Collaborative Care:

Case Study of Integrating Primary Care in a Mental Health Setting

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Objectives

- Examine a reverse co-location model of collaborative care
- Identify important features of model
- Present challenges and stimulate discussion on how to overcome challenges
- Identify others who might be interested in helping us improve this model

The Case for Integrated Care

People with severe mental Illness die
25 years earlier than the general population
(on average)

(60% due to physical health conditions
…COPD, CAD, Cancer)

Why Reverse Co-Location?

- Medical home in a community based outpatient practice is right for most patients **but not all patients**.

Patients with severe mental illness:

- » often need for frequent mental health services
- » may require specialized care:
  - ability to connect with community mental health resources
  - team based care with focus on behavioral health
  - ability to deal with crisis
- » may feel more comfortable in behavioral health setting

WakeBrook

- Inpatient Unit: 16 beds (soon to be expanded to 28)
  - » 500-600 admits per year
- Residential Facility Based Crisis Unit: 16 beds
  - » 500 admits per year
- Residential Detox Unit: 16 beds
  - » 900 admits per year; #1 alcohol, #2 opioids
- Crisis and Assessment Services: 12 chairs
  - » 5000 patients per year
- Child Psychiatry Clinic
- Substance abuse treatment program for pregnant and/or parenting women and their children

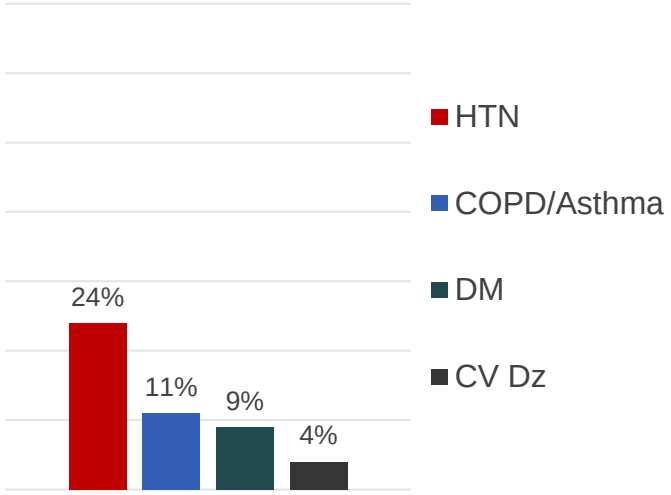
- Primary Care Service

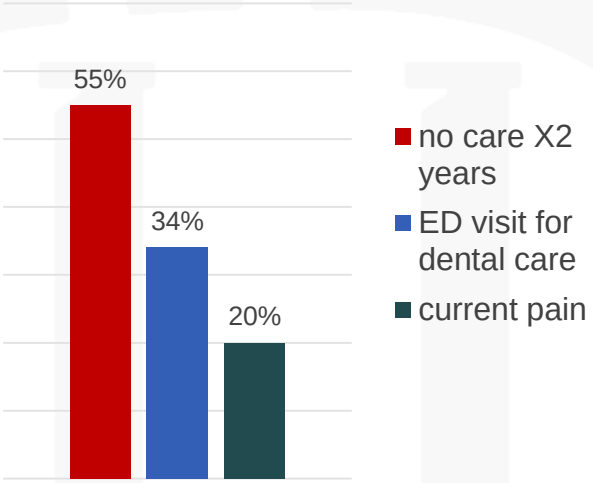
WakeBrook Primary Care Service

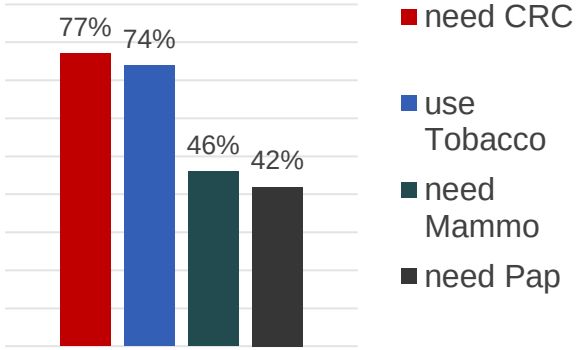
- Staffing:
  - MD Medical Director: 0.4 FTE
  - MD supervision: 1.0 FTE
  - FNP/PA: 3.5 FTE

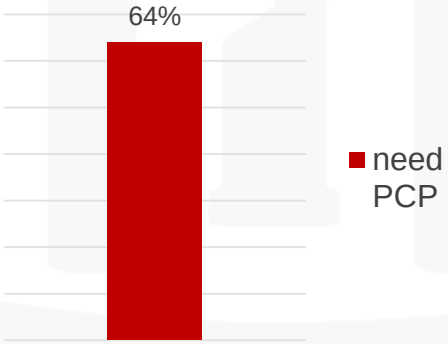
- Description of Work:
  - Intake physicals and consultations on units
  - Full scope outpatient family medicine office for patients with SMI
    - Coordinated and accessible care over time
    - Focus on quality improvement
    - Team based care with behavioral health

Needs Identified on Units

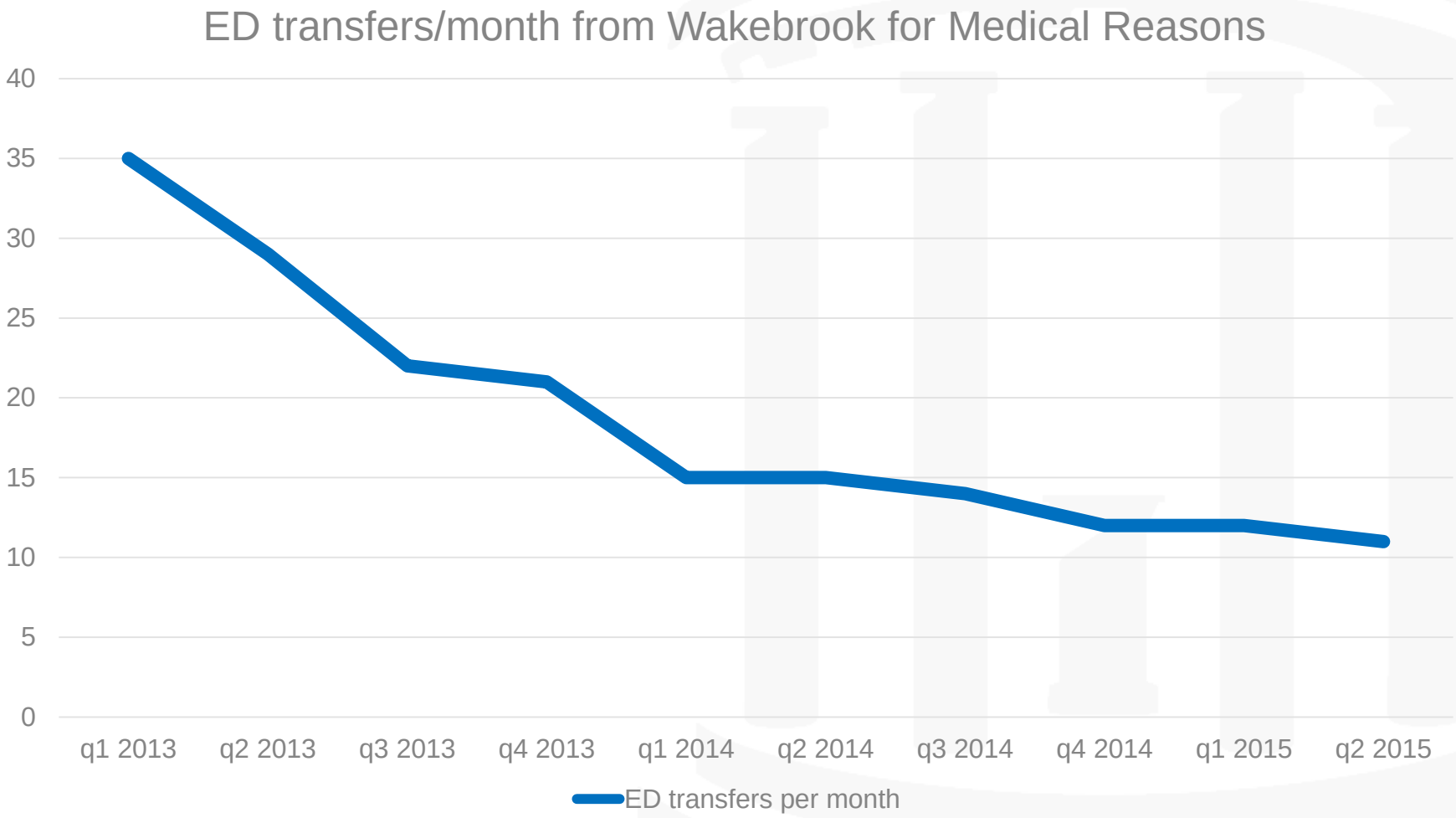








Early Impact of our Work on Units



Our Primary Care Practice Team

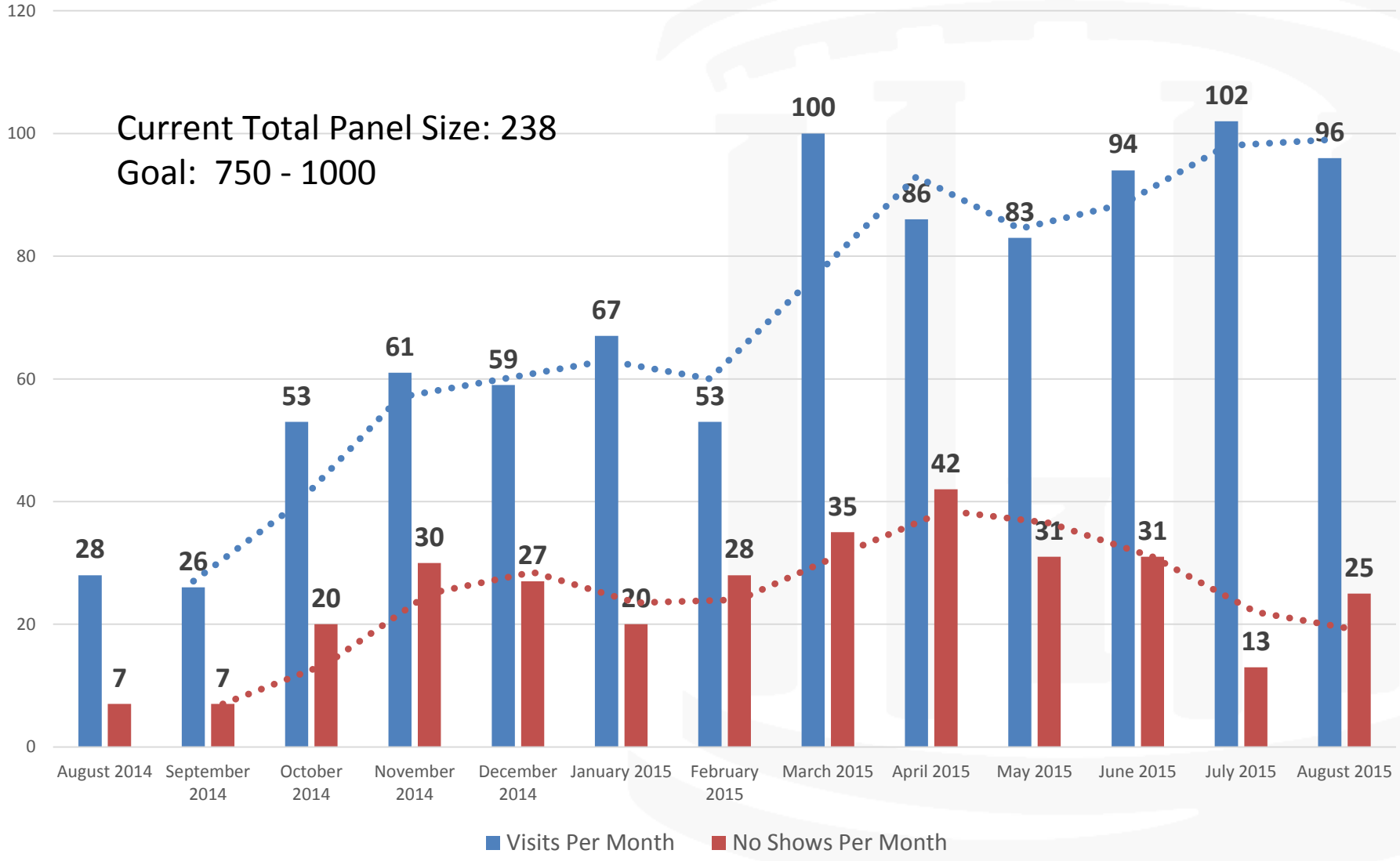
- Flex clinicians who work on units

- Full time RN with care manager role
- Full time office manager with quality improvement role

- Pharmacy technician (50%)
- Dental team (dental students with faculty supervision)
- Peer support (100%)

Note: positions in red being added currently (SAMHSA funded)
start up funds provided by UNC HCS and Wake County

Growing the Primary Care Office



The Clients in our Primary Care Office

Physical Health Diagnoses	n	%
HTN	107	45%
DM	43	18%
COPD	25	11%
CAD	10	4%
Psychiatric Diagnoses	**n**	**%**
Psychotic Disorder	177	74%
Severe Mood Disorder	22	9%
Personality Disorder	20	8%
Substance Use Disorder	56	24%

Insurance Status (%)		
	Medicaid	28%
	Dual	16%
	Medicare	26%
	Other Govt	5%
	Private	3%
	Uninsured	22%

Behavioral Health Connection	n	%
UNC ACT team	47	20%
Fellowship ACT team	5	2%
Easter Seals ACT team	2	1%
Carolina Outreach ACT team	5	2%
STEP clinic	60	25%
Naftel	15	6%
WakeMed	6	3%

Triple Aim Dashboard for Quality

	9/1/2015	
Population Health	n	%
Tobacco Use	160	67%
BMI >30	133	63%
DM with systolic >140	13	30%
DM with A1c >9	5	12%
HTN with SBP >140	36	34%
eligible women with Pap q3 yrs	pend	pend
patients >50 with CRC screen	pend	pend
Cost	n	%
Emergency room visits past 3 mo	pend	pend
Hospitalization past 3 months	pend	pend
Patient Experience	n	%
Time to third available appt	pend	pend
Cycle time	pend	pend
Patient satisfaction	pend	pend

Challenges

- Develop long term financial viability
  - Contracts that pay for value not for volume
  - Collect data for utilization outside of our office
- Find most effective and efficient ways to communicate with behavioral health team
- Measure patient experience