



Small County Care Integration Learning Collaborative

CHARTER

Problem Statement

- Individuals living with serious mental illness die (SMI), on average, 25 years earlier than the general population (National Association of State Mental Health Program Directors, 2006). This is a serious public health crisis for state mental health agencies.
- Organizational culture and regulatory differences between primary care and mental health care perpetuate discordant relationships between primary care and mental health care providers and prevent attempts to integrate systems.
- Treatment practices and funding for people with multiple conditions is siloed, episodic, and uncoordinated. This is demonstrated at the federal and state levels and gets mirrored at the local level.
- Fractured coordination with primary care results in marginalization, stigma and poor health outcomes for those with severe mental health illnesses.
- Clients with serious mental illness are provided with very few opportunities and needed supports to become more involved in their own physical health care, from care planning to self-management.
- The coordination of physical and mental health care for clients with serious mental illness is complex. Lack of coordination for individuals with SMI has a harmful effect on wellness and quality of life and increases overall medical costs.
- For most clients, mental health and physical health care agency staff underestimate their opportunity to improve their clients' health outcomes.

Aim

In the next 12 months, 13 teams consisting of Small County Mental Health Care staff and clients will achieve better health status for individuals living, or at risk for, serious mental illness. The teams will support the physical health of clients, with a particular focus on cardiovascular disease and diabetes, as well as their use of physical health services. This will be accomplished by mental health agencies changing and improving systems of communication, collaboration, coordination with primary care to enhance client wellness.

Guidance

This section provides additional information for teams to support their success in achieving their aims. The guidance below is organized as criteria and definitions. The expectations identify activities and strategies that all teams will use throughout the collaborative because during the pilot teams learned that these activities yield more organizational improvements and coordinated care. The definitions help to provide a shared understanding of terms that will be used throughout the collaborative.

Expectations

- It is expected that counties in this collaborative will collect data electronically, and it is recommended counties use registries.
- Include IT staff in improvement teams because use of electronic tools to collect and share data will be important in this collaborative.
- Each site will define their appropriate target population based on their scope of services.
- Integration at the client level will be the focus of changes. Changes at the client level will be a catalyst for structural integration.
- Teams will maintain a focus not only on health, but also on wellness.
- Mental health will collaboratively plan the changes with primary care partners, but mental health will oversee the testing of the changes; primary care offices may be involved in testing as partnerships develop.
- Alcohol and other drugs, public health, and social service agencies are also important partners for clients with serious mental illness to achieve whole health. Changes and testing related to integration of public health and social services may occur organically within some of the county teams.
- Given the impact of alcohol and drug use on life expectancy of individuals living with SMI, consider using routine screening for substance use disorders.
- Incorporate physical health monitoring into mental health services.
- Increase the use of electronic collection of clients physical health data

Definition

- The term “support systems” refers to family or any other individuals identified by clients as those who can assist them with management of their chronic conditions.

OBJECTIVES

Client Self-Management Objectives

1. Reduce the number of clients who are smoking
2. Increase the average time per week that clients exercise
3. Increase the number of SMI clients with a BMI greater than 30 who have used a self-management strategy to lose weight
4. Increase the number of clients with SMI and diabetes who do their own regular glucose monitoring

Integration Process and System Objectives

1. Increase the percentage of clients with a designated primary care provider documented in the mental health record
2. Increase appropriate monitoring of clients physical health care by mental health professionals
3. Increase the number of encounters (telephone, email, in-person) between mental health professionals and primary care providers
4. Decrease the number of emergency care visits
5. Reduce the percentage of clients with SMI whose last blood pressure was greater than 140/90
6. Increase the percentage of clients that have diabetes who have had A1Cs monitored by primary care provider in the past 4 months
7. Increase the percentage of clients that are on a second generation antipsychotic who have had their A1c or fasting glucose screened in the past year
8. Reduce the percentage of clients whose A1C is above 9
9. Increase the number of SMI clients with regular primary care visits

GOALS

Improving Clients Use of Self-Management Techniques

1. Decrease the percentage of clients who are smoking to less than 50% (from county base-line)
2. Increase the number of clients that exercise at least 3 times per week for at least 20 minutes each time to 70%.
3. Reduce by 20% all clients with a BMI above 30
4. Increase the percentage of clients who have had a primary care visits in the past 6 months to 80%
5. Increase the percentage of clients with diabetes who do regular monitoring of blood glucose to above 90%
6. Increase the percentage of obese clients who are engaging in self-management weight loss activities to at least 50%.

Improving Integration Processes and Systems

1. At least 90% of SMI clients have a primary care provider
2. There will be regular and direct consultation (telephone, email, in-person) between mental health professionals and primary care providers for at least 70% of clients
3. There will be a 50% decrease in client visits to urgent care/emergency rooms/hospitals
4. Reduce the percentage of SMI clients with blood pressure above 140/90 to less than 20%
5. Increase percentage of clients with BP and BMI documented in mental health records within the past 12 months to 90%
6. Increase the percentage of clients that have diabetes who have documented A1Cs in mental health records the past 6 months to 80%
7. Increase the percentage of clients that are on a second generation antipsychotic who have a documented A1C in the past 12 months to 80%
8. Reduce the percentage of clients with an A1C above 9 to less than 20%
9. At least 95% of SMI clients demographics, blood pressure, body mass index, and A1C levels will be documented in a registry