

I'd like to thank the Chair of the committee and the rest of the committee members for this opportunity to speak before you. My name is Kevin Eastman and I am the Executive Director of Weber Human Services, which is the Local Mental Health and Substance Abuse Authority for Weber and Morgan counties. Weber Human Services has participated for over a year now in meeting with the Healthcare Reform Task Force subcommittee in an effort to flesh out the best ideas for improving the healthcare system in Utah for individuals suffering with behavioral health issues. While much of our discussion has been around future designs of systems if our State decides to expand Medicaid coverage, the concepts presented today will also benefit those whose lives are currently covered within the Medicaid system of care. Today we are presenting to you a pilot program that has the potential of producing the greatest improvement in the healthcare outcomes and the greatest reductions in the healthcare costs for these individuals since the implementation of the pre-paid mental health plans in the 1990's. All without a federal mandate.

In 2010, Weber Human Services took a great leap forward to build the infrastructure necessary for delivering effective healthcare (behavioral and physical healthcare) to a SMI (seriously mentally ill) population using the most advanced evidence based practices in the field. In partnership with Midtown Community Health Center, we opened a fully integrated health clinic to serve the needs of our SMI population in a single setting where primary care practitioners and behavioral healthcare providers can work together to meet the ongoing needs of these individuals.

The implementation of this model has achieved significant improvements in the health risk factors of over 1000 SMI clients served in Weber and Morgan counties. But continued analysis of this model across the country has shown that more effective change in outcomes will require a major shift in the roles, processes, and care provided in this integrated setting. To achieve this shift, we propose a pilot program that will create a behavioral health home for individuals with serious mental illness or a substance use disorder that is proactive and coordinated, and that includes accountability for a defined population of clients. This concept is in addition to the established integrated clinic I just mentioned.

Let me walk you through a specific scenario to illustrate what this behavioral health home looks like, and why both of these services are among many healthcare reforms that need to be created to obtain better outcomes and reduce costs.

Imagine a 45 year old woman without any current health risk factors needing to manage her own preventive healthcare. She should have a health maintenance exam every 1-2 years with a clinical breast and pelvic exam; she should have her BMI and blood pressure checked every 2-3 years along with appropriate cancer screenings. She should also have a mammogram every 2-3 years. How many of us are even aware of the recommended preventive services for our age and gender, let alone having made and kept appointments for each of these services?

Now imagine this same or similar scenario if it were you, and that you have an accompanying serious mental illness. Not only are you needing to receive all of these preventive healthcare services for your physical healthcare, but the side effects of the medications prescribed to you to alleviate your symptoms for your behavioral condition, has put you at risk for high blood pressure and has elevated your BMI. For anyone not suffering from a serious mental illness this is a manageable scenario but to someone who has major depression or any other serious mental illness, physical health is the last thing on their mind. You want to sleep all day and have no desire to shower, dress, or even go outside. You feel so bad that

your limbs hurt and you have no energy. So as a result, your physical health ailments do not get addressed. They become more severe and the treatments become more expensive.

So what is the answer?

It is coordinating that care in a behavioral health home. In remembering the scenario, the individual would be monitored by a nurse care manager and assisted by a care coordinator to navigate a complex healthcare system.

Assistance would include:

- seeing that the necessary appointments get scheduled;
- providing whatever coaching and barrier identification is needed so that the appointments are kept;
- communicating the necessary historical information and current symptoms to all healthcare professionals;
- making sure that prescriptions are filled and prescriber instructions are understood and followed; and
- delivering nutrition and exercise education.

As this assistance is given, the health home team continually tracks the healthcare outcomes of the individual. While we will need the assistance of the Department of Health and their Medicaid utilization data to complete our data registry, our proposal includes tracking the following **performance measures** to demonstrate reductions in costs and improvements in health outcomes:

- Hospital admissions
- Hospital emergency department visits
- Medication adherence
- Smoking status
- BMI
- Blood pressure
- Blood sugar
- Cholesterol

As a whole the team is responsible for taking all available measures necessary to reduce hospital admissions and emergency department visits of every individual who agrees to be part of the program. The ultimate goal is to defy the statistic that individuals with a SMI die on average 25 years earlier than someone who does not suffer with a mental illness, often due to preventable chronic health conditions. We also believe that in so doing, we can reduce the cost of caring for the most chronic individuals.

I'd be glad to answer any questions you may have.