RN Primary Care Manager in Behavioral Health Settings

Integrated Care and the Expanding Role of Nurses

Seattle Airport Marriott, SeaTac, WA
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The Healthier Washington Practice Transformation Support Hub
Welcome & Introductions

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Medical Co-Morbidities in Populations with Serious and Persistent Mental Illness (SPMI)

Session 1
Learning Objectives

• Understand the impact of medical comorbidity on patients with serious mental illnesses

• Describe evidence-based treatment approaches for reducing cardiometabolic risk in this population

• Identify the roles for nurses in integrated care models, including behavioral health homes
The Problem: Premature Mortality

- Adult Medicaid enrollees with schizophrenia have a reduced life expectancy that is, on average, 25 years shorter than the general population.

- They are more than 3.5 times as likely to die of cardiovascular disease.
Increased Rates of Chronic Diseases

National Cardiometabolic Screening Program (2005-2008), n = 10,084 at 100 CMCHs

- Obesity
  - 27% were overweight; 52% were obese

- Dyslipidemia
  - 45% had TG > 150 mg/dl
  - 35% had total
  - 33% had FBG > 100 mg/dl

- Hypertension
  - 51% had BP > 130/85 mm Hg

Correll CU et al Psychiatr Services 2010; 61: 892-898
Impact of Schizophrenia on Diabetes

- Prevalence of T2 DM = 11.3% (US population = 8%)¹
- Increased rates of diabetes complications²
- More diabetes-related hospitalizations³
- More hospitalizations for ambulatory care sensitive conditions⁴
- Increased risk of re-hospitalization for T2DM in 30 days⁵
- Increased diabetes-specific mortality³

⁴Druss BG, et al. Med Care 2012; 50(5): 428-433
⁵Chwastiak L, et. al. Psychosomatics 2014; 55(2): 134-143
MH Disorder as Predictor of High Cost

Melek et al Milliman Inc, 2013

Private Sector | Medicare | Medicaid

No Mental Disorder | Any Mental Disorder

$0  $200  $400  $600  $800  $1,000  $1,200  $1,400  $1,600
Contributing Factors

• **Individual**
  - Psychiatric symptoms
  - Health behaviors
  - Poverty
    - Limited resources
    - Competing priorities

• **Provider/treatment**
  - Metabolic effects of medications
  - Inadequate training and time
  - Lesser quality of care for medical conditions

• **System**
  - Fragmentation of physical health and mental health services and funding
Obesity

Prevalence of Current Smoking

- Schizophrenia
- Bipolar Disorder
- Any psychiatric illness
- No Psychiatric Illness

Dickerson F, et al., Psychiatr Serv 2013; 64 (1): 44
Impact of Antipsychotic Medications

Estimated Weight Change at 10 Weeks on “Standard” Dose

Low Rates of Treatment for Medical Problems at Baseline in CATIE Phase 1 Trial

- The standards of care for managing patients with schizophrenia extend beyond psychiatric treatment

## Quality of Diabetes Care

<table>
<thead>
<tr>
<th>HEDIS measure</th>
<th>Any MH Dx, %</th>
<th>No MH Dx, %</th>
<th>Adjusted OR</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c</td>
<td>43.8%</td>
<td>47.0%</td>
<td>0.88 (0.86-0.89)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Eye exam</td>
<td>51.1</td>
<td>58.9</td>
<td>0.73 (0.72-0.74)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>LDL screening</td>
<td>24.4</td>
<td>26.9</td>
<td>0.88 (0.86-0.89)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Medical attention for nephropathy</td>
<td>12.0</td>
<td>12.4</td>
<td>0.96 (0.94-0.99)</td>
<td>0.0023</td>
</tr>
<tr>
<td>At least 2 HEDIS measures</td>
<td>38.4</td>
<td>42.8</td>
<td>0.83 (0.82-0.85)</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

Druss BG, et.al. Medical Care 2012; 50(5): 428-433
What Can Reduce CVD Risk?

Meta-analysis for AHRQ: 33 RCTs from 1980-2012\(^1\)
  • 28 studies addressed weight
  • One weight loss study of Schizophrenia and Diabetes\(^2\)

Comprehensive review for NIMH\(^3\) (80 of 108 studies related to obesity)
  • Strong evidence for use of four interventions
    – Metformin for obesity
    – Lifestyle modification for obesity
    – Bupropion for tobacco cessation
    – Varenicline for tobacco cessation

\(^2\)McKibbin CL, et al. Schizophr Res. 2006 Sep;86(1-3):36-44.
\(^3\)McGinty EE et al. Schizophr Bull. 2016 Jan;42(1):96-124
2014 Treatment Guidelines for Schizophrenia (UK NICE)

• Routinely monitor weight and metabolic indicators of morbidity.
• Combined healthy eating and physical activity program
• Offer relevant interventions for rapid or excessive weight gain, abnormal lipid levels or problems with blood glucose management
• Consider interventions for smoking cessation:
  • NRT; Bupropion, Varenicline
Counseling by CMHC Clinicians (n=154)

- The majority of clinicians do not provide specific counseling on three CVD risk factors.
- Healthier clinicians may be more likely to explicitly support healthy behaviors in clients.
- Clinicians who had training were more likely to counsel.

Chwastiak LA et al Psychosomatics 2013; 54: 328-335
### Primary Care Nurse Manager (PCARE)

<table>
<thead>
<tr>
<th></th>
<th>Usual Care</th>
<th>Intervention Group</th>
</tr>
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<tbody>
<tr>
<td>Preventive Services</td>
<td>21.8%</td>
<td>57.8%</td>
</tr>
<tr>
<td>Cardiometabolic Interventions</td>
<td>27.7%</td>
<td>34.9%</td>
</tr>
<tr>
<td>Have Primary Care Provider</td>
<td>51.9%</td>
<td>71.2%</td>
</tr>
<tr>
<td>Framingham Risk Index</td>
<td>9.8%</td>
<td>6.9%</td>
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</table>

- RCT,
- N= 407 with SMI
- One year

PCARE: Care Management Roles

- Identify high-risk individuals
- Patient education
- Individualized planning with patients
- Facilitate patient engagement
- Monitoring of health status and adherence
- Track outcomes in registries
- Track care transitions
# Integrating Care: Three Models

<table>
<thead>
<tr>
<th>Facilitated Referral</th>
<th>Co-located partnership</th>
<th>“In House”</th>
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<tbody>
<tr>
<td>BHA assures coordination of PC services, which are provided off-site</td>
<td>BHA arranges for a PC org to provide PC services—or a PC clinic-- on-site at the BHA</td>
<td>BHA provides its own full array of PC services (BHA = FQHC)</td>
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<tr>
<td>PCARE model</td>
<td>SAMHSA PBHCI</td>
<td>Cherokee</td>
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National Demonstration of Integrated Care (SAMHSA PBHCI)...

- Primary Behavioral Health Care Initiative [PBHCI]
- 200+ CMHC’s in US over eight years.
  - Co-location of primary care
  - Use of registry
  - Care management
  - Health behavior change
...Did Not Improve Care or Outcomes

<table>
<thead>
<tr>
<th></th>
<th>Pair 1</th>
<th>Pair 2</th>
<th>Pair 3</th>
<th>Combined</th>
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<tr>
<td>SBP</td>
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<td>DBP</td>
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<td>HDL-C</td>
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<td>FPG</td>
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Challenges

• No consistent care model
  – Variability in outcomes and quality of care
  – Hard to scale
• Primary care services were often not financially sustainable
• Nurse care manager role was not sustainable when grant funding ended
• Co-located is not the same as integrated
Integration Scores for PBHCI Grantees: Culture was Lowest
HOME Research Study (RCT)

- N = 447 patients with SMI and 1+ CVD risk factors
  - Primary outcome: 10-year CVD risk
- Behavioral Health Home vs usual care
  - Part-time PC ARNP + full-time RN care manager supervised by FQHC medical director
- Among those with diabetes and hypertension, those in BHH were more likely to receive pharmacotherapy
- BHH more likely to receive preventive care services
- No difference in clinical outcomes

(Medicaid) Behavioral Health Homes

• The ACA created a new option for state Medicaid programs to provide health homes for enrollees with chronic conditions, including behavioral health conditions
  • Became effective 1/1/2011
• Program provides financial incentives for states
• Required
  • Continuity
  • IT
  • Coordinate care (not required to provide all services)
Missouri Health Home Overview

- Strategies: Case management coordination and facilitation of healthcare
- Primary care nurse care managers
- Disease management for persons with complex chronic medical conditions, SMI, or both
Behavioral Health Homes

- Team approach
- Population-based screening
- Measurement-based care
- Treatment-to-target
- Care coordination
  - Health education
  - Address barriers to care
  - Ensure linkage to medical care

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<th>Active Patients</th>
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<td><strong>Flags</strong></td>
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Disease Management Diabetes Outcomes
(2822 Continuously Enrolled Adults)*

June, 2013

<table>
<thead>
<tr>
<th></th>
<th>LDL</th>
<th>BP</th>
<th>A1c</th>
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<tbody>
<tr>
<td>Feb'12</td>
<td>22%</td>
<td>27%</td>
<td>18%</td>
</tr>
<tr>
<td>Feb'13</td>
<td>38%</td>
<td>46%</td>
<td>42%</td>
</tr>
<tr>
<td>June'13</td>
<td>47%</td>
<td>59%</td>
<td>53%</td>
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<tr>
<td>Goal</td>
<td>36%</td>
<td>65%</td>
<td>60%</td>
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*29% of continuously enrolled adults

Challenges and Barriers

• Medicaid Demonstration requirements - metrics
• Existing funding of FFS care vs. addressing social needs
• Cultural change in dedicated MH staff
• Workforce development (e.g., training in motivational interviewing)
• Registry development and implementation
• Money in the short term
Lessons Learned

• Data is required to identify treatment and prevention opportunities
• Training helps implement new evidence-based interventions
  – Might allow use of a lower-cost FTE
• Personal interaction is the true change agent
As of May 2017, 21 states and the District of Columbia have a total of 32 approved Medicaid health home models.

States with Approved Health Home SPAs (number of approved health home models)

Alabama, Connecticut, District of Columbia (2), Iowa (2), Maine (2), Maryland, Michigan (2), Minnesota, Missouri (2), New Jersey (2), New Mexico, New York, North Carolina, Ohio, Oklahoma (2), Rhode Island (3), South Dakota, Tennessee, Vermont, Washington, West Virginia (2), Wisconsin

Note that Idaho, Kansas, and Oregon have terminated their Medicaid health home state plan amendments and are no longer providing services under 1945 of the Social Security Act/Section 2703 option.
Role(s) of the Nurse

- Screen for chronic medical conditions
- Participate in treatment of risk factors
- Educate about risk reduction
- Advocate for and link with treatment
- Identify barriers and address
- Support adherence to pharmacologic treatment
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