Partners in Recovery

CMHA

Community Mental Health Affiliates

Options to Health: Primary and Behavioral Health Care Initiative (PBHCI)

William Rabitaille, MD, THOCC

Fran Cerasoulo, LPN, CMHA

Jane Ungemack, DrPH, UCHC

Marie Mormile-Mehler, VP of Planning & Performance Improvement – CMHA

June 22, 2012

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O2H: Options to Health

MISSION

To improve the quality of life of CMHA adult patients who do not have a physician in the community through medical care, wellness education, and the integration of medical and psychological treatment.

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O2H: Options to Health Integrated Team

The Hospital of Central CT (THOCC)

- William Rabitaille, MD
- Liza House, APRN

Community Mental Health Affiliates, Inc. (CMHA)

- Frances Cerasuolo, LPN, Program Coordinator
- Agnes Gargas, Medical Assistant
- Talitha White, Medical Case Manager
- Teresa Works, VP of Adult Behavioral Health/ Residential Services

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O2H Care Management/Coordination Model- Primary Care/Wellness Patients

Post-intake, client scheduled for 1st appointment with APRN

→ Case manager (CM) phones client to arrange for transportation to appt.; reminder call day before appt.

→ Appointment with APRN, baseline vitals are collected and labs ordered

→ CM phones client day before labs to ensure fasting; arranges/ provides transportation to lab

→ 2-3 week FU appt with APRN; CM phones client day before follow-up appt., arranges transportation

→ FU appt. with APRN; APRN identifies specialist referrals; Project Coordinator/LPN, CM makes specialist appts; enrolls client in wellness programs

→ LPN or CM e-mails summary of medical treatment goals to client's behavioral health clinician & psychiatrist

→ 02H Medical Team attends weekly clinical rounds in CMHA behavioral health clinic

→ CM, LPN, MA sends client information to specialist, makes reminder calls, arranges transportation, and accompanies client to specialist visit(s)

→ LPN receives and shares specialist reports with APRN & follows up to ensure client receives specialist care

→ CM provides support – emergency food & clothing, transportation connection to services; coordinates client wellness activities

→ Client attends FU appts. with CM supports, reminders and transportation

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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***

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Community Connections to Support O2H Wellness Services

Relationships established with area corporations and agencies for patient wellness support, materials and education:

- THOCC for exercise physiologist to develop exercise program for residential patients, dietician for Health Eating Program, and health educator for Diabetes Group
- Interim Health Care for visiting nurse services
- Lincare for patient education on respiratory illness and use of equipment
- Glaxo-Smith Kline for smoking cessation/patient education
- Eli Lily for curriculum and staff training on smoking cessation
- Communicare for smoking cessation groups

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O2H Client Demographic Profile: April 2011- March 2012

Gender	• Male	58%
	• Female	40%
	• Transgender	2%
Age	• 18-34 yrs.	34%
	• 35-44 yrs.	25%
	• 45 or older	40%
Employment	• Part-time/volunteer	7%
	• Looking for work	33%
	• Disabled/unemployed	52%
Racial/Ethnic Background	• Caucasian/White	64%
	• Hispanic	28%
	• African-American/Black	17%

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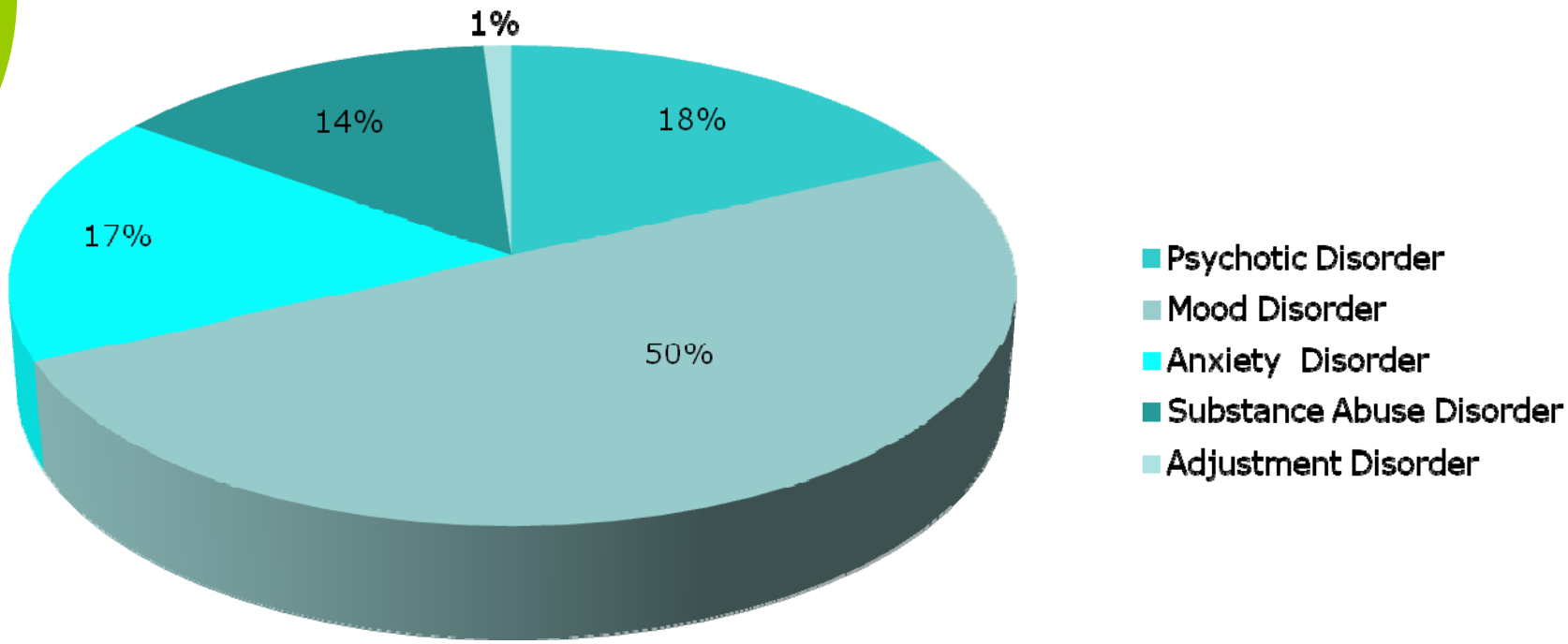
O2H Primary Behavioral Health Diagnosis Type (N=124)



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Challenges of the SMI Population

- More than 1/3 of SMI clients do not have PCP
- Clients often are not aware of the importance of a PCP
- Clients' previous negative experiences with medical systems and stigma
- Fear of an illness diagnosis and treatment
- Low compliance with testing, medications and other recommended regimens
- High no show rates related to low motivation and disorganization
- Lack of transportation
- Lack of basic necessities – food, clothing and stable housing
- Lack of social supports

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O2H Client Health Risk Indicators

High blood pressure	14%
Overweight	25%
Obese	46%
Borderline/high triglyceride levels	36%
Borderline/high cholesterol levels	35%
Current smoker	73%
Poor Health (self-rated)	20%

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Keys to Success: Care Management and Coordination for SMI Clients

- Biweekly meetings with team and evaluator to problem solve
- Service location – PCP office within CMHA behavioral health outpatient clinic & THOCC Clinic
- Integrated health information - behavioral health and physical health record in CMHA EMR system
- On-line access for lab results through THOCC

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Keys to Success: Care Management and Coordination for SMI Clients

- In-service training for medical and behavioral health care personnel (UMASS Primary Care Behavioral Health Integration Certification)
- Media campaign and outreach/ education to clients and staff within CMHA
- Health Information Technology – E-prescribe/Direct lab orders, Exchange of CCD file, Connection to CT HIE

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