100, 200<br>(200 mg max) | Once a day, Do not give if Pulse <55, 25 – 100 mg/day usual, can go to max 200 mg |
| **** Remember BP 139/89 is fine for all patients** | **Adjust meds q 2 weeks, follow q 3-6 mos once stable** | **If K+ falls below nl and BP responding, add 10 meq K+ up to total dose 20 mg** |

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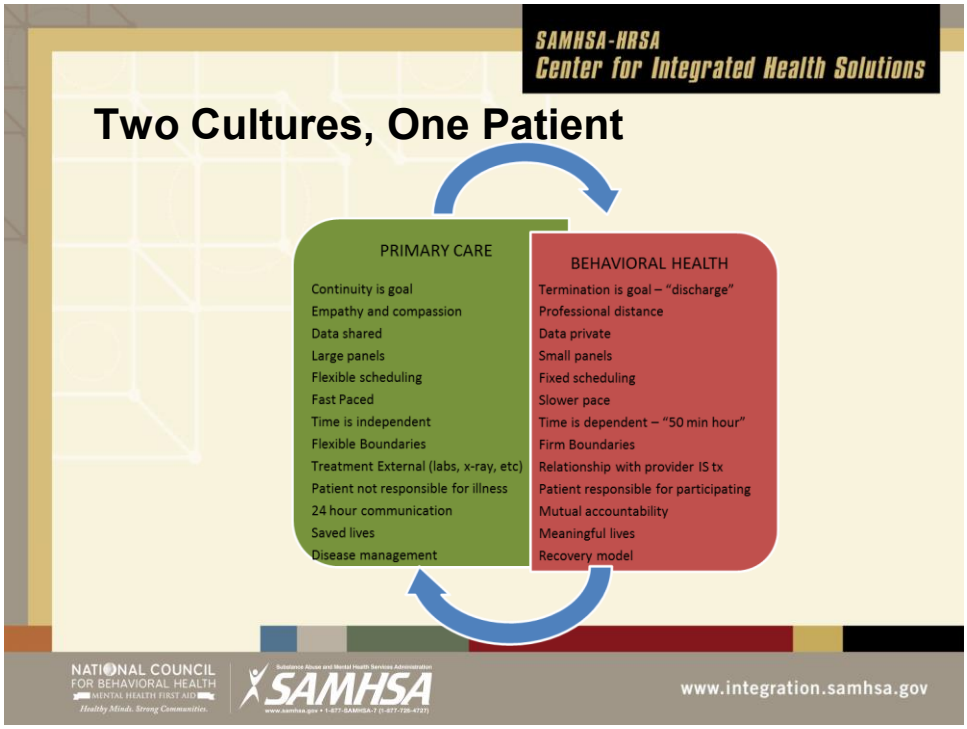



PSYCHIATRIC SERVICES

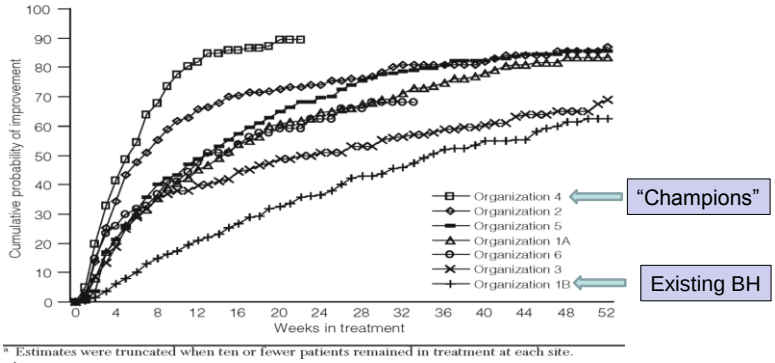
psychiatryonline

**From: Implementation of Collaborative Depression Management at Community-Based Primary Care Clinics: An Evaluation**

Psychiatric Services. 2011;62(9):1047-1053. doi:10.1176/appi.ps.62.9.1047

***Figure 1***

Estimated time elapsed between initial assessment and improvement of depression during the first year of treatment at six organizations[a]




[a] Estimates were truncated when ten or fewer patients remained in treatment at each site.

**Figure Legend:**
**Estimated time elapsed between initial assessment and improvement of depression during the first year of treatment at six organizations**

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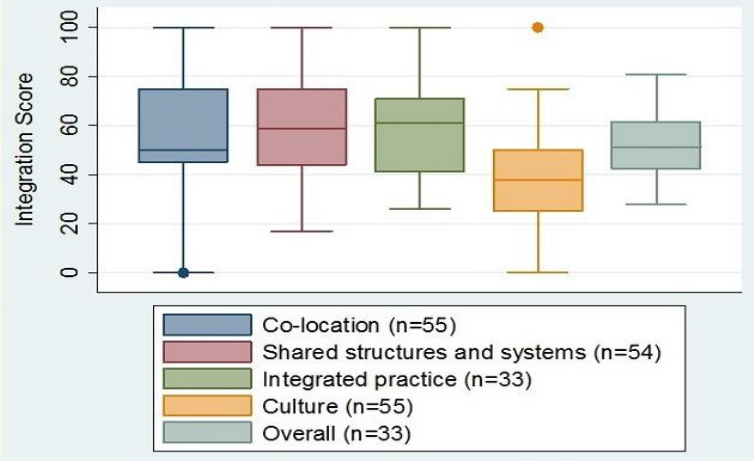
## Integration Scores for 53 PBHCI Grantees




Collaboration on Tx Plans

Collaboration on Goals

Overall Leadership Collaboration

Overall Provider Collaboration



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## Culture Data

TABLE 3.5 (*continued*)

| Dimension | Services | Level Details | Level of Integration N (%) High | Med | Low | Missing |
|---|---|---|---|---|---|---|
| Culture[d] | PC-BH collaboration on treatment plans | **High**: More than 80% of respondents describe collaboration on treatment plans as "close" or "usual"<br>**Med**: 50%-80% describe collaboration as above<br>**Low**: Less than 50% | 1 (2) | 10 (18) | 42 (76) | 2 (4) |
| | PC-BH collaboration on consumer goals | **High**: PC and BH work together on specific goals for more than75% of PBHCI consumers<br>**Med**: For 50%-75% of consumers<br>**Low**: For less than 50% of consumers | 11 (20) | 34 (62) | 10 (18) | 0 (0) |
| | Overall PC-BH leadership collaboration | **High**: More than 80% of respondents report no challenges related to PC-BH leadership shared decisionmaking<br>**Med**: 50%-80%<br>**Low**: Less than 50% report no barrier | 14 (25) | 23 (42) | 18 (33) | 0 (0) |
| | Overall PC-BH provider collaboration | **High**: more than 80% of respondents report no challenges related to PC-BH provider shared decisionmaking<br>**Med**: 50%-80%<br>**Low**: Less than 50% report no barrier | 14 (25) | 18 (33) | 23 (42) | 0 (0) |

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## Principles of Team-Based Heath Care

| Principles | Personality Traits |
|---|---|
| Shared goals | Honesty |
| Clear roles | Discipline |
| Mutual trust | Creativity |
| Effective communication | Humility |
| Measurable processes and outcomes | Curiosity |

Mitchell, et al 2012, Institute of Medicine, Washington, DC.
www.iom.edu/tbc

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## Elements of High Functioning Integrated Care Teams

- Leadership and organizational commitment to integrated care
- Time and energy for team development
- Team processes worked out to foster integration
- Commitment to outcomes

Lardieri, Lasky, Raney 2014:
http://www.integration.samhsa.gov/workforce/team-members

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## PCP ROLES

- Establish Priorities with Data
- Education
- Develop Collaborative Relationships
- Case Consultation

## PSYCHIATRIST ROLES

- Medical Leadership
- Shared Medical Oversight
- Collaboration with other Team Members in Comprehensive Care Management


Missouri Physician Summits 2012 and 2013

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## END

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