Letters

Culturally Congruent Intensive Case Management Service for Three Refugee Communities

TO THE EDITOR: Premigration trauma and postmigration stressors increase risk of serious mental illness among refugees, which in turn undermines their settlement and community integration (1). The recovery of these individuals is further complicated by other challenges, including elevated levels of shame and stigma attached to mental illness and a lack of cultural congruence between the provider and client (2).

Afghanistan, Sri Lanka, and Somalia have consistently made up a high number of refugee claimants worldwide (3). In 1999, after consultation with community groups and stakeholders, the Toronto Branch of the Canadian Mental Health Association developed the Rehabilitation Action Program, an intensive case management (ICM) service targeting these three communities in Toronto. Funded by the Ontario government, the program provides culturally and linguistically appropriate ICM (4). Characterized by a low client-to-staff ratio and frequent and prolonged contact with clients, ICM addresses client needs with a focus to improve their quality of life through case coordination and direct services such as home visits and counseling. In the program, each client is matched with a case manager who speaks the client's preferred language. The program also trains volunteer case aides from the local communities. After receiving training on mental health literacy and on assisting clients with independent living skills (5), the case aides, under supervision, are assigned to a client and aim to increase or maintain the client's independent living skills.

Using administrative data of clients enrolled in the program from 2006 to 2010 (N=90; mean age 40.88±10.36 years; 69% women, N=62), we examined the effectiveness of the program by assessing the enrollment status two years after program admission, the estimated length of stay, as well as changes in length of hospitalization, medication adherence, and employment status from baseline to two-year follow-up. The research team developed and pilot-tested a review protocol (interrater reliability κ=.86).

Clients' primary diagnosis was mood disorders (52%, N=47), followed by schizophrenia or psychotic disorders (47%, N=42) and personality disorders (1%, N=1). Only 10 (11%) indicated English as their primary language. At two-year follow-up, 22% (N=20) had met treatment objectives and left the program, whereas 42% (N=38) remained in the program. About 25% (N=23) withdrew from the program, 8% (N=7) relocated, and 2% (N=2) died. Kaplan-Meier survival analysis over the study period showed the estimated median length of stay has been 790 days (95% confidence interval=485.72–1,094.28).

Paired t tests comparing baseline and two-year follow-up data were conducted. Compared with a baseline measurement period ranging from six months to one year (online supplement), clients had fewer hospital visits by two years postadmission (t=3.60, df=42, p<.001; effect size [ES]=–.77), improved treatment adherence (t=2.46, df=43, p<.05; ES=.49), and better employment outcomes (t=3.07, df=57; p<.01; ES=.57). No change in hospitalization days was observed. Given the lack of control group in this study, the results provide some preliminary evidence for effectiveness of a culturally congruent ICM for refugee communities.

REFERENCES

1. Dapunt J, Kluge U, Heinz A: Risk of psychosis in refugees: a literature review. Translational Psychiatry 7:e1149, 2017
2. Abe-Kim J, Takeuchi DT, Hong S, et al: Use of mental health–related services among immigrant and US-born Asian Americans: results from the National Latino and Asian American Study. American Journal of Public Health 97:91–98, 2007
3. Refugee Population by Country or Territory of Origin. Washington, DC, World Bank, 2018. https://data.worldbank.org/indicator/SM.POP.REFG.OR?view=chart
4. Bhui K, Warfa N, Edonya P, et al: Cultural competence in mental health care: a review of model evaluations. BMC Health Services Research 7:15, 2007
5. Case Aide–Rehabilitation Action Program (RAP). Toronto, Canadian Mental Health Association, Toronto Branch. https://toronto.cmha.ca/get-involved-2/volunteer/case-aide-rehabilitation-action-program-rap

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Received February 20, 2018; revision received May 16 and June 13, 2018; accepted June 29, 2018.

Psychiatric Services 2018; 69:1116; doi: 10.1176/appi.ps.201800082

Health Screening and Follow-up Care Among Medicaid Beneficiaries With Serious Mental Illness Enrolled in Managed Care Plans

TO THE EDITOR: Studies have consistently documented high rates of obesity and tobacco use among individuals with serious mental illness (1). In recent years, Medicaid programs have enrolled individuals with serious mental

illness into managed care plans (2), which are responsible for ensuring that their members receive preventive care. Despite the movement to managed care, not much is known about whether this population receives routine screening and follow-up care for common comorbid health conditions and health behaviors.

As part of a project that developed quality measures for health plans (3), we pilot-tested measures that assessed the proportion of health plan members with serious mental illness (schizophrenia, bipolar disorder, or major depression) who received screening and follow-up care (when indicated) for obesity and tobacco use during calendar year 2012. Following procedures used for reporting HEDIS measures, health plans in three states used their claims and administrative data to identify a random sample of members with serious mental illness and then reviewed all available medical records (primary care and behavioral health clinic records) and claims and administrative data for these members to look for evidence of screening and follow-up care.

Screening and follow-up rates varied widely across plans. Overall, 54% of 855 individuals with serious mental illness had their body mass index (BMI) documented during the year (N=464, range 19%–80%) (online supplement). Among those with a BMI ≥30, 38% (N=86) received counseling, medications, or other follow-up care for unhealthy weight (range 14%–43%). Forty-seven percent of 756 were screened for tobacco use (N=356, range 15%–76%). Among tobacco users, 57% (N=113) received counseling, medications, or other follow-up care for tobacco use (range 48%–66%). We then calculated an overall rate for each health plan to assess the proportion of members with serious mental illness who were screened and received follow-up care if the screening results were positive. This yielded an average performance rate of 38% (N=323) for obesity (range 12%–55%) and 36% (N=269) for tobacco use (range 10% to 64%).

These rates of screening and follow-up care were lower than those for other populations. During the same year, accountable care organizations that reported similar measures for the Physician Quality Reporting System reported that 54% of their members received screening and follow-up care (when indicated) for BMI and that 81% received screening and follow-up care (when indicated) for tobacco use (4). Although average screening and follow-up rates were low across the three health plans, the range across plans was wide, suggesting that some plans have room for improvement and others may have performed well. This variation could be driven by many factors, including geographic differences in the availability of services and different processes that health plans use to monitor and coordinate care. Performance on these measures can provide health plans and Medicaid programs with information to further investigate the sources of variation in screening and follow-up rates. We report these findings to encourage quality improvement efforts and provide a benchmark by which to measure progress. The National Quality Forum endorsed the measures piloted in this study, and they are available for states and health plans to implement (5).

REFERENCES

1. Compton MT, Daumit GL, Druss BG: Cigarette smoking and overweight/obesity among individuals with serious mental illnesses: a preventive perspective. Harvard Review of Psychiatry 14:212–222, 2006
2. Gifford K, Ellis E, Coulter Edwards B, et al: Medicaid Moving Ahead in Uncertain Times: Results From a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018. Menlo Park, CA, Kaiser Family Foundation, Oct 2017. http://files.kff.org/attachment/Report-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2017-and-2018. Accessed Feb 2, 2018
3. Brown, JD, Scholle SH, Croake S, et al: Development and Testing of Behavioral Health Quality Measures for Health Plans. Washington, DC, Mathematica Policy Research, March 2015. https://aspe.hhs.gov/basic-report/development-and-testing-behavioral-health-quality-measures-health-plans-final-report
4. 2012 Reporting Experience Including Trends (2007–2013). Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program. Baltimore, Centers for Medicare and Medicaid Services, March 14, 2014
5. Measure 2601, Body Mass Index Screening and Follow-up for People With Serious Mental Illness, and measure 2600, Tobacco Use Screening and Follow-up for People With Serious Mental Illness or Alcohol or Other Drug Dependence. Washington, DC, National Quality Forum. https://www.qualityforum.org/home.aspx

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The authors conducted this work under contract HHSP23320100019WI/HHSP23337001T with the Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services (HHS). The authors appreciate the guidance of D.E.B. Potter of ASPE. The views and opinions expressed in this article are those of the authors and do not necessarily reflect the views, opinions, or policies of ASPE or HHS.

The authors report no financial relationships with commercial interests.

Received February 19, 2018; revisions received May 17 and July 13, 2018; accepted July 27, 2018.

Psychiatric Services 2018; 69:1116–1117; doi: 10.1176/appi.ps.201800081

Use of Medicaid Web Portals for Outpatient Electronic Pharmaceutical Data

TO THE EDITOR: Clinicians use medication histories for coordination of care, to assist in care decisions, and to prevent medication errors. Compiling a medication history is difficult and time consuming, requiring discussion with the patient, family members, other clinicians, and the patient's pharmacy (1). Outpatient electronic pharmaceutical claims data (EPCD) can improve the efficiency and accuracy of medication history collection and can be accessed when pharmacies are closed.

A statewide electronic medication reconciliation program, such as systems offered for controlled substances, would clearly benefit clinicians (2). Although programs are