DSRIP 1115 Medicaid Waiver Program

Chronic Disease Management for Behavioral Health Providers

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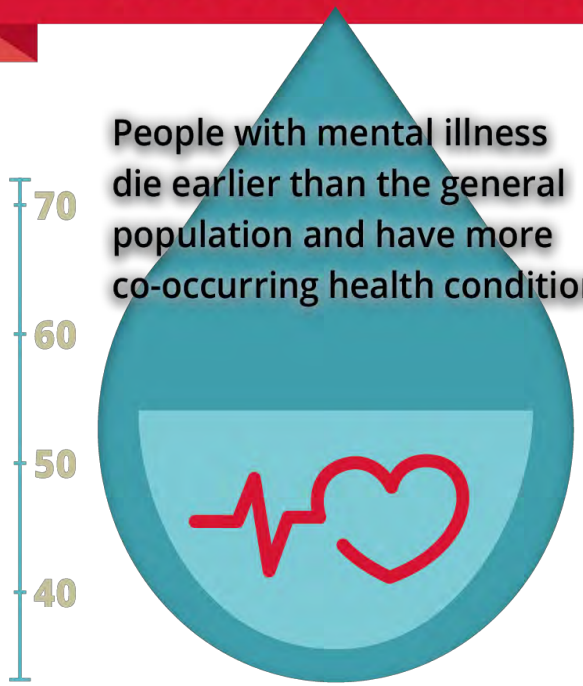
Learning Objectives

- Define the latest guidelines for diabetes, hypertension (high blood pressure) and dyslipidemia (cholesterol/lipid disorders)
- Understand the intersection of behavioral health and chronic disease management
- Identify barriers to the integration of behavioral health care and chronic disease management
- Identify and utilize strategies to overcome identified barriers

Outline

- Overview of Chronic Disease Management
- The intersection of Chronic Disease and Behavioral Health
- Integration barriers/solutions
- Case Study/discussion/Q and A

The PROBLEM



People with mental illness die earlier than the general population and have more co-occurring health conditions.

68% of adults with a mental illness have one or more chronic physical conditions

more than **1 in 5** adults with mental illness have a co-occurring substance use disorder

SAMHSA-HRSA
Center for Integrated Health Solutions

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
MENTAL HEALTH FIRST AID
Healthy Minds. Strong Communities.

SAMHSA
Substance Abuse and Mental Health Services Administration
www.samhsa.gov 1-877-SAMHSA-7 (1-877-726-4727)

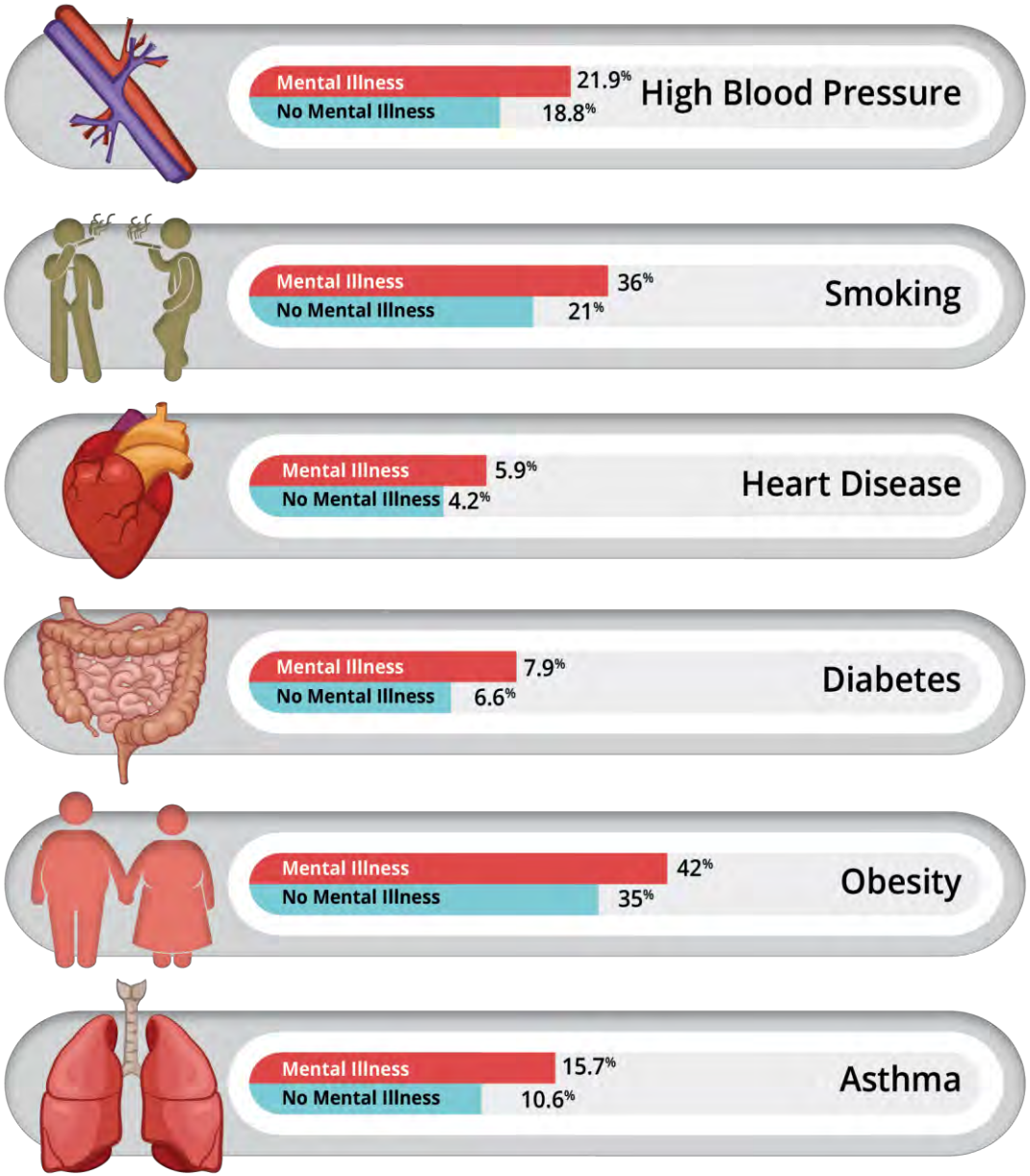
www.integration.samhsa.gov

Brown et al. 2010

NETWORK 4 HEALTH

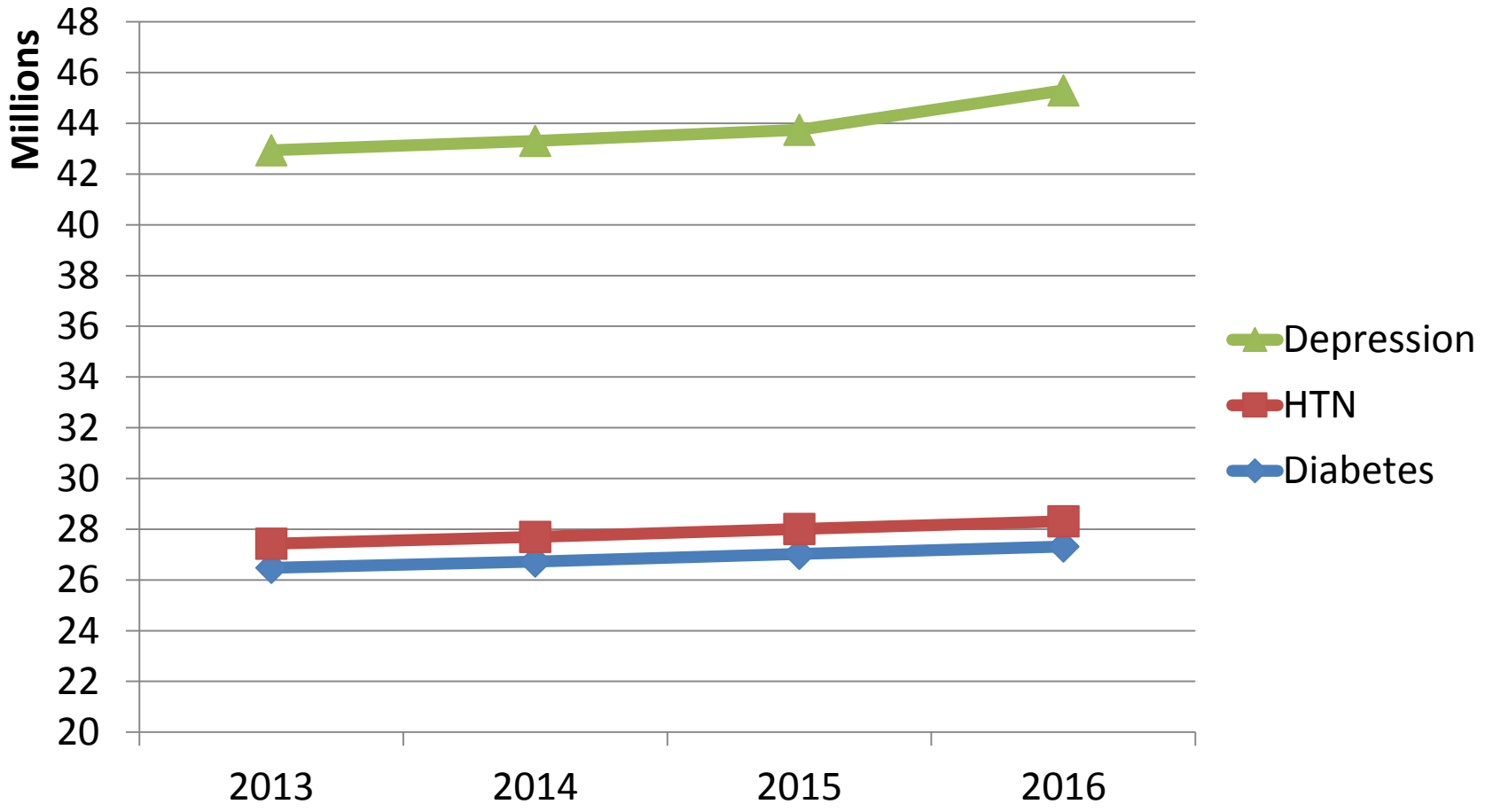
OVERVIEW OF CHRONIC DISEASE MANAGEMENT

Co-occurrence between mental illness and other chronic health conditions:



https://www.integration.samhsa.gov/integrated-care-models/primary-care-in-behavioral-health, accessed 5/9/18
Liu et al. (2017)

Diabetes, HTN, and Depression Prevalence US – 2013 - 2016



http://ghdx.healthdata.org/gbd-results-tool accessed 4/25/18

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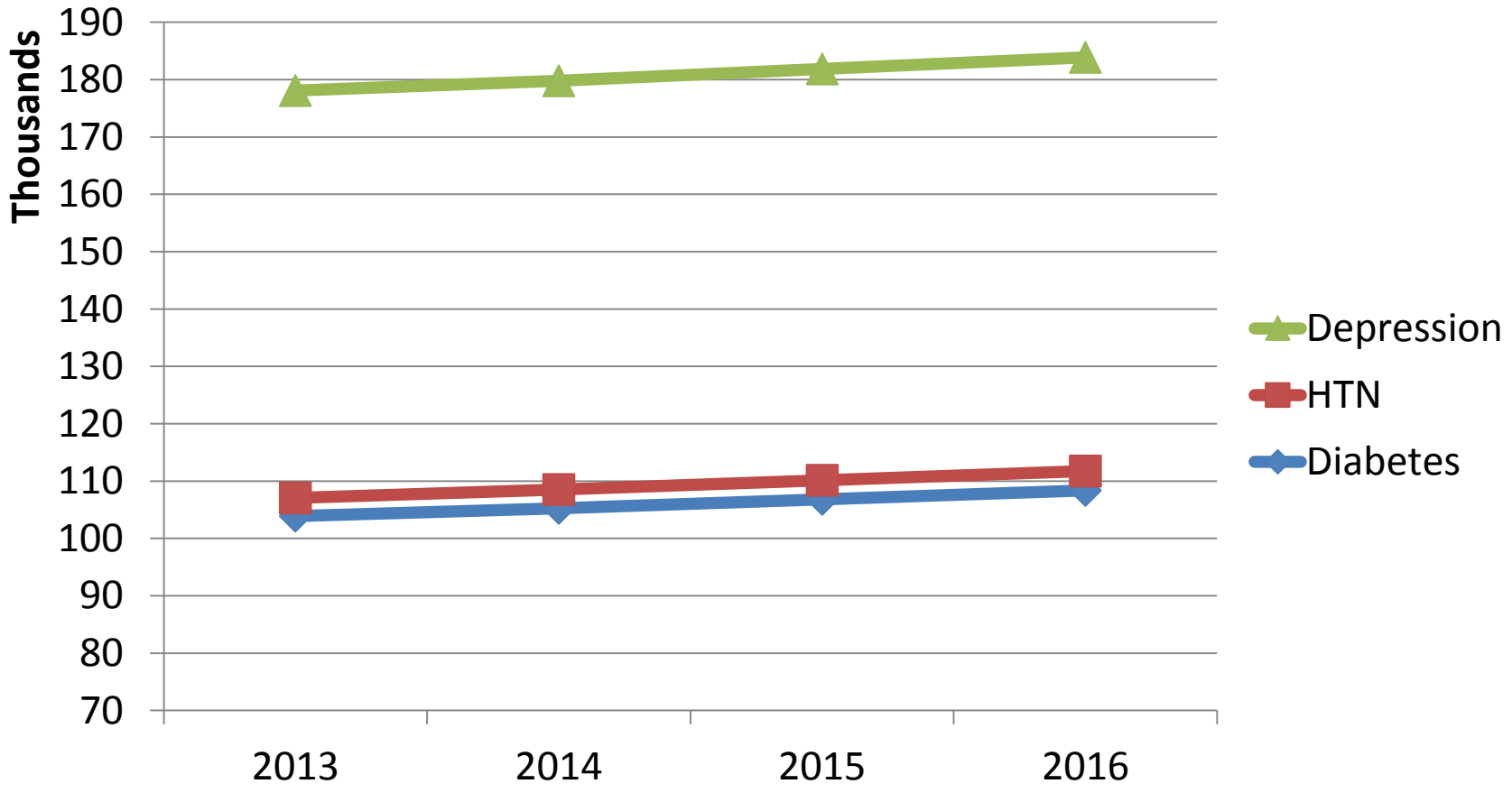
Diabetes, HTN, and Depression Prevalence NH – 2013 - 2016



http://ghdx.healthdata.org/gbd-results-tool accessed 4/25/18

NETWORK 4 HEALTH

ADA Standards of Care 2018

TABLE 2. Criteria for Testing for Diabetes or Prediabetes in Asymptomatic Adults

1. Testing should be considered in overweight or obese (BMI ≥25 kg/m^2 or ≥23 kg/m^2 in Asian Americans) adults who have one or more of the following risk factors:
   - First-degree relative with diabetes
   - High-risk race/ethnicity (e.g., African American, Latino, Native American, Asian American, Pacific Islander)
   - History of CVD
   - Hypertension (≥140/90 mmHg or on therapy for hypertension)
   - HDL cholesterol level <35 mg/dL (0.90 mmol/L) and/or a triglyceride level >250 mg/dL (2.82 mmol/L)
   - Women with polycystic ovary syndrome
   - Physical inactivity
   - Other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans)
2. Patients with prediabetes (A1C ≥5.7% [39 mmol/mol], IGT, or IFG) should be tested yearly.
3. Women who were diagnosed with GDM should have lifelong testing at least every 3 years.
4. For all other patients, testing should begin at age 45 years.
5. If results are normal, testing should be repeated at a minimum of 3-year intervals, with consideration of more frequent testing depending on initial results and risk status.

Standards of Medical Care in Diabetes-2018 Abridged for Primary Care Providers. (2018). *Clinical Diabetes: A Publication Of The American Diabetes Association*, *36*(1), 14-37. doi:10.2337/cd17-0119

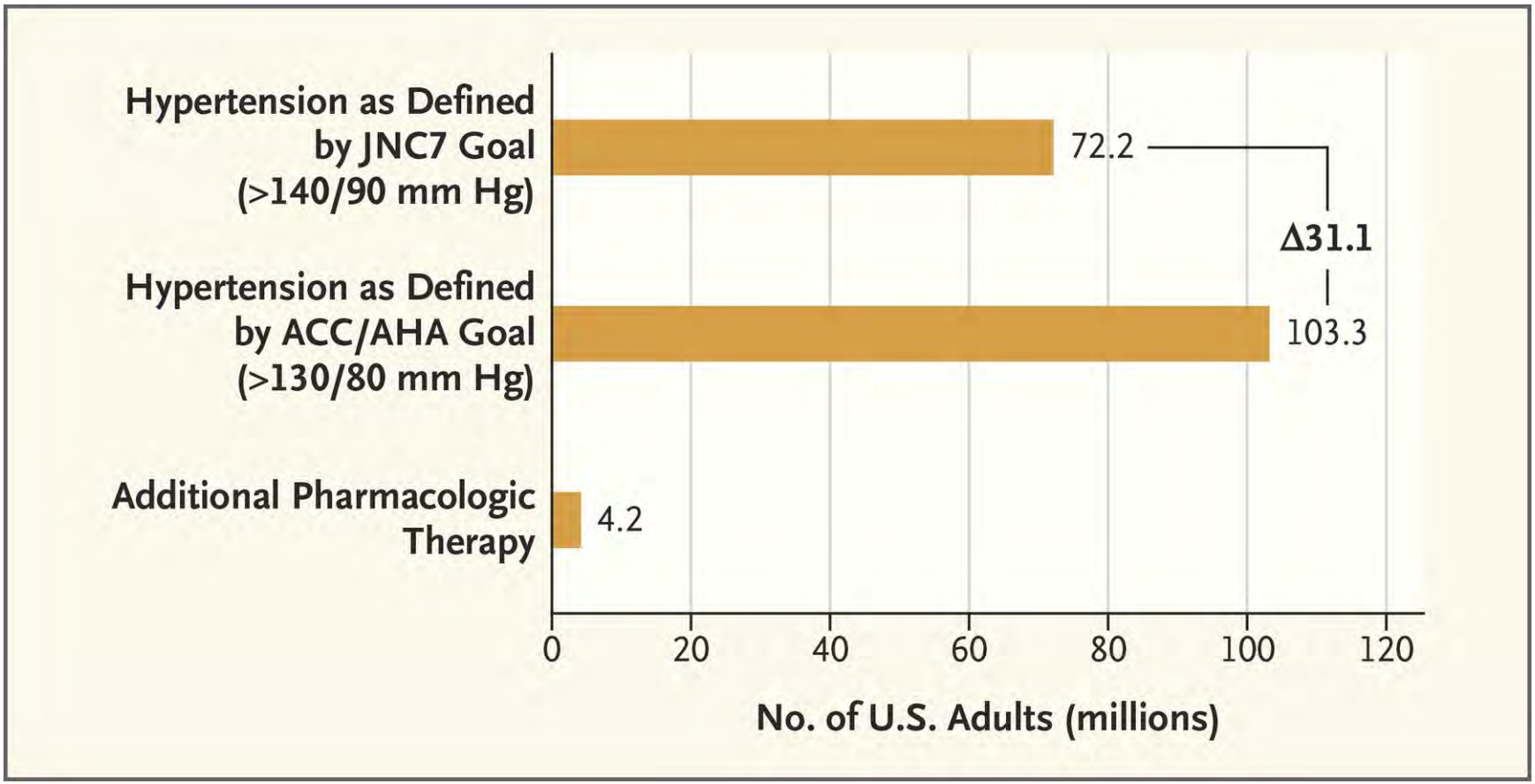
ADA Standards of Care 2018

TABLE 1. Criteria for the Screening and Diagnosis of Diabetes		
	Prediabetes	Diabetes
A1C	5.7–6.4%*	≥6.5%†
FPG	100–125 mg/dL (5.6–6.9 mmol/L)*	≥126 mg/dL (7.0 mmol/L)†
OGTT	140–199 mg/dL (7.8–11.0 mmol/L)*	≥200 mg/dL (11.1 mmol/L)†
RPG	—	≥200 mg/dL (11.1 mmol/L)‡

**For all three tests, risk is continuous, extending below the lower limit of the range and becoming disproportionately greater at the higher end of the range. †In the absence of unequivocal hyperglycemia, results should be confirmed by repeat testing. ‡Only diagnostic in a patient with classic symptoms of hyperglycemia or hyperglycemic crisis. RPG, random plasma glucose.*

Standards of Medical Care in Diabetes-2018 Abridged for Primary Care Providers. (2018). *Clinical Diabetes: A Publication Of The American Diabetes Association*, *36*(1), 14-37. doi:10.2337/cd17-0119

Hypertension Guidelines



Muntner, P., et al. (2018). Potential U.S. Population Impact of the 2017 ACC/AHA High Blood Pressure Guideline. *Journal Of The American College Of Cardiology (JACC)*, *71*(2), 109-118. doi:10.1016/j.jacc.2017.10.073

NETWORK 4 HEALTH

Dyslipidemia

- USPSTF updated guidelines in 2016
- Universal screening is recommended for all adults 40 – 75 years old

Adults 40 – 75 with NO history of CVD, ≥ 1 CVD risk factors, and calculated 10 year CVD event risk ≥ 10%	Adults aged 40 – 75 with NO history of CVD; ≥ 1 CVD risk factors, and calculated 10 year CVD event risk of 7.5 – 10%
Initiate use of low to moderate dose statins	Discuss with patient and selectively offer use of low to moderate dose statins

Bibbins-Domingo, K. et al 2016

NETWORK 4 HEALTH

THE INTERSECTION OF CHRONIC DISEASE AND BEHAVIORAL HEALTH

Psychosocial Screening

- Psychosocial care should be integrated with a collaborative, patient-centered approach and provided to all people with diabetes, with the goals of optimizing health outcomes and health-related quality of life. **A**
- Providers should consider assessment for symptoms of diabetes distress, depression, anxiety, disordered eating, and cognitive capacities using patient-appropriate standardized and validated tools at the initial visit, at periodic intervals, and when there is a change in disease, treatment, or life circumstance. Including caregivers and family members in this assessment is recommended. **B**
- Consider screening older adults (aged ≥65 years) with diabetes for cognitive impairment and depression. **B**

Psychosocial care for People with Diabetes: A position statement of the American Diabetes Association. Diabetes Care 2016;39;2126-2140

NETWORK 4 HEALTH

Is this Depression or Diabetes Distress?

PHQ3 and PHQ9

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last 2 *weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).	TOTAL:			

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

DDS17

Figure 1. DDS17 Scoring Sheet

Instructions for Scoring:

The DDS17 yields a total DD scale score plus 4 subscale scores, each addressing a different kind of distress. To score, simply sum the patient's responses to the appropriate items and divide by the number of items in that scale. The letter in the far right margin corresponds to that item's subscale as listed below. We consider a mean item score of ≥3 (moderate distress) as a level of distress worthy of clinical attention. Place a check on the line to the far right if the mean item score is ≥3 to highlight an above-range value.
We also suggest reviewing the patient's responses across all items, regardless of mean item scores. It may be helpful to inquire further or to begin a conversation about any single item scored ≥3.

Total DDS Score:

a. Sum of 17 item scores. _____
b. Divide by: 17
c. Mean item score: _____ ≥3_____

A. Emotional Burden:
a. Sum of 5 items (1, 3, 8, 11, 14) _____
b. Divide by: 5
c. Mean item score: _____ ≥3_____

B. Physician-related Distress:
a. Sum of 4 items (2, 4, 9, 15) _____
b. Divide by: 4
c. Mean item score: _____ ≥3_____

C. Regimen-related Distress:
a. Sum of 5 items (5, 6, 10, 12, 16) _____
b. Divide by: 5
c. Mean item score: _____ ≥3_____

D. Interpersonal Distress:
a. Sum of 3 items (7, 13, 17) _____
b. Divide by: 3
c. Mean item score: _____ ≥3_____

Table 1. Diabetes Distress Screening Test

Listed below are 2 potential problem areas that people with diabetes may experience. Consider the degree to which each of the 2 items may have distressed or bothered you during the past month and circle the appropriate number. If the scores are 3 or greater for either question, complete the 17-question Diabetes Distress Scale (**Table 2**).

	Not a Problem	Slight Problem	Moderate Problem	Somewhat Serious Problem	Serious Problem	Very Serious Problem
1. Feeling overwhelmed by the demands of living with diabetes.	1	2	3	4	5	6
2. Feeling that I am often failing with my diabetes routine.	1	2	3	4	5	6

Fisher et al. Diabetes Care 35:259-264, 2012

Hyperglycemia and Dyslipidemia Risk 2nd Generation Antipsychotics

Drug	Weight Gain/Diabetes	Hypercholesterolemia (High Cholesterol
Aripiprazole (Abilify)	+	-
Asenapine (Saphris)	++	-
Brexpiprazole (Rexulti)	+	+
Cariprazine (Vraylar)	+	-/+
Clozapine (Colzaril)	++++	++++
Iloperidone (Fanapt)	++	++
Lurasidone (Latuda)	-/+	-/+
Olanzapine (Zyprexa)	++++	++++
Paliperidone (Invega)	+++	+
Pimavanserin (Nuplazid)	+	-
Quetiapine (Seroquel)	+++	+++
Risperidone (Risperdal)	+++	+
Ziprasidone (Geodon)	-/+	-/+

"Atypical antipsychotics have been associated with development of hyperglycemia; in some cases, may be extreme and associated with ketoacidosis, hyperosmolar coma, or death. Use with caution in patients with diabetes or other disorders of glucose regulation; monitor for worsening of glucose control"

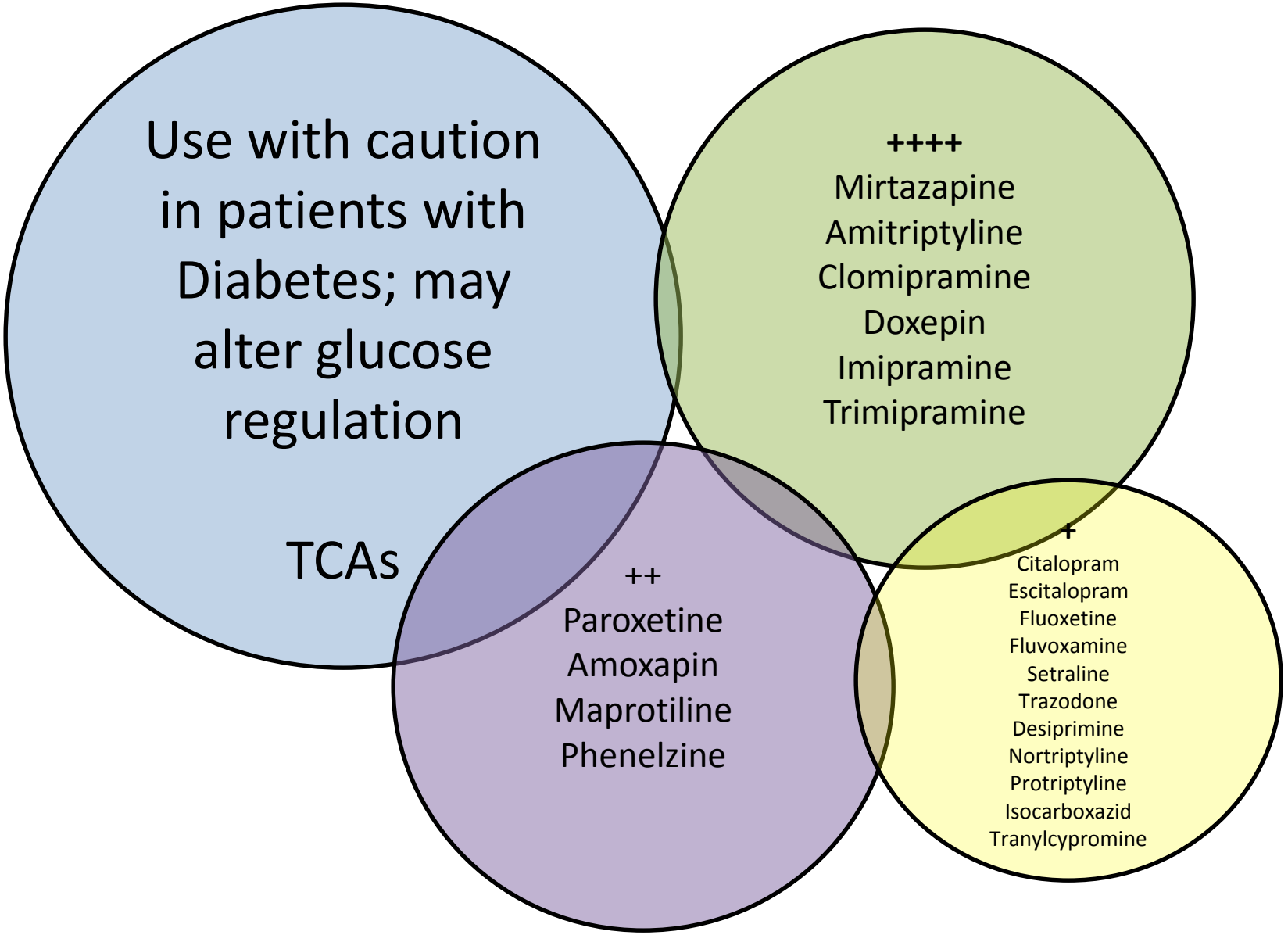
ADA; Diabetes Care,27:2: 596-601
Lexicomp http://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7897 accessed 4/18/18

Monitoring protocol for patients on SGAs

	Baseline	4 weeks	8 weeks	12 weeks	Quarterly	Annually	Every 5 years
Personal/Family History	X					X	
Weight (BMI)	X	X	X	X	X		
Waist Circumference	X					X	
Blood pressure	X			X		X	
Fasting Plasma Glucose	X			X		X	
Fasting lipid profile	X			X			X

ADA; Diabetes Care,27:2: 596-601

Selected Antidepressants Diabetes Risk and Weight Gain



Lexicomp http://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7897 accessed 4/18/18
Gafoor et al 2018

When to refer to Behavioral Health

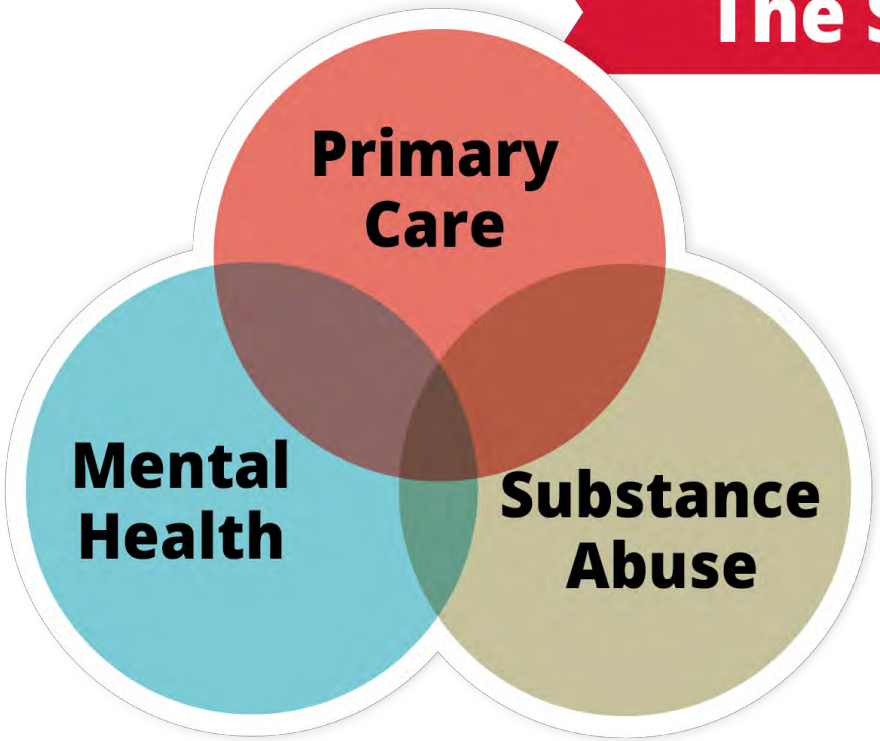
TABLE 5. Situations That Warrant Referral of a Person With Diabetes to a Mental Health Provider for Evaluation and Treatment

- If self-care remains impaired in a person with DD after tailored diabetes education
- If a person has a positive screen on a validated screening tool for depressive symptoms
- In the presence of symptoms or suspicions of disordered eating behavior, an eating disorder, or disrupted patterns of eating
- If intentional omission of insulin or oral medication to cause weight loss is identified
- If a person has a positive screen for anxiety or fear of hypoglycemia
- If a serious mental illness is suspected
- In youth and families with behavioral self-care difficulties, repeated hospitalizations for diabetic ketoacidosis, or significant distress
- If a person screens positive for cognitive impairment
- Declining or impaired ability to perform diabetes self-care behaviors
- Before undergoing bariatric or metabolic surgery and after surgery if assessment reveals an ongoing need for adjustment support

Psychosocial care for People with Diabetes: A position statement of the American Diabetes Association. Diabetes Care 2016;39;2126-2140

INTEGRATION

The SOLUTION



The solution lies in integrated care – the coordination of mental health, substance abuse, and primary care services.

Integrated care produces the best outcomes and is the most effective approach to caring for people with complex healthcare needs.

https://www.integration.samhsa.gov/integrated-care-models/primary-care-in-behavioral-health

NETWORK 4 HEALTH

Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understanding of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet ill-defined team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth understanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013

Table 3. Advantages and Weaknesses at Each Level of Collaboration/Integration

COORDINATED		CO-LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Advantages					
▸▸ Each practice can make timely and autonomous decisions about care ▸▸ Readily understood as a practice model by patients and providers	▸▸ Maintains each practice's basic operating structure, so change is not a disruptive factor ▸▸ Provides some coordination and information-sharing that is helpful to both patients and providers	▸▸ Colocation allows for more direct interaction and communication among professionals to impact patient care ▸▸ Referrals more successful due to proximity ▸▸ Opportunity to develop closer professional relationships	▸▸ Removal of some system barriers, like separate records, allows closer collaboration to occur ▸▸ Both behavioral health and medical providers can become more well-informed about what each can provide ▸▸ Patients are viewed as shared which facilitates more complete treatment plans	▸▸ High level of collaboration leads to more responsive patient care, increasing engagement and adherence to treatment plans ▸▸ Provider flexibility increases as system issues and barriers are resolved ▸▸ Both provider and patient satisfaction may increase	▸▸ Opportunity to truly treat whole person ▸▸ All or almost all system barriers resolved, allowing providers to practice as high functioning team ▸▸ All patient needs addressed as they occur ▸▸ Shared knowledge base of providers increases and allows each professional to respond more broadly and adequately to any issue
Weaknesses					
▸▸ Services may overlap, be duplicated or even work against each other ▸▸ Important aspects of care may not be addressed or take a long time to be diagnosed	▸▸ Sharing of information may not be systematic enough to effect overall patient care ▸▸ No guarantee that information will change plan or strategy of each provider ▸▸ Referrals may fail due to barriers, leading to patient and provider frustration	▸▸ Proximity may not lead to greater collaboration, limiting value ▸▸ Effort is required to develop relationships ▸▸ Limited flexibility, if traditional roles are maintained	▸▸ System issues may limit collaboration ▸▸ Potential for tension and conflicting agendas among providers as practice boundaries loosen	▸▸ Practice changes may create lack of fit for some established providers ▸▸ Time is needed to collaborate at this high level and may affect practice productivity or cadence of care	▸▸ Sustainability issues may stress the practice ▸▸ Few models at this level with enough experience to support value ▸▸ Outcome expectations not yet established

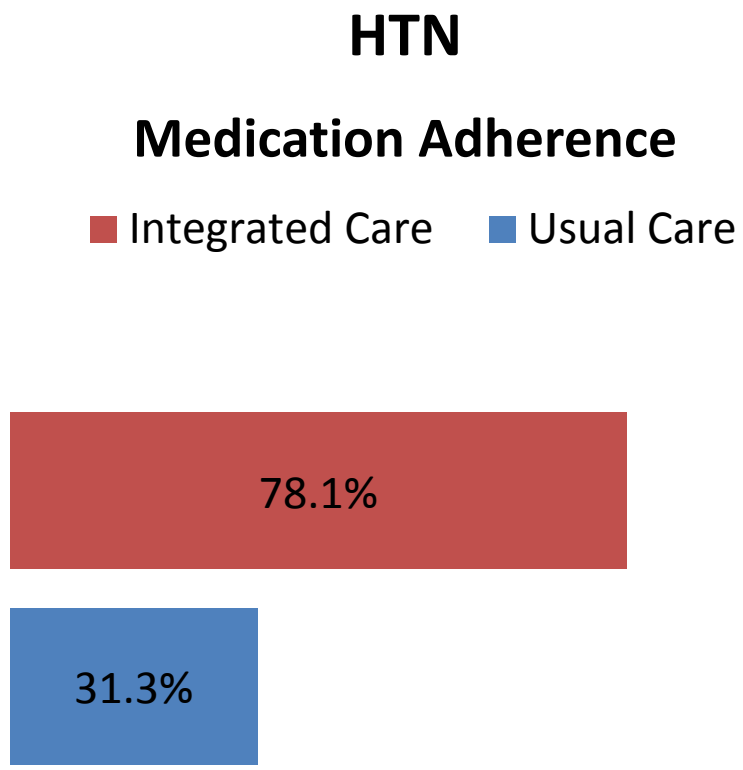
Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013

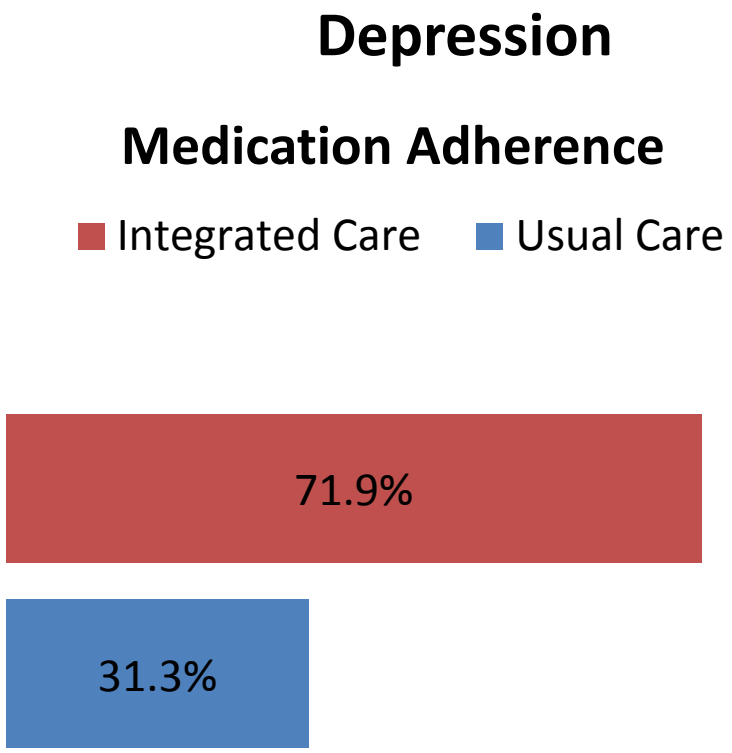
Does Integrated care work?

- Integrated care improved quantitative and qualitative measures related to diabetes, hypertension, dyslipidemia as well as depression (Katon et. Al. 2011)
- Improved blood pressure control and adherence to antihypertensive medications and antidepressants (Bogner et al. 2008)
- Improves patient engagement and is cost effective (Goodrich et al 2013)
- Improvement in depression symptom severity, treatment response and remission rates was consistently positive across all levels of integration (Butler et al 2011)
- Patients perceived personal, interpersonal and organizational benefits from integrated care. (Davis et al 2018)

NETWORK 4 HEALTH

HTN and Depression





Bogner et al, AnnFamMed 2008

Mental Health Provider Directory Listing

The American Diabetes Association Mental Health Provider Directory lists individuals who treat the psychosocial/mental health ne of people with diabetes. Listing in the Directory is available to providers that certify that they meet the following criteria:

1. Currently licensed as a mental health provider
2. Professional member of the ADA (Associate, Professional 1, Professional 2); and
3. Demonstrated competence treating the mental health needs of people with diabetes by: (a) Successful completion the A APA continuing education program (Learn more.) Or (b) Two or more years of experience addressing the mental health ne of people with diabetes. Apply now.

Disclaimer: The Association does not render medical advice nor recommend specific providers or treatment.

Search for **Telemedicine** providers

Adult Services	Pediatric Services	Miles Radius	From Postcode		
Yes	- Any -	50 Miles	03102	Apply	Reset

▸ Show/Hide Map

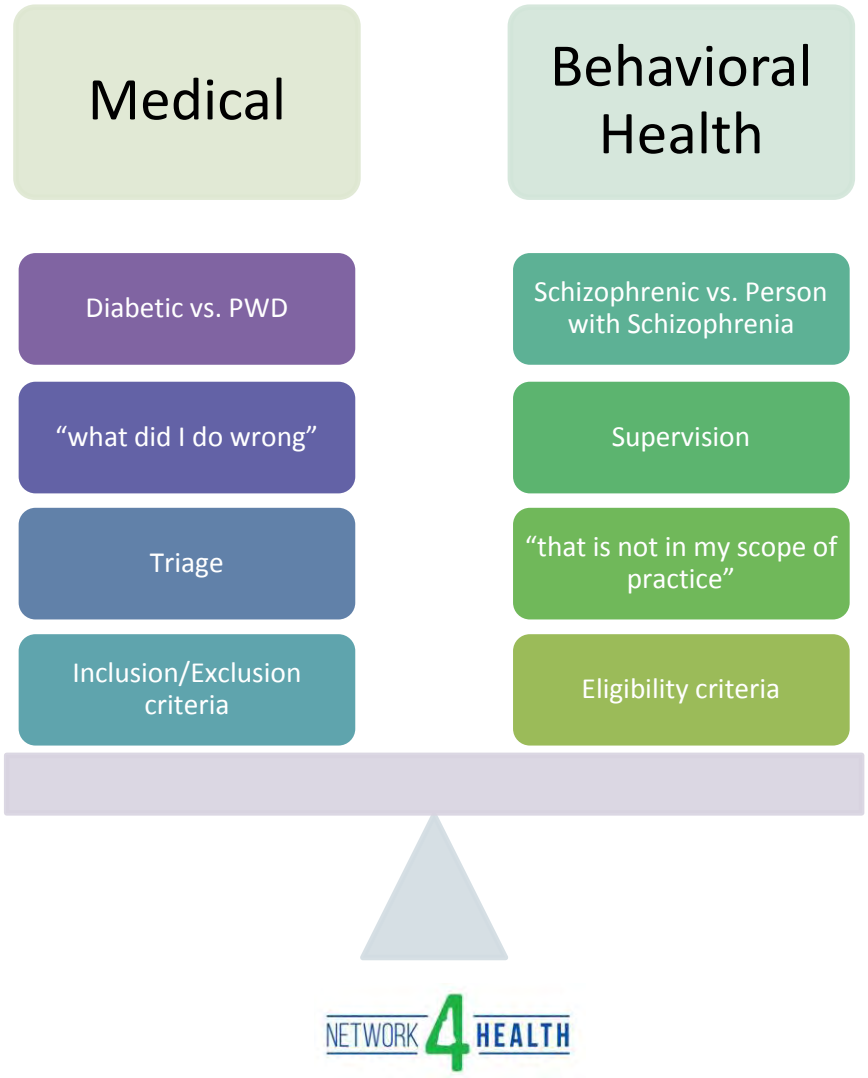
Name: Kara Harrington, PhD
Adult Services: Yes
Pediatric Services: Yes
Phone: 978-254-3023
Driving directions
Distance: **45.32** miles

Name: Ann Goebel-Fabbri, PhD
Adult Services: Yes
Pediatric Services: Yes
Phone: 617-513-9327
Driving directions
Distance: **49.78** miles

https://professional.diabetes.org

BARRIERS/SOLUTIONS OF INTEGRATED CARE

Language


Medical
Behavioral Health
Diabetic vs. PWD
Schizophrenic vs. Person with Schizophrenia
"what did I do wrong"
Supervision
Triage
"that is not in my scope of practice"
Inclusion/Exclusion criteria
Eligibility criteria
NETWORK 4 HEALTH

Integration barriers

- Physical proximity
- Differing treatment goals and priorities
- Medication reconciliation
- Care Coordination - Shared care plans
- Education
  - Social Workers
  - Psychiatrists
- Work-arounds
- Technology is critical for tying together the health care system

Siantz et al 2017
Weiner et al 2005
Benzer et al 2015

NETWORK 4 HEALTH

42 CFR Part 2

- Intended to ensure that a patient receiving treatment for a SUD does not face adverse consequences
- Protects the confidentiality of SUD patient records by restricting disclosure or re-disclosure of such records
- What is the impact on integrated care? (McCarty et al 2017)
  - Legal uncertainty
  - Barrier to communication and information sharing
  - Different interpretations of the law (HIPAA versus 42CFR2)
  - Difficulty in securing an ROI

McCarty et al. 2017

CASE STUDY

Case Study - James

- 56 year old male with a history of Type 2 Diabetes, Peripheral neuropathy, Orthostatic hypotension, substance use disorder, schizophrenia
- Diagnosed with a diabetic foot ulcer, osteomyelitis and released to the shelter from the local hospital with instructions for no weight bearing. Has appointment with wound care in 1 week
- He was advised to quit smoking, and given a prescription for nicotine patches
- He was given prescriptions for his basal/bolus insulins, metformin, an antibiotic, and an antipsychotic.
- Has Medicare with QMB and income from SSDI

Case Study – James Outcome

- Readmitted to hospital multiple times
- Spent 2 months inpatient receiving IV antibiotics. Discharged and readmitted the same day for bleeding after walked on wound to get wound supplies
- Multiple surgeries with amputations of parts of foot to address osteomyelitis
- Moved out of area and had amputation
- Returned to area and was hospitalized when he ran out of insulin. Released to a rooming house. Readmitted for cardiac issue – discharged to Mental Health Supportive Housing with Mental Health Case Manager

Case Study – James Final Outcome

- Exercising daily and
- Eating 3 balanced meals daily,
  - Improvement in:
    - daily blood sugar results
    - self-efficacy as evidenced by daily blood sugar checking prior to each meal and asking for help with managing frequent hypoglycemia
- Referrals:
  - DSMES with MH Case Manager attending
  - PT/OT for new prosthesis

“Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”

Dr. Martin Luther King, Jr.

in a speech to the Medical Committee for Human Rights, 1966

References

- Standards of Medical Care in Diabetes-2018 Abridged for Primary Care Providers. (2018). *Clinical Diabetes: A Publication Of The American Diabetes Association*, *36*(1), 14-37. doi:10.2337/cd17-0119
- Standards of Medical Care in Diabetes-2018. (2018). *Diabetes Care*, *41*(Suppl 1), S1-S153. doi:10.2337/dc18-Sint01
- Liu, N. H., Daumit, G. L., Dua, T., Aquila, R., Charlson, F., Cuijpers, P., & ... Saxena, S. (2017). Excess mortality in persons with severe mental disorders: a multilevel intervention framework and priorities for clinical practice, policy and research agendas. *World Psychiatry: Official Journal Of The World Psychiatric Association (WPA)*, *16*(1), 30-40. doi:10.1002/wps.20384
- Walker, E. R., McGee, R. E., & Druss, B. G. (2015). Mortality in mental disorders and global disease burden implications: a systematic review and meta-analysis. *JAMA Psychiatry*, *72*(4), 334-341. doi:10.1001/jamapsychiatry.2014.2502
- https://www.nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf accessed 5/9/18
- Druss, B. G., Chwastiak, L., Kern, J., Parks, J. J., Ward, M. C., & Raney, L. E. (2018). Psychiatry's Role in Improving the Physical Health of Patients With Serious Mental Illness: A Report From the American Psychiatric Association. *Psychiatric Services (Washington, D.C.)*, *69*(3), 254-256. doi:10.1176/appi.ps.201700359
- Brown, C., Leith, J., Dickerson, F., Medoff, D., Kreyenbuhl, J., Fang, L., & ... Dixon, L. (2010). Predictors of mortality in patients with serious mental illness and co-occurring type 2 diabetes. *Psychiatry Research*, *177*(1-2), 250-254. doi:10.1016/j.psychres.2010.01.004
- Vera, M., Perez-Pedrogo, C., Huertas, S. E., Reyes-Rabanillo, M. L., Juarbe, D., Huertas, A., & ... Chaplin, W. (2010). Collaborative care for depressed patients with chronic medical conditions: a randomized trial in Puerto Rico. *Psychiatric Services (Washington, D.C.)*, *61*(2), 144-150. doi:10.1176/ps.2010.61.2.144

NETWORK 4 HEALTH

References

- Knowles, S. E., Chew-Graham, C., Adeyemi, I., Coupe, N., & Coventry, P. A. (2015). Managing depression in people with multimorbidity: a qualitative evaluation of an integrated collaborative care model. *BMC Family Practice*, *16*32. doi:10.1186/s12875-015-0246-5
- https://www.integration.samhsa.gov/integrated-care-models/primary-care-in-behavioral-health, accessed 5/9/18
- http://ghdx.healthdata.org/gbd-results-tool accessed 4/25/18
- Muntner, P., et al. (2018). Potential U.S. Population Impact of the 2017 ACC/AHA High Blood Pressure Guideline. *Journal Of The American College Of Cardiology (JACC)*, *71*(2), 109-118. doi:10.1016/j.jacc.2017.10.073
- Bibbins-Domingo, K., Grossman, D. C., Curry, S. J., Davidson, K. W., Epling, J. J., García, F. R., & ... Pignone, M. P. (2016). Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: US Preventive Services Task Force Recommendation Statement. *Jama*, *316*(19), 1997-2007. doi:10.1001/jama.2016.15450
- Fisher, L., Hessler, D. M., Polonsky, W. H., & Mullan, J. (2012). When is diabetes distress clinically meaningful?: establishing cut points for the Diabetes Distress Scale. *Diabetes Care*, *35*(2), 259-264. doi:10.2337/dc11-1572
- Olson, K., Delate, T., & Duagn, D. (2006). Monitoring of patients given second-generation antipsychotic agents...American Diabetes Association. American Psychiatric Association, American Association of Clinical Endocrinologist, et al: Consensus development conference on antipsychotic drugs and obesity and diabetes. Diabetes Care 27:596-601, 2004. *Psychiatric Services*, *57*(7), 1045-1046.

NETWORK 4 HEALTH

References

- Lexicomp http://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7897 accessed 4/18/18
- Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013
- Katon, W. J., Lin, E. B., Von Korff, M., Ciechanowski, P., Ludman, E. J., Young, B., & ... McCulloch, D. (2010). Collaborative care for patients with depression and chronic illnesses. *The New England Journal Of Medicine*, *363*(27), 2611-2620. doi:10.1056/NEJMoa1003955
- Bogner, H. R., & de Vries, H. F. (2008). Integration of depression and hypertension treatment: a pilot, randomized controlled trial. *Annals Of Family Medicine*, *6*(4), 295-301. doi:10.1370/afm.843
- Goodrich, D. E., Kilbourne, A. M., Nord, K. M., & Bauer, M. S. (2013). Mental health collaborative care and its role in primary care settings. *Current Psychiatry Reports*, *15*(8), 383. doi:10.1007/s11920-013-0383-2
- Butler, M., Kane, R. L., McAlpine, D., Kathol, R., Fu, S. S., Hagedorn, H., & Wilt, T. (2011). Does integrated care improve treatment for depression? A systematic review. *The Journal Of Ambulatory Care Management*, *34*(2), 113-125. doi:10.1097/JAC.0b013e31820ef605
- McCarty, D., Rieckmann, T., Baker, R. L., & McConnell, K. J. (2017). The Perceived Impact of 42 CFR Part 2 on Coordination and Integration of Care: A Qualitative Analysis. *Psychiatric Services (Washington, D.C.)*, *68*(3), 245-249. doi:10.1176/appi.ps.201600138

NETWORK 4 HEALTH

References

- Siantz, E., Henwood, B., Xu, Z., Sarkin, A., & Gilmer, T. (2017). Health Care Decisions among Mental Health Services Consumers in San Diego County: Implications for Integrated Care. *Health & Social Work*, *42*(1), 48-56. doi:10.1093/hsw/hlw060
- Weiner, S. J., Barnet, B., Cheng, T. L., & Daaleman, T. P. (2005). Processes for effective communication in primary care. *Annals Of Internal Medicine*, *142*(8), 709-714.
- Benzer, J. K., Cramer, I. E., Burgess, J. J., Mohr, D. C., Sullivan, J. L., & Charns, M. P. (2015). How personal and standardized coordination impact implementation of integrated care. *BMC Health Services Research*, *15*448. doi:10.1186/s12913-015-1079-6
- Davis, M. M., Gunn, R., Gowen, L. K., Miller, B. F., Green, L. A., & Cohen, D. J. (2018). A qualitative study of patient experiences of care in integrated behavioral health and primary care settings: more similar than different. *Translational Behavioral Medicine*, doi:10.1093/tbm/ibx001

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