IBHP Phase III Project

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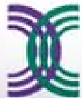
Dimensions of the Behaviorally Enhanced PCMH

1. A clear model and strategy for participating with person centered health care homes based on a focused partnership model of integration.
5. The ability to practice as a team to coordinate care within the BE/PCMH and across services in the behavioral health and medical service delivery stems to ensure that the total healthcare of the consumer is coordinated and properly managed.

IBHP Phase III Project

- Conduct more thorough analysis of the San Diego Primary and Behavioral Health Care Integration Project (SAMHSA funded project)



Intended areas of study

- Examine the differences in primary health indicators for 250 public agency mental health clients who are:
  - Linked to a paired BE-PCMH
  - Linked to an existing, external PCP
  - Not linked to any services
- Examine the differences in behavioral health indicators for the three groups listed above
- Examine the difference in emergency room usage and hospitalizations
- Examine participation rates in wellness programming and identify barriers/facilitators

Intended areas of study

- For the two distinct behavioral health/physical health organization pairings, address participation in and satisfaction with the program.

Collaborative Partners

- Neighborhood Healthcare paired with Mental Health Systems
- Imperial Beach Health Center paired with Community Research Foundation

Goal of SD-PBHCI

1. **To provide primary care screening, assessment, and necessary follow up treatment to persons with serious mental illness (SMI).**

PBHCI Program Components

- Embed a full-time nurse care manager (NCM) in each of the two participating community mental health agencies
- Provide screening at regular intervals:
  - Blood Pressure
  - Glucose
  - Cholesterol
  - Obesity
  - Tobacco use
  - Alcohol and other drugs
  - LOCUS IV (recovery environment)
  - NOMS

PBHCI Program Components

- Refer participants to NHC or IBHC for additional assessment or treatment or Referral to existing, external PCPs
- Co-locate a part-time NP at MH site to provide routine PC services in the MH setting
- NCM and NP will participate in weekly team meetings at both MH and PC sites to link together all integration efforts and enhance bidirectional communication
- MH staff to incorporate care management for physical health conditions in treatment plan
- Use of registries

PBHCI Program Components

- Develop wellness programming at the MH agency
- Exchange of information between clinic and MH agency.

Target Population

- Adult/older adults with SMI
- Must be current recipient of MH services
- Must enroll in program, consent to release information between treatment providers, and sign informed consent
- Over the project term, SD-PBHCI will serve 1,050 unduplicated adults with SMI

Progress

- Enrolled 35 participants in three week period between February 1-19, 2010
  - **Gender:** male (21); female (14)
  - **Age:** 18-24 years (1); 25-44 years (13); 45-64 years (21); 65+ (0)
  - **Ethnicity:** white (23); Hispanic (8); black (1); unk (3)
  - **Income:** <100% of FPL (25); 100-200% FPL (5); >200% FPL (5)
  - **Insurance Status:** Medicaid/Medicare (8); uninsured (27)
- To date, all enrolled participants chose to be linked to the CHC for follow-up assessment/treatment

Initial Screening Results

	Number Screened	Number Positive	Percent Positive
Blood Pressure	35	10	**28.6%**
Blood Glucose	35	1	**2.9%**
Lipids	35	21	**60.0%**
Obesity	35	20	**57.1%**
Tobacco Use	35	21	**60.0%**

	Mood disorder	Anxiety disorder	Psychotic disorder	Eating Disorder	Personality Disorder
Number of individuals	**17**	**2**	**9**	**0**	**1**
Percentage of program participants	**58.6%**	**6.9%**	**31.0%**	**0%**	**3.4%**

Council of Community Clinics

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