Primary and Behavioral Health Care Integration Projects in Texas
SAMSHA Grant (October 2009 through September 2013)

Lubbock Regional MHMR Center

The Lubbock Regional Mental Health and Mental Retardation Center (LRMHMRC) submitted and has been awarded SAMHSA grant for a Primary and Behavioral Health Care Integration Project. LRMHMRC will work with the Larry Combest Community Health and Wellness Center to initiate a clinic that will integrate primary medical services into psychiatric/mental health services provided to consumers who have serious mental illnesses. An agreement is also in place for this project with Texas Tech University Health Sciences Center and the Combest Health and Wellness Center Community Alliance.

*Of the adults with serious mental illness served at LRMHRMC, **47%** have Medicaid coverage and **81%** report not having a source for primary care or using the ER for primary care.*

The purpose of this project is to develop a new clinic where primary care is fully integrated into LRMHMRC outpatient psychiatric services, using the Chronic Care Model to guide the process. The full range of primary medical and behavioral health services will be provided in the new clinic, as well as chronic disease management, health maintenance, health and wellness, and referrals for advance care. The population focus for this project is people with series mental illness who live in the Texas South Plains counties of Lubbock, Cochran, Crosby, Hockly and Lynn. Currently, LRMHMRC serves over 1300 adults with serious mental illness. Of those adults many have both serious behavioral health and physical health diagnosis.

LRMHMRC Adults with Serious Mental Illness

Behavioral Health Diagnosis	Physical Health Diagnosis
33% have major depression	17% have diabetes
29% are bipolar	43% are obese
34% have schizophrenia	35% have hypertension
34% have co-occurring substance abuse problems	28% have asthma
53% smoke cigarettes	

The goals of the project are to provide seriously mentally ill consumers of the LRMHMRC with ready access to primary care services within their familiar psychiatric clinic; have consumers identify LRMHMRC clinic as their primary care home, as well as the site of their psychiatric care; contribute to

LRMHMRC staff's assessment and ongoing treatment of consumers; and through the provision of primary care and wellness services, improve the health and extend the lives of individuals with serious mental illness who choose to use the expanded clinic services.

The outcomes expected from the integration of primary care into the behavioral health clinic services for consumers with serious mental illness include:

- At least 70% of LRMHMRC SMI consumers will identify the clinic as their primary care home
- At least 90% of LRMHMRC clinical staff will indicate that the integrated primary care positively contributed to their comprehensive assessment of new consumers
- At least 90% of LRMHMRC clinical staff will indicate that the integrated primary care positively contributed to their prescribing for and services to SMI consumers
- Of LRMHMRC SMI consumers using the clinic for primary care:
    - At least 40% of those with diabetes will have improved HbA1c levels
    - At least 45% of those with hypertension will have reduced blood pressure
    - At least 35% of those who are obese will have reduced BMI
    - At least 25% of those with respiratory conditions and asthmas will have fewer exacerbations and hospitalizations related to their respiratory conditions
    - At least 5% of those who smoke will quit
    - At least 10% will have few psychiatric hospitalizations
    - At least 80% will indicate satisfaction with services received

The total grant award is $500,000 in Grant Year 1, with a per person per month cost of approximately $24. This includes infrastructure costs that will not continue after the first year and the costs of the grant evaluation. These costs are small in comparison to the potential savings if the goals of the project are met.

Austin Travis County Integral Care

The Health Integration Project (HIP) is a collaborative project with Austin Travis County Mental Health Mental Retardation Center (ACTMHMR) and CommUnityCare. The overall purpose of the project is to enable the Travis County community to expand and enhance primary health care treatment services for people with severe mental health disorders; substance abuse disorders, and physical health disorders. This project will focus on Travis County and the persons served by ATCIC and CommUnity Care. To work toward eliminating the high incidence of untreated chronic and benign health care issues in persons with serious mental illness, ATCIC will support CommUnityCare in employing a general practitioner to be located in the Center's Psychiatric and Counseling Services Center. ATCIC provides service on average to an unduplicated 6,000 adults and 5,000 children per quarter. Approximately 75% of adults and 30% of children presenting at ATCIC for services have no primary medical home. Half of the adults and over 75% of the children are Medicaid recipients.

Of the adults with serious mental illness served at ATCIC, ***49%*** *have Medicaid coverage and* ***75%*** *report not having a source for primary care. For children,* ***75%****have Medicaid coverage and* ***30%*** *report not having a source of primary care.*

Although ATCIC does not have physical health diagnosis in the current electronic medical record, research consistently shows the high rates of physical health chronic diseases in persons with serious mental illness. The Bazelon Center for Mental Health report that persons with schizophrenia have a predisposition to diabetes, however, atypical medication may exacerbate this predisposition. Cardiovascular diseases are also prevalent with individuals experiencing severe mental illness. This increased rate also is exacerbated by psychotropic medications, which contributes to obesity. Persons with severe mental illness tend to smoke more, have poor nutritional habits and live sedentary lifestyles, which contribute to poor health outcomes in comparison to the general population. Through this project, ATCIC will begin collecting physical health data on program participants.

ATCIC Adults and Children with Serious Mental Illness

Adult	Children
Behavioral Health Diagnosis	**Behavioral Health Diagnosis**
20% have major depression	51% have anxiety/behavioral disorder
40% are bipolar	33% adjustment disorder
30% have schizophrenia	8% have major depression
	7% are bipolar
	1% have schizophrenia

The Center currently collaborates with the Travis County FQHC placing behavioral health specialist in CommUnityCare clinics to provide screening/assessment and intervention for persons identified during primary care visits. This program (E-MERGE) provides behavioral health services integrated into primary healthcare for improved patient outcomes in the community clinics by assisting individuals with chronic health conditions such as diabetes, heart disease and asthma for behavioral health problems, such as depression, anxiety and substance use disorders. Documentation is maintained in an electronic medical record within the FQHC which is then placed on an electronic health information exchange, Indigent Care Collaboration (ICC), which ATCIC also utilizes to share health information with ICC members within the area health district. While E-MERGE has proven to be a valuable community resource, there are several drawbacks. One difficulty is that E-MERGE is primarily designed for those residents who are not eligible for ATCIC services because their diagnosis does not match the target population. Additionally, the care provided by E-MERGE is often of a reactive rather than preventive nature. Placing a primary care provider in the community mental health center clinic will help to engage individuals in their healthcare and connect them to an ongoing relationship with the full-scope medical home.

Goals and Objectives of Integration

Goal 1. To improve overall wellness and physical health status of people with serious mental illness.
Objective 1.1 At 6-month follow-up participants will acknowledge their participation in a wellness plan incorporated into their behavioral health recovery plan. Objective 1.2 At month 3 follow –up Project team will have completed three key questions in "The Model for Improvement" prepared to apply PDSA Cycle to implement change specific to primary care within a behavioral health setting. *Objective 1.3* At 12 months 50% of individual participants will be involved with ongoing health promotion activities.
Goal 2. To make available coordinated primary care services in a community mental health center.
Objective 2.1 By 6--month follow-up, participants will report engagement in their healthcare and ongoing relationship with primary care provider improving quality of life (mental and physical health). Objective 2.2 By 6-month primary care services will be incorporated into initial screening eligibility procedures for person entering behavioral health services. Objective 2.3 By 6-month Project team will have applied one PDSA cycle on all identified chronic diseases within the client population specific to screening, assessment and wellness planning. Objective 2.4 By 6-month follow-up, participants will report their goals and objectives specific to maintaining and improving overall wellness.
Goal 3. To improve the physical health status of people with serious mental illness.
Objective 3.1 By 6-month follow-up, a smaller proportion of participants will report gaps in basic physical health needs and other services compared to baseline. *Objective 3.2* By 6- month-follow-up, participants will acknowledge utilization of wellness plan as part of recovery concept.
Goal 4. To reduce early mortality among people with serious mental illness by 10 years over the next 10 years.
Objective 4.1 By 5th year follow-up, a greater proportion of participants will report enhanced physical health outcomes due to early intervention. *Objective 4.2* By 5th year follow-up, a greater proportion of participants and providers will report reduced difficulty with maintenance of chronic disease. *Objective 4.3* By 5th year follow-up, a greater proportion of participants will independently manage wellness plans and health care needs.

The total grant award is $498,037 in Grant Year 1, with a per person per month cost of approximately $32.50. This includes infrastructure costs that will not continue after the first year and the costs of the grant evaluation. These costs are small in comparison to the potential savings if the goals of the project are met.