Washtenaw Community Health Organization (WCHO) Pilot Disease Management Program

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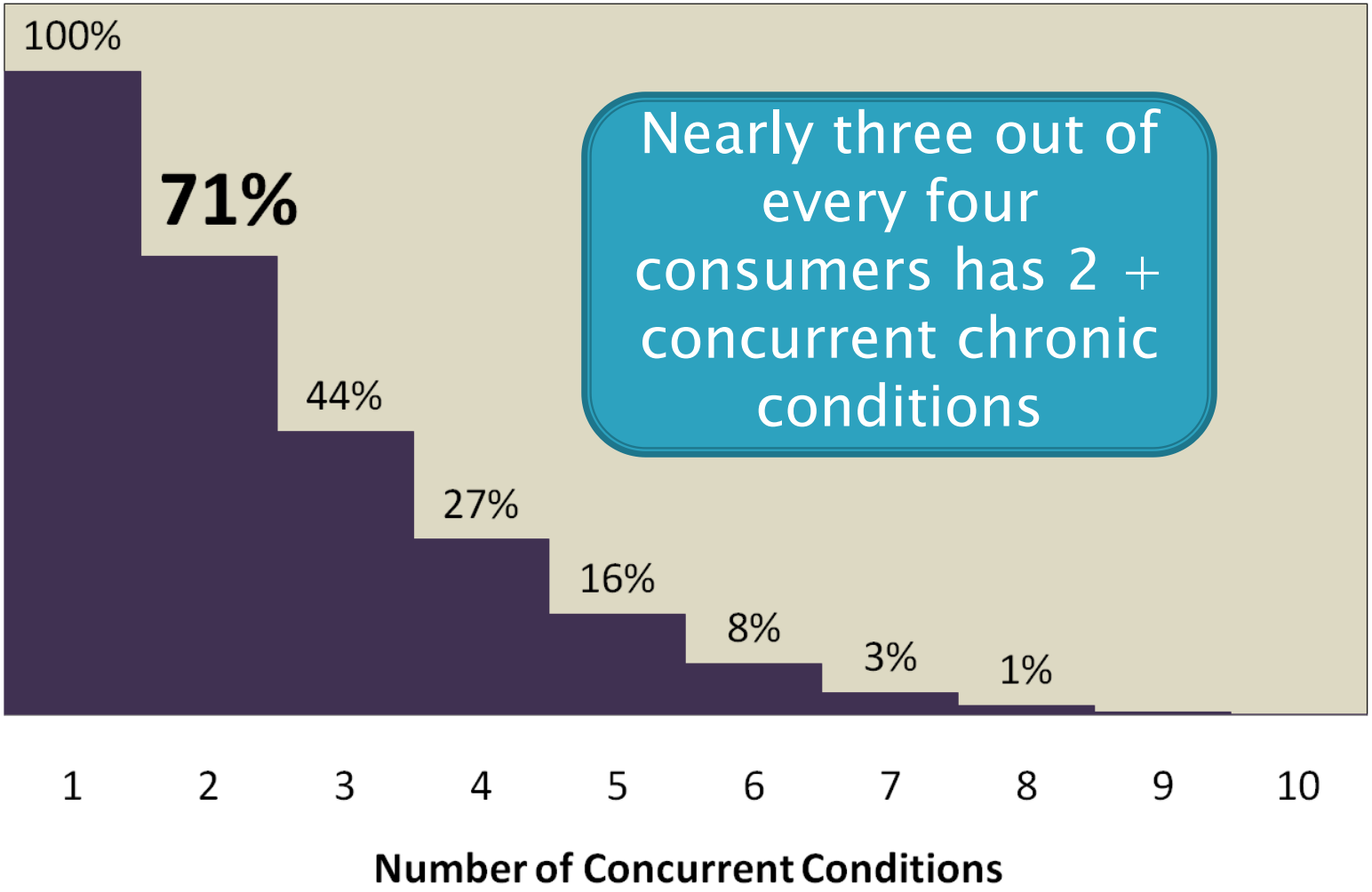
What We Know About Morbidity and Mortality?

Individuals with serious mental illness served by our public mental health systems die, on average, 25 years earlier than the general population.

NASMHPD 2006

Frequency of Multimorbidity, WCHO Consumers



Mental Illness, Developmental Disabilities, Substance Use Disorder, Asthma, Emphysema, Bronchitis, Heart Disease, Diabetes, Hepatitis, Hypertension, Cholesterol, Chronic Pain.

WCHO Experience With Integrated Health

- Began Integrated Health efforts in 2004
- Goal: improve physical health of CMH consumers by creation of medical home in primary care sites
- 5 primary care clinics
- Results based on data from 2007- 2009:
  - 64 consumers discharged to primary care
  - ~15% readmitted to CMH

Pilot Disease Management Program

Purpose:

To improve physical health outcomes for individuals with SMI/SUD/DD through a set of interventions directed towards improved management of particular core diseases, conditions and co-morbidity clusters.

Target Populations: ~ 1100 fee-for-service individuals (i.e. spend down and dual eligibles)

Initial Infrastructure Achievements

- Creation of disease registries through use of an annual Personal Health Review
- Creation of central data warehouse through health information exchange with MSA
- Evaluation of self report/self rated health status (from PHR) based on claims in data warehouse for CMH consumers
- Creation of labs module in EMR (HbA1c, cholesterol, triglycerides, glucose)

WCHO QHP Reports

- Consumer Detail Report
- Consumers without Health Services
- Flat File Export
- High Cost Consumer DD
- High Cost Consumer MI
- High Cost Consumer SA
- High Cost Consumer seen at ER
- High Cost Diagnosis Cluster Report
- High Cost Primary Diagnosis Report
- High Cost Treatment Report
- Services by Location

For Services between 1/1/2008 and 12/31/2008

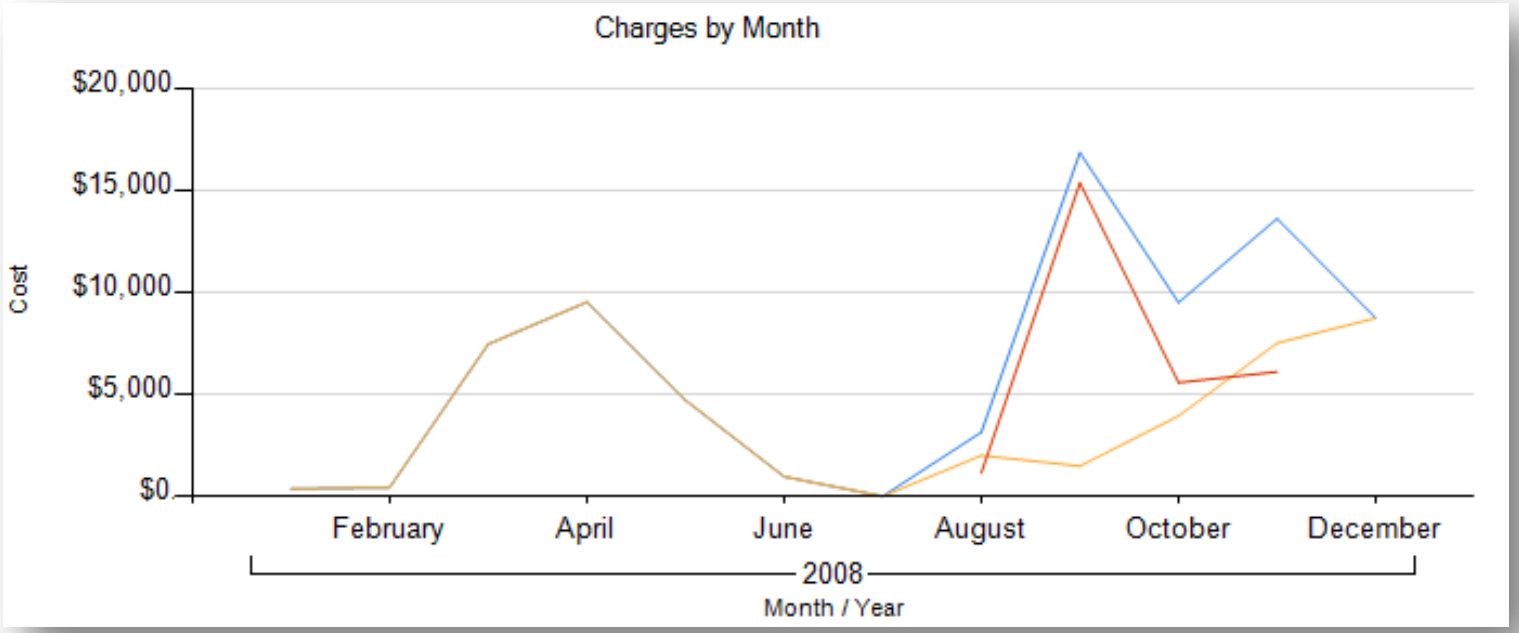
1 of 6 100% Find | Next Select a forma

High Cost Consumer Report - TOP 50 Seen at ER

For Services Between 1/1/2008 and 12/31/2008

	Consumer ID	Medicare Eligible	Date of Birth	Gender	ER Charges	ER Medicare
1	216143	No	2/23/1986	F	$7,292.28	$18,009.95
2	11089	Yes	7/16/1953	M	$1,883.52	$2,914.97
3	37886	No	4/9/1960	F	$1,500.76	$3,058.22
4	258381	No	6/9/1986	M	$1,016.76	$2,592.38
5	93814	Yes	5/28/1933	M	$826.92	$3,672.80

WCHO

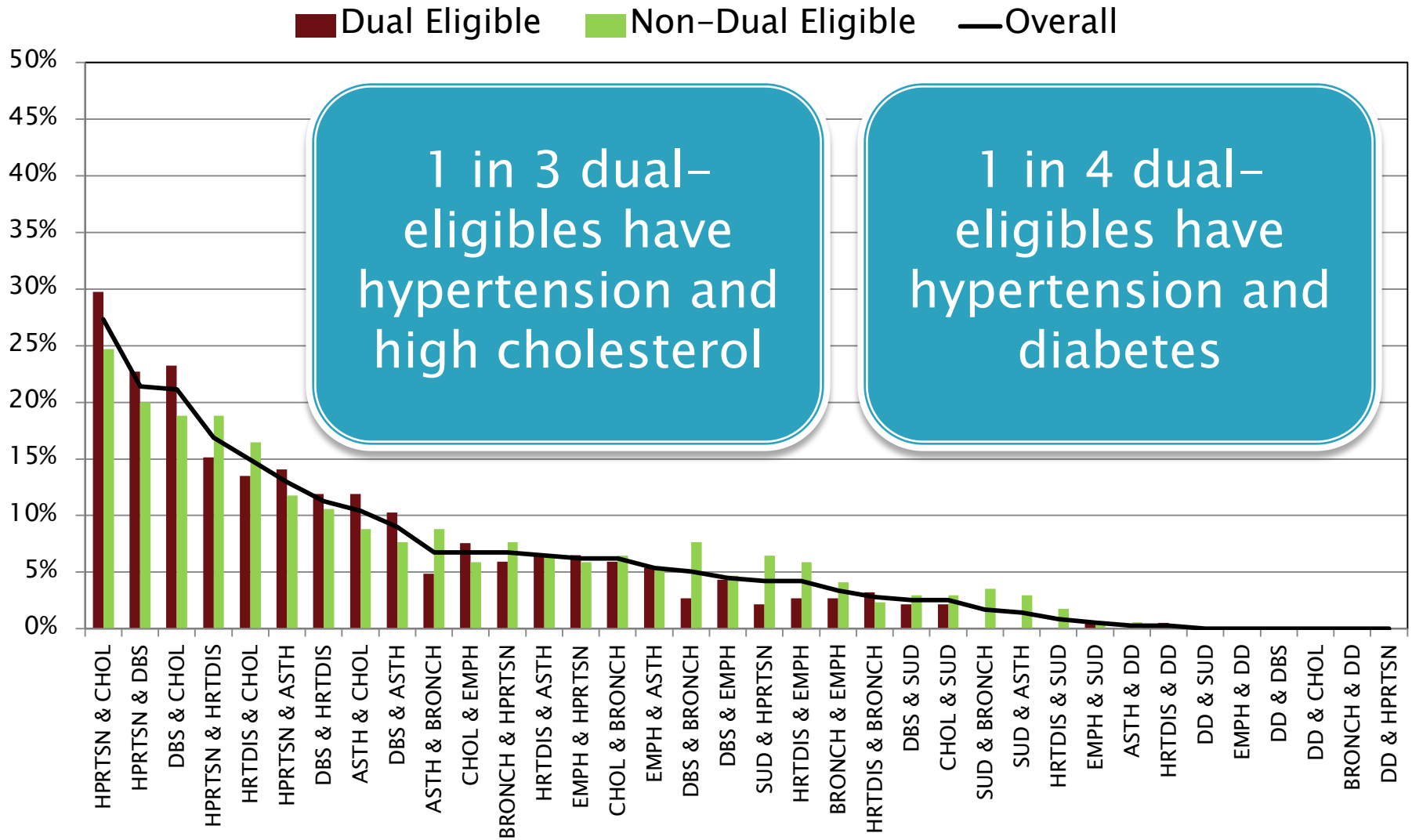


Primary Diag.	Diagnosis	Total Raw Charges	Medicare Rates Total	Highest Estimated Charges	Data Source
4739	CHRONIC SINUSITIS NOS	$14.40		$14.40	Physical Health Data
	HX-LATEX ALLERGY	$1,257.32		$1,257.32	Physical Health Data
3229	MENINGITIS NOS	$914.70	$1,600.10	$1,600.10	Physical Health Data
V452	VENTRICULAR SHUNT STATUS	$272.14	$555.42	$555.42	Physical Health Data
78900	ABDMNAL PAIN UNSPCF SITE	$515.04	$1,706.87	$1,706.87	Physical Health Data
7231	CERVICALGIA	$1.91	$0.00	$1.91	Physical Health Data

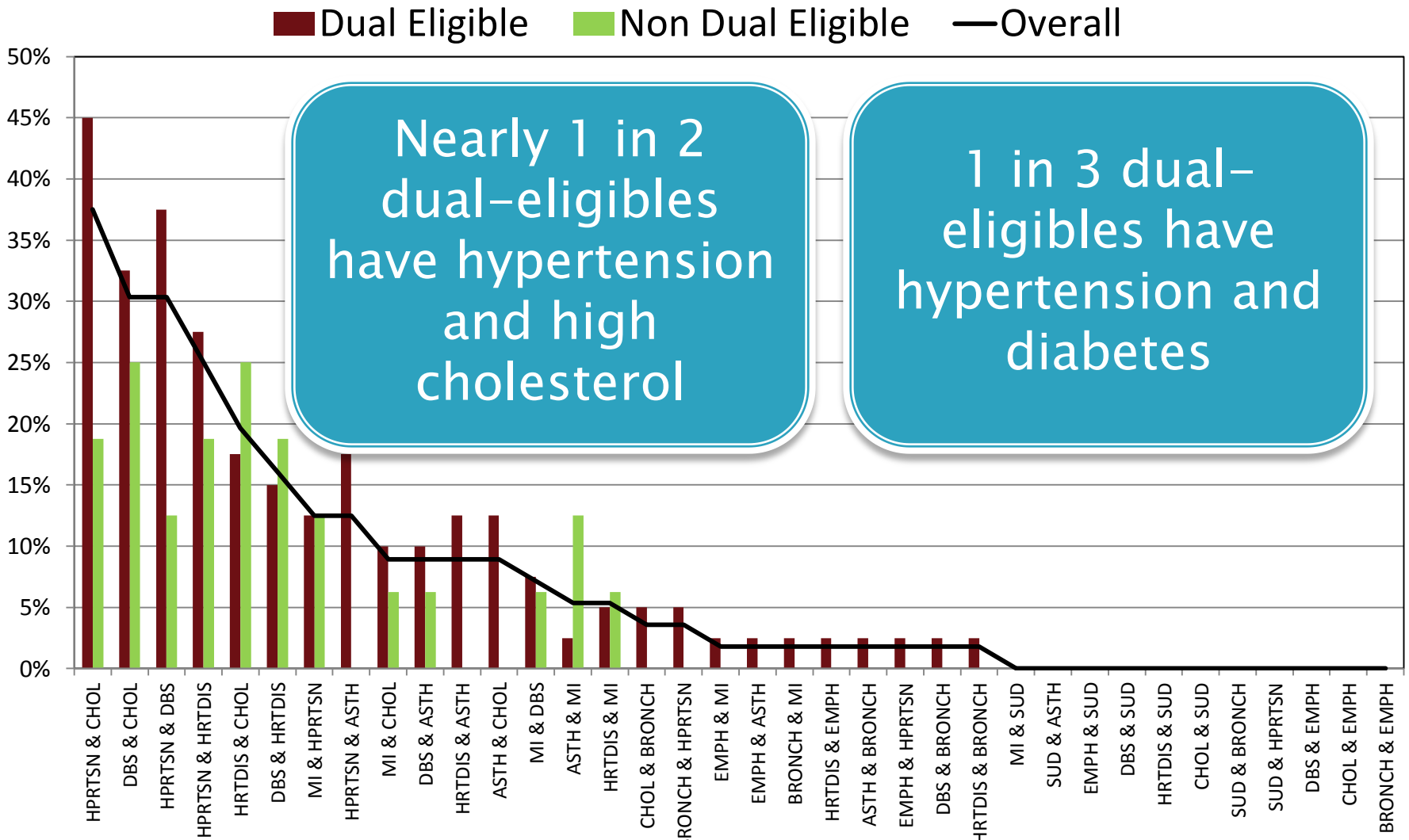
Variables Used for Stratification of Target Population

- Consumer self rated health as “poor” or “fair”
- Presence of disease or clusters of conditions (diabetes, hypertension, cardiovascular disease, asthma/ COPD)
- Utilization of medical hospitalization and ER in last year
- Presence of certain ambulatory sensitive conditions (heart disease symptoms)
- Tobacco use
- Disease management team ended up providing services for ~450 consumers

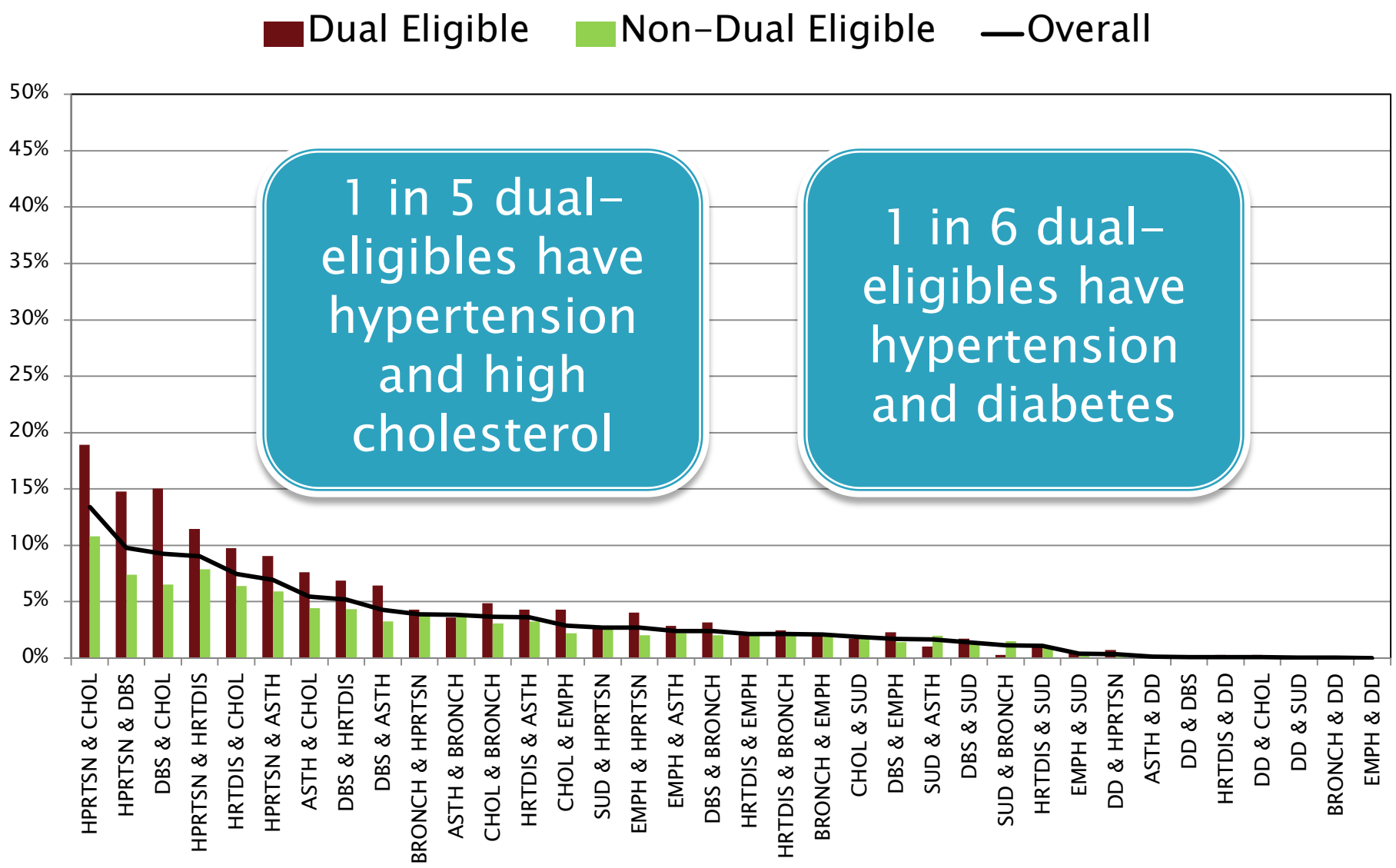
WCHO Disease Mgt Consumers with Mental Illnesses (MI)



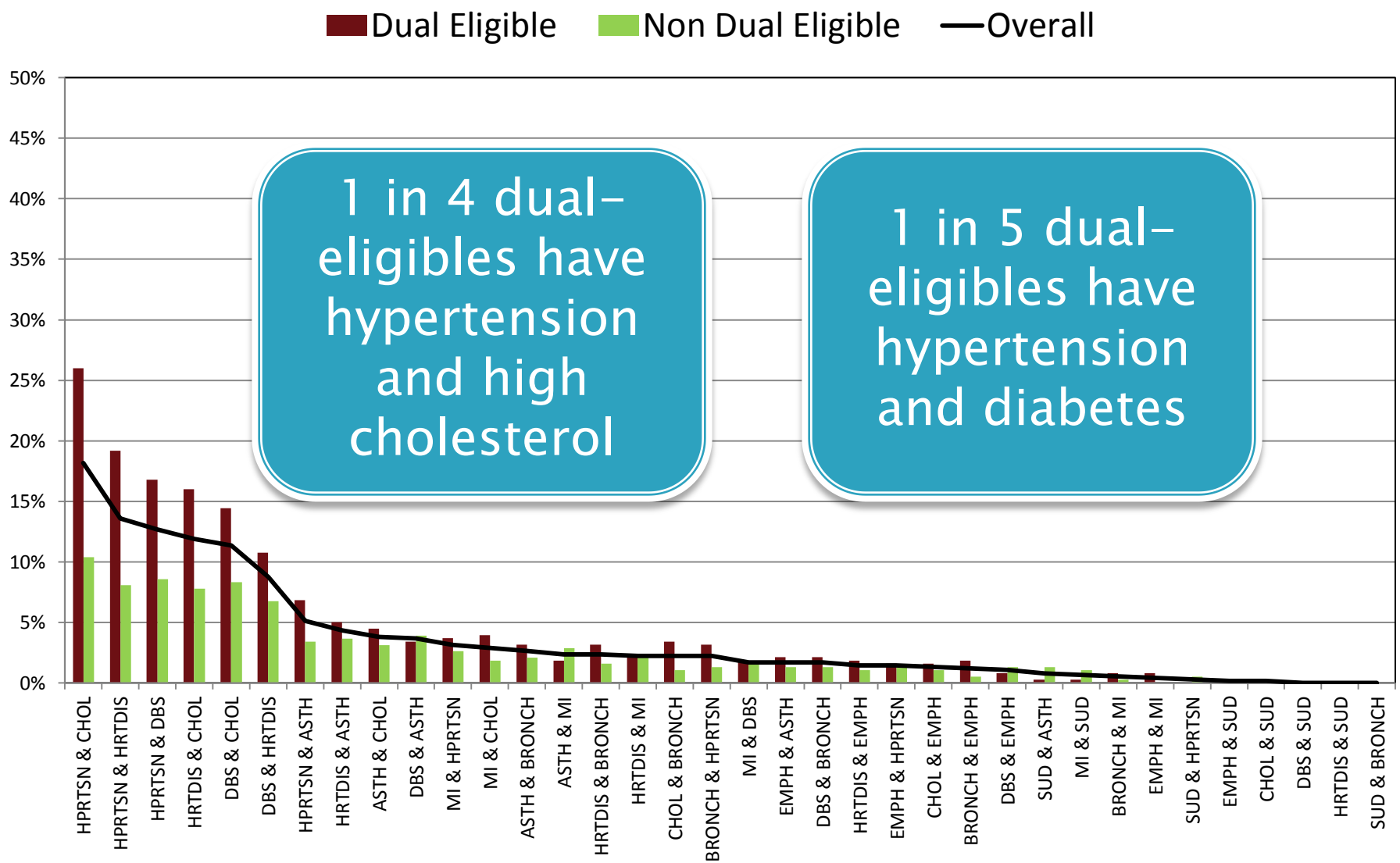
WCHO Disease Mgt Consumers with Developmental Disabilities (DD)



All WCHO MI Consumers



All WCHO DD Consumers



	DM Consumers	Non DM Consumers
Dual Eligible	52%	31%
Substance Use Disorder	36%	31%
Tobacco user	24%	18%
Atypical Antipsychotics	70%	51%

Interventions

Intervention Strategies

- Use of Comprehensive Care Coordination Team Approach
- Supports Coordination with Social Supports
- Use of “High Touch” Approach
- Health Promotion/ Self Management

Intervention Strategies

Creation of Disease Management Team

- ✓ 3 care coordinator RNs
- ✓ 1 full time certified peer support specialist
- ✓ 1 registered dietician/health educator
- ✓ 1 half-time family nurse practitioner

Intervention Strategies

Use of Comprehensive Care Coordination Team Approach

- ✓ Person centered
- ✓ Disease Management Team care coordinator is the "go-to"
- ✓ Other team members may include:
  - primary care physician
  - on-site family nurse practitioner
  - behavioral health professionals (social worker, job coach, mental health RN, psychiatrist, behavioral psychologist, therapist)
  - independent living support staff
  - medical specialist (cardiologist, endocrinologist, etc)
  - pharmacist

Intervention Strategies

Supports Coordination with Social Supports

Linking and coordinating with community partners in the following life domains

- ✓ Housing
- ✓ Employment
- ✓ Natural supports
- ✓ Transportation
- ✓ Education
- ✓ Recreation
- ✓ Public safety
- ✓ Spirituality

LIFE DOMAIN	COMMUNITY RESOURCES	FUNDERS	OTHER SERVICE PROVIDERS	COUNTY DEPARTMENTS	ASSOCIATIONS/ ALLIANCES	PUBLIC OFFICALS	COMMUNITY OF INTEREST
Housing	Landlords Utility Companies	Section 8 HUD Entitlements Mortgage lenders Habitat Community Foundation County CBDG MSDHA Barrier Busters Consumer Loan Fund	Housing Commissions Avalon CHA Shelter Adult Foster Care Assisted Living Group Homes SOS Housing Bureau for Seniors Ozone	Planning Public Health County extension ECTS Treasurer's Office	Continuum of Care Housing Alliance CSH Consortium AA Community Development Ypsi Community Development HSCC	Public Housing Boards City Council BOC Social Sec Admin	Homelessness and Housing
Work **Paid or volunteer**	Employers Skill Bank Volunteer Organizations	MRS WCHO Ticket to Work CIL Talent Exchange ECTS	Fresh Start SE Providers WISD	Support Services ECTS	SE Exec Committee SE Network HSCC Ad Hoc Committee	State Legislature Congress	H&H Support Services
Family/Friends	Faith Organizations	FIA – Home Help WCHO-Respite WCHO – NAMI and ACA funding	Respite Wrap-Around Child Waiver FIA Schools	ECTS Children's services Public Health	NAMI Friends of the DD HSCC	BOC State Legis. DCH	Children's Well Being Homelessness and Housing Health
Recreation	City and County Parks Rec Centers Community at large (movies, malls, resturants0	SLP Budgets Life Enhancement WCHO CIL (Talent Exchange)	Project Transition SLP Providers Fresh Start Full Circle Therapeutic Riding Inc.	Parks and Rec.	Friends of the DD	Park Commission	Health?
Education	Head Start Public Schools Community Colleges Universities	Entitlement Scholarships Loans	WISD	Juvenile Detention Head Start County Extension	Transition Council HSCC	Boards of Ed Regents State and Fed Legislature	Children's Well Being
Spirituality	Local churches Synagogues, Mosques		Group homes and SLP providers assist with attendance		Parish Partnerships Interfaith Alliance HSCC		Children's Well Being Health
Transportation	Private market Public Transportation	FIA WCHO MRS	AATA Milan Transit Cab Companies CBDG Funds?	Facilities	HSCC Supported Employment Ex Comm.	AATA Board	Homeless and Housing Health Planning
Public Safety	Police Departments Sheriff's Department		Jail Services WCHO Court Services Dawn Farms	Sheriff's Department Juvenile Detention	Affiliation JD workgroup Local Jail Diversion Workgroup Crisis Relief Task Force	BOC Sheriff Prosecutor Public Defender	Public Safety and Justice Health Homeless and Housing

Care Interventions

"High Touch" Approach

- Face to face contact is provided by Care Coordinator "where the consumer is at" figuratively and literally
- Expectation of an in home assessment upon enrollment
- Use of Peer Support Specialists
- Care Coordinators have opportunities for face to face interaction with primary care physicians and specialists
- Care Coordinators work as an integrated part of behavioral health team
- Certain Care Coordinators are assigned to primary care clinics serving high volume at risk populations (Packard health clinic, Ypsilanti Health Clinic, Neighborhood Family Health Clinic)
- Care Coordinators training in motivational interviewing

Care Interventions

Health Promotion/ Self Management

- ✓ Self Management/ Wellness Classes
- ✓ Diabetes Management
- ✓ Health Bodies Healthy Minds
- ✓ Stress Management
- ✓ Tobacco Treatment
- ✓ Healthy Lifestyles Series
- ✓ Weight Loss Series
- ✓ Physical Activity
- ✓ Nutrition for Diabetes
- ✓ Music in Motion

Care Interventions

Peer Support Specialist Assists With:

- ✓ Care coordination (phone calls, attending appointments, etc)
- ✓ Medical appointments
- ✓ Physical activity in community
- ✓ Health food choices in grocery store
- ✓ Creating daily schedules
- ✓ Accessing community resources
- ✓ Transportation needs
- ✓ Money Budgeting

Outcomes

Outcomes

Actively Receiving RN Care Coordination:
Consumer has been assigned a care coordinator

Engaging in care coordination
Care coordinator is working on patient activation

No care coordination
Not part of Disease Management target population

What we know about BMI

- Estimate of body fat
- Risk for heart disease, hypertension, type II diabetes, gall stones, breathing problems, certain cancers

Case Studies

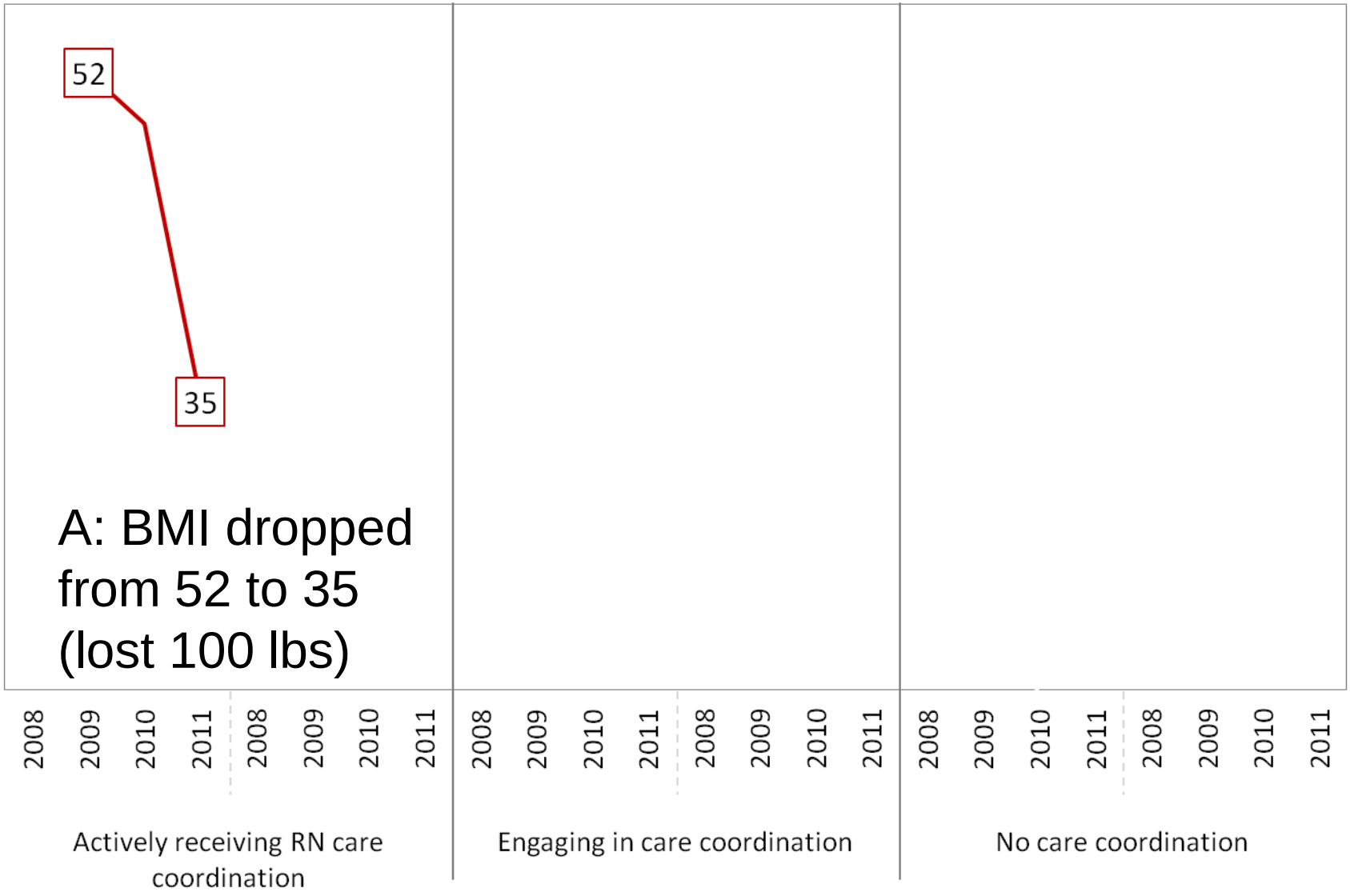
The following consumers all have had (concurrently):

- Schizoaffective disorder
- Uncontrolled Diabetes
- High Cholesterol
- Hypertension
- Prescribed at least one Atypical Antipsychotic

Actively Receiving RN Care Coordination

Consumer A

- 44 year old female
- Lives independently
- Supports Coordination
- Psychiatry services
- Mental health nursing services
- Dialectical Behavioral Therapy
- Disease Management Health Promotion and Self-Management groups
- Disease Management Care Coordination


52
35
A: BMI dropped from 52 to 35 (lost 100 lbs)
2008
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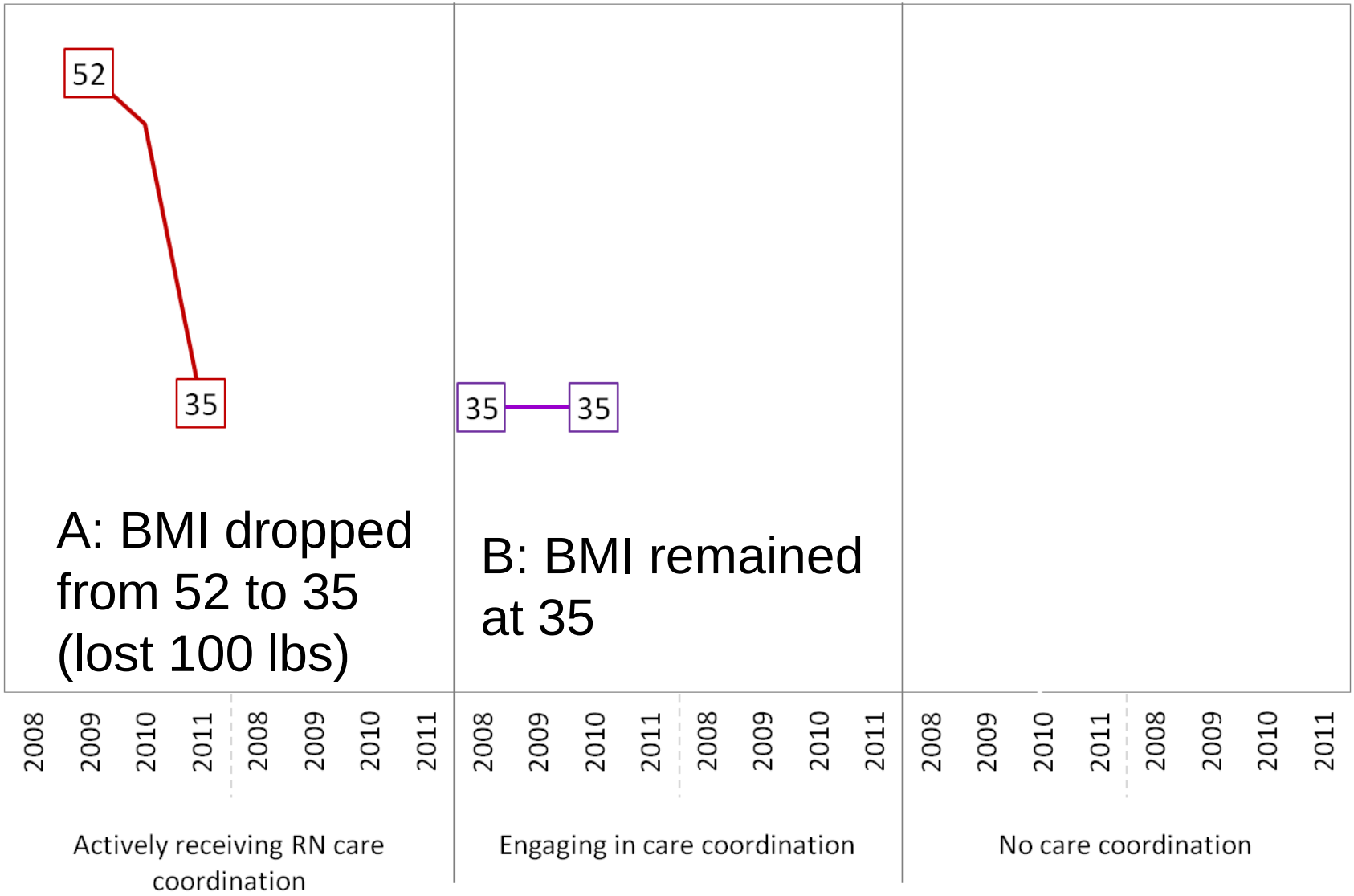
Actively receiving RN care coordination
Engaging in care coordination
No care coordination

Engaging in Care Coordination

Consumer B

- 56 year old female
- Adult Foster Care setting
- Supports coordination
- Psychiatry services
- Mental health nursing services
- Has seen the Disease Management Care coordinator two times in the last year but **did not engage in services**


52
35
35
35
A: BMI dropped from 52 to 35 (lost 100 lbs)
B: BMI remained at 35
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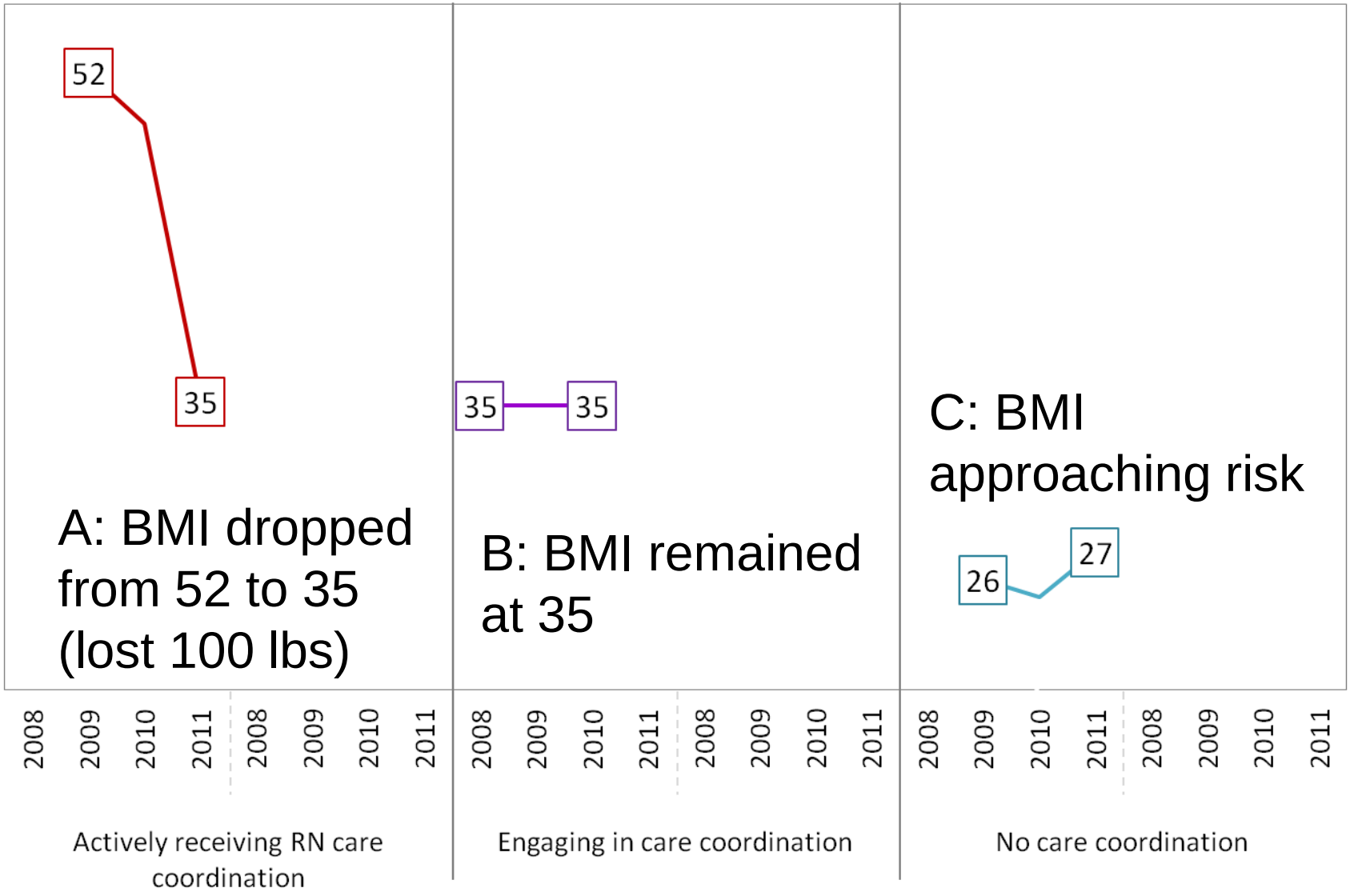
2011
Actively receiving RN care coordination
Engaging in care coordination
No care coordination

No Care Coordination

Consumer C

- 47 year old male
- Lives independently
- Supports coordination
- Psychiatry services
- Mental health nursing services


52
35
A: BMI dropped from 52 to 35 (lost 100 lbs)
35
35
B: BMI remained at 35
C: BMI approaching risk
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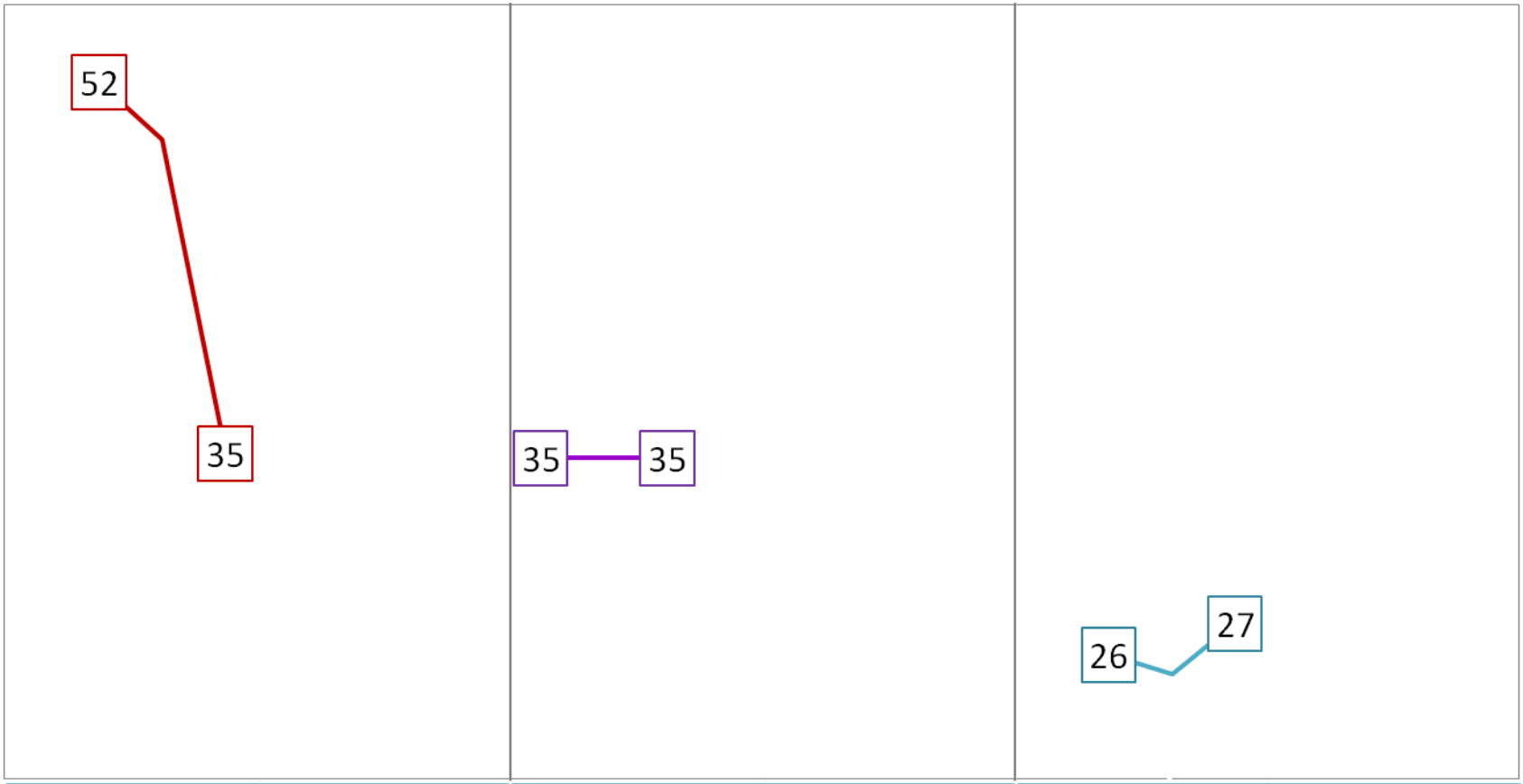
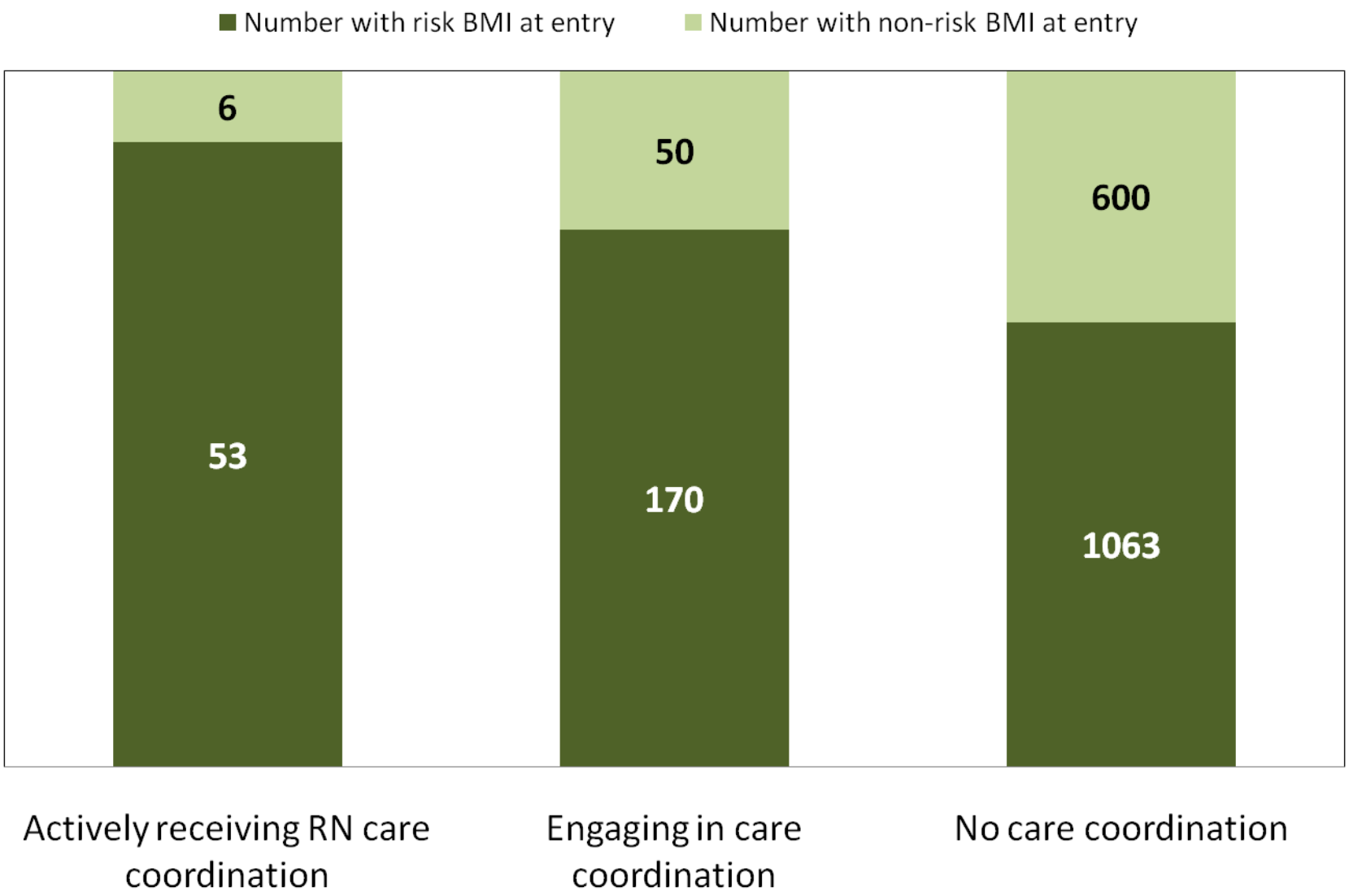
Actively receiving RN care coordination
Engaging in care coordination
No care coordination

THIS PATTERN HOLDS FOR WCHO CONSUMERS



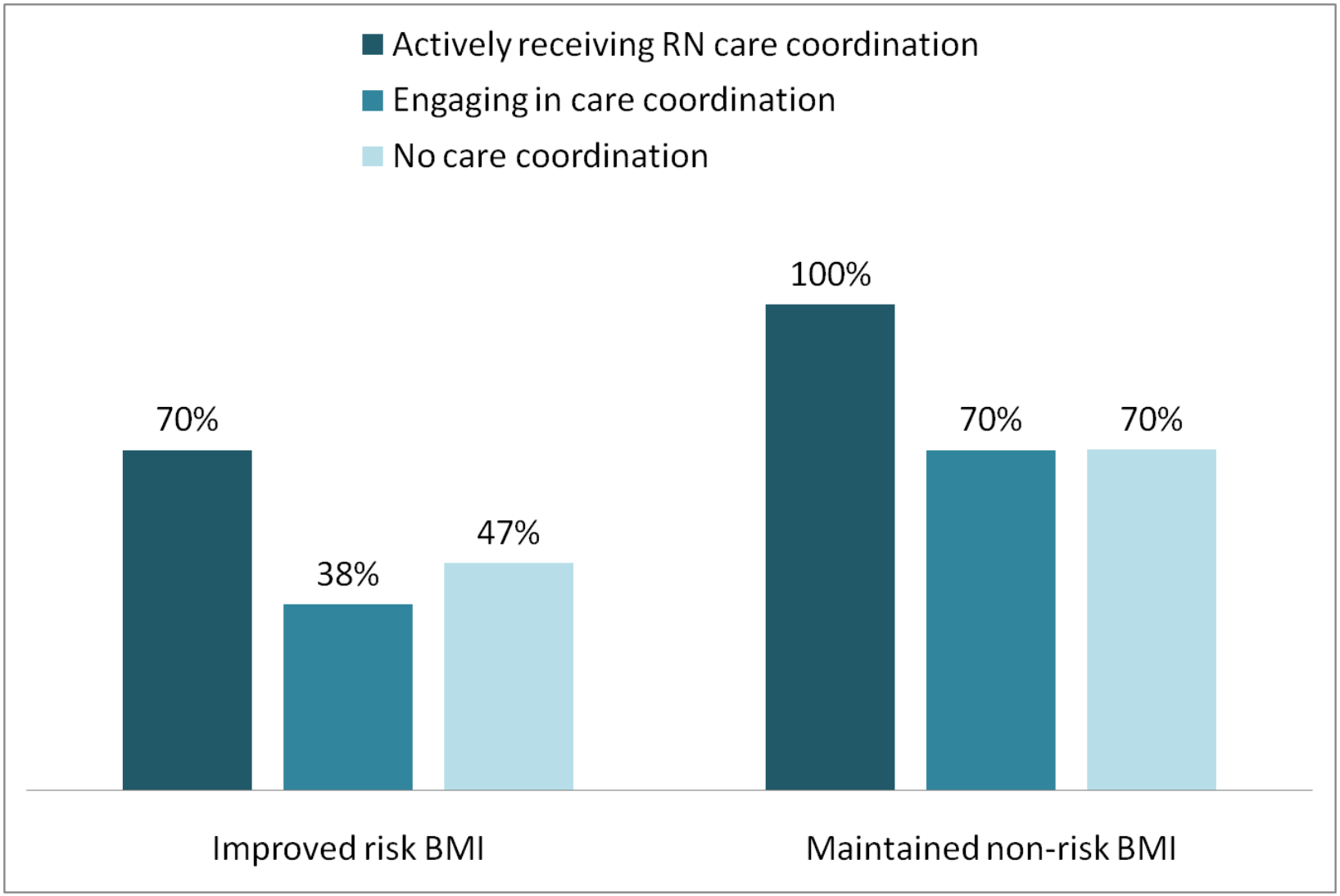
Actively receiving RN care coordination	Engaging in care coordination	No care coordination
1.45 BMI points LOST per year (p=0.0224)	No evidence of change (p=0.6390)	**0.28 BMI points GAINED** per year (p<0.0001)

Most WCHO Disease Management Consumers At Risk



Cases with at least at least one BMI measurement in a personal health review

High Probability Of Success



Cases with at least at least two BMI measurements in a personal health review

Consumer A now is…..

- Taking classes at the Ann Arbor Community Rec and Ed
- Attending class at Washtenaw Community College with her daughter
- Successfully completed water aerobic and yoga classes at the YMCA
- Enjoying thrift shopping at Kiwanis on Saturdays
- A non-smoker!

Ongoing Infrastructure Efforts

- Deployment of mobile technology
- Development of fully integrated meaningful use certified EMR
  - Clinical decision support
  - Dashboard of behavioral and physical health parameters
  - Behavioral and physical health related outcomes
  - Referral tracking
  - Personal health record
  - Patient education

Discussion