STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

JAN 1 6 2009

The Honorable Ulysses Currie, Chair
Senate Budget and Taxation Committee
3 West Miller Senate Building
Annapolis, MD 21401-1901

The Honorable Norman H. Conway, Chair
House Appropriations Committee
Room 121, House Office Building
Annapolis, MD 21401-1912

Re: 2008 Joint Chairmen's Report, Page 115, M00L01.02 – Status on plans to develop a pilot integrated care management plan for persons with serious mental illness and chronic physical health issues.

Dear Chairman Currie and Chairman Conway:

Pursuant to page 115 of the 2008 Joint Chairmen's Report the Department of Health and Mental Hygiene (DHMH) provides the following status report on its plans to develop a pilot integrated care management plan for persons with serious mental illness and chronic physical health issues.

In recognizing the correlation between mental illness and chronic physical health issues, the importance of prevention strategies and integrated care management systems in addressing overall health needs are apparent. This is supported by recent findings presented by the National Association of State Mental Health Program Directors' (NASMHPD) Medical Directors Council on Smoking, Morbidity and Mortality in People with Serious Mental Illness, Obesity Reduction and Prevention Strategies for Individuals with Mental Illness, as well as similar findings in Medscape, Heart Healthy: Preventive Medicine 2008. The most concerning of their findings is that individuals with mental illness die 25 years earlier than those without mental illness. Individuals with mental illness have a higher rate of chronic physical health problems than those in the general population. The main reasons noted were: smoking and an increased risk of obesity, and with obesity increases in metabolic symptoms, such as diabetes. ASMPHD studies noted that one of the most common contributors to early death among mentally ill patients is smoking. In understanding this correlation, and noting that more than 75 percent of people with mental illness are tobacco dependent, the Department recognizes the need to focus on integration of care with particular emphasis on smoking. Similarly, as noted in the Medscape article, "heart disease remains the leading cause of mortality, and a major cause of morbidity in the United

States, despite prevention efforts and advances in clinical care." Individuals with depression or bi-polar disorder are almost twice as likely to be obese as the general population, and in individuals with schizophrenia, that risk rises to three times higher. This in part is due to many psychotropic medications causing weight gain.

Thus, the Department plans to take a comprehensive approach to addressing the issue. We have decided to approach the problem from three angles: First, using a public health approach, the Department's administrations are working collaboratively in promoting wellness throughout the care continuum. Second, integration of care systems are being established through ongoing community partnerships, such as: the John Hopkins program "Access to Wellness Design" (described below). Through these partnerships, the Department will be able to better identify health risk factors and develop interventions that provide greater opportunity for improving an individual's overall health. Additionally, through continued collaborations with the National Association of Mental Health Program Directors, Psychological Association, the University of Maryland, and others in the academic arena, the Department will be able to better identify the connections between somatic health and mental health, determine the related barriers, and subsequently integrate best practices towards prevention of morbidity and mortality.

Public Health Approach

To address the most pressing health risks, the Department emphasizes the urgency of enhancing prevention efforts. With 75 percent of those with mental illness being smokers, we want to place particular emphasis on a tobacco-free lifestyle. DHMH is fortunate to have considerable experience in non-smoking initiatives, including the development of a 'quit line,' and implementing pilot programs to address the risk of increased cancer, stroke and heart disease. Thus, the Department's Mental Hygiene Administration (MHA) is collaborating with the Department's Center for Health Promotion, Education and Tobacco Use Prevention to implement several pilot projects to encourage individuals with mental illness to quit smoking. This includes tailoring the current quit line for individuals with serious mental illness.

1. MHA is chairing a committee of stakeholders, including consumers who have stopped smoking, to plan various pilot projects within peer-support programs, outpatient mental health centers and psychiatric rehabilitation programs.
2. MHA, in conjunction with On Our Own of Maryland, will incorporate non-smoking with Wellness Recovery Action Plan (WRAP) training. On January 22, 2009, a DHMH sponsored conference will highlight this initiative and provide greater information on best practices to stop smoking targeted to individuals with serious mental illness.
3. Additionally, MHA is collaborating with National Alliance on Mental Illness (NAMI) to implement the Six Weeks to Wellness Program, which was created by NAMI. This program emphasizes prevention to improving overall wellness through educating individuals with serious mental illness and their families on proper nutrition for weight control. Additionally, the program shares information regarding yoga techniques and provides consultation regarding appropriate medications to control anxiety.

4. In setting a standard for the State, effective September 2008 all State psychiatric hospitals became smoke-free, decreasing the health risk for these patients through providing ongoing smoking cessation programs, nicotine replacement therapy, education, and support. Maryland is the only state in the Northeast United States to take an entire hospital system tobacco-free.

We believe these public health approaches to healthy lifestyles will have a significant impact on the physical health of those with mental illness in our state.

Integration of Care Approach

The vast majority of individuals served in the Public Mental Health System are Medicaid recipients. As a step toward an integration of care systems, the Department chairs a Medicaid Managed Care Organization (MCO) Integration of Care Committee which meets bi-monthly. Committee members include representation from the provider community, MCO care manager designees, the Public Mental Health System's Administrative Services Organization (ASO), the Mental Hygiene Administration (MHA), representatives for co-occurring disorders and consumers. Through this group, issues are identified and solutions are found to improve care. One example of the improved service coordination facilitated by this Committee is the Pharmacy data-link, which provides Medicaid physicians access to pharmacy information for individuals receiving mental health services. This system provides access to both psychotropic as well as somatic prescriptions. Another program that was developed, which is monitored by MAPS, identifies consumers that frequent emergency rooms and have multiple inpatient admissions. This program provides coordination of community transition with the MCO, the ER, MHA, the provider, and the Core Service Agency. Additionally, MHA, its Administrative Service Organization (ASO), and Medicaid staff participate in the MCO Medical Directors meeting, which serves as a forum to educate and resolve administrative problems that in turn improve communications between somatic and mental health administrators. Discussions for the development of a pilot project for data sharing have begun within this group having a specific review on mental health usage patterns.

Through ongoing collaborations with the Department's Mental Hygiene Administration (MHA), consumers, family members, advocates, providers, Core Service Agencies, the University of Maryland, and Johns Hopkins Hospital School of Medicine, some pilot programs using an integrated care model have been implemented in the State. Highlighted below are the Hopkins' Bayview and the University of Maryland's programs:

- Hopkins BayView *Access to Wellness*

  The program chose to focus on risk factors that could be 'modifiable' and subsequently targeted 5 interventions: smoking cessation, nutrition, get it moving (life style), diabetes, and hypertension. The program is called Access to Wellness.

Access to Wellness (A2W) is designed to target the risk factors of an individual consumer and to improve both health literacy and health behavior. Consumers entering A2W take a comprehensive health screen that includes lab work. The A2W nurse practitioner reviews the results and personally makes specific health recommendations for each consumer. These recommendations are sent to the individual's existing primary care physician and a wellness plan is developed by the consumer based on his/her preferences. Health education sessions, follow up and coaching in line with those goals are provided by the nurse, case manager and peer support specialist. To date, the most frequently selected consumer goal is weight loss. They report good success with weight loss, increasing activity and smoking cessation on a relatively small individual level scale. The next step will be a broader plan using standardized curricula for basic health behavior training and outcomes will be measured.

- University of Maryland's *STIRR Research Project*

The University developed the STIRR project (Screen, Test, Immunize, Reduce Risk and Refer). They are targeting 2 groups: (1) people with severe mental illness, including schizophrenia, bipolar and other severe and chronic mental disorders, who are at increased risk for HIV and HCV infection and (2) those who also have a co-occurring substance abuse disorder who are at an even greater risk and are more likely not to receive recommended preventive and medical services. The intervention is delivered at the site of mental health care by an external team of specialists, and requires about one hour of client contact over 3 sessions. It consists of 3 basic components: implementation support, on-site services and treatment referral/support, all delivered over a 6-month period. The STIRR nurse works with mental health providers to coordinate the referral for medical treatment. The STIRR team also offers consultation and education regarding issues of infectious disease and substance abuse treatment.

The study is designed for a total of 238 individuals with co-occurring disorders across 5 Outpatient Mental Health Centers (OMHC) in Baltimore City. Early immunization/intervention completion rates among those in STIRR appear promising at all clinics—first visit at 100 percent, second visit ranging in 73 percent to 100 percent, and the third visit with three OMHCs reporting 67 percent to 96 percent.

These pilot programs offer great promise as models for systems to integrate mental and somatic health care.

Working with Academia and National Associations

In addition to these current pilot programs, there is increased interest in creating a medical home. The Department has always believed that a medical home offers the greatest promise for quality and continuity of care. Anthony Lehman, MD, Chairman Department of Psychiatry at University of Maryland, has recently completed a paper on integrated care and the medical home. The University is exploring grant opportunities to further its study. MHA will continue to collaborate with University to further both the integration of care and medical home programs. Staying aligned with the academic centers' work in this area keeps us informed and assists us in better identifying the connections between somatic health and mental health, recognizing the barriers, and then learning how to integrate best practices.

The Department looks forward to collaborating with the NASMPHD on finalizing recommended guidelines for physicians that will standardize medical tests, assessments, and the care given to individuals with mental illness toward improved wellness. Similarly, the Department will work with the American Psychological Association and all stakeholders to educate mental health specialists about the physical concerns confronting individuals with mental illness.

Summary

The Department does not have access to new dollars to develop additional integrated care system pilot programs at this time. Therefore, we will be encouraging state-wide efforts in prevention strategies and setting standards that facilitate healthy choices with regard to smoking, physical activity and nutrition for individuals with mental illness. We know that these are effective interventions for improving morbidity and mortality for mental health consumers in our State. The Department will continue its collaborations with stakeholders, including John Hopkins University and the University of Maryland, on models that focus on early prevention strategies, integration of care approaches and those that combine changing health behavior with motivational enhancements toward an individual's overall improved health.

If you have any questions concerning this report, please do not hesitate to contact Anne Hubbard, Director of Governmental Affairs, at 410-767-6481.

Sincerely,

John M. Colmers
Secretary

cc: Renata Henry, Deputy Secretary of Behavioral Health and Disabilities
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