

## **Driving Outcomes in Integration**

### *Profiles of High Achieving Grantees in PBHCI*

How do you replicate success in integrating primary care into behavioral health practice? To find out, the [SAMHSA-HRSA Center for Integrated Health Solutions](#) (CIHS) analyzed health indicator (H-indicator) data from all Primary and Behavioral Health Care Integration (PBHCI) grantees from grant and conducted interviews with all grantees that were in the top five percent of health improvement for each health indicator. This overview outlines the key findings that all providers can learn from these high achievers in driving health outcomes.

#### **Asian Counseling and Referral Services (ACRS)**

Seattle, Washington

*Blood Pressure (30% improvement. PBHCI average is 18%)*

*Waist Circumference (58% improvement. PBHCI average is 40%)*

- ACRS case managers have strong relationships with the people on their caseload. Cultural concordance between case managers and consumers helps to build this relationship. This relationship is used to promote healthy living among both case managers and consumers. Case managers have wellness goals and participate in wellness programming with consumers. Many groups incorporate snacks or a potluck, and when the group eats, case managers lead discussions around healthy eating.
- ACRS operates a day program, which doubles as a second home for many consumers. These consumers are onsite multiple times per week, which provides many opportunities to participate in wellness programming while attending other classes such as English as a Second Language, employment programs, acupuncture, dental services, and lunch programs. Consumer access to wellness classes while already onsite provides easy entrée into wellness programming.
- Treatment plans always includes wellness goals. Clinicians use motivational interviewing to gauge an individual's willingness to change and craft a treatment plan goal to fit the individual. Some examples include walking around their block once per day, taking prescribed medications, limiting salt intake, and participating in additional wellness groups.

#### **Fordham-Tremont Community Mental Health Center**

Bronx, New York

*BMI (55% improvement. PBHCI average is 44%)*

- Nurses meet with consumers one-on-one to discuss wellness at least quarterly. The conversation starts with a review of the consumer's health status. This is followed by discussion of healthy eating, medications, condition information and different wellness class options. The nurses use motivational interviewing techniques during these conversations.
- Consumers and staff members design wellness classes. At the core of each wellness class is an established practice like [WHAM](#), [trauma-informed care](#), mindfulness-based stress reduction, and providing compassionate care. The content is then modified based on suggestions from consumers and staff members. The same individuals review the feedback from class participants after each session ends and adjust the course accordingly.

- The clinical team reviews service metrics, health outcomes and consumer satisfaction on a monthly basis. Some key metrics are enrollment and reassessment, retention rate, disparities in access and health outcomes, wellness class attendance rates, and consumer satisfaction.

### **Heritage Behavioral Health Center**

Decatur, Illinois

*Cholesterol (58% improvement. PBHCI average is 38%)*

- All staff members review aggregate health data on a monthly basis. The review includes H Indicators, selected NOMs, SF-36, and nights spent troubled (e.g., jail, homeless, ER). This information features a breakout by various demographic groups. The team reviews these numbers, along with anecdotal information from consumer interactions, to discuss what is working well and what can be improved.
- For the first two years of the grant, evaluation staff regularly performed fidelity tests to their health home model. This process worked as a quality improvement process (ensure all new services were properly provided to consumers) and a workforce development process (issues with fidelity doubled as workforce development opportunities).
- Wellness classes were initially designed using the Lilly [self-help curriculum](#) as a guideline. However, classes were quickly altered internally. Disease self-management courses and cholesterol medication led to positive health outcomes for clients with high cholesterol.

### **Kent Center for Human/Organizational Development**

Warwick, Rhode Island

*Blood Pressure (32% improvement. PBHCI average is 18%)*

- Many consumers participated in wellness programming at the local YMCA. The YMCA has provided specially trained Health Navigators who meet with all consumers prior to becoming a member. The Health Navigator reviews health and wellness goals with the consumer and coaches them on how to use the equipment at the YMCA.
- Each consumer's treatment plan includes wellness goals, which are tied to the consumer's health status. For a person with high blood pressure, common treatment plan goals include a reduction in sodium intake, weight loss, stress coping skills, regular PCP visits and smoking cessation class, when appropriate.
- Consumer feedback is a key component of wellness services at the Kent Center. Consumers in the primary care clinic provide feedback to the nurse each time they are in the clinic. Consumers also provide feedback to the integration specialist at each reassessment interview. This feedback centers around satisfaction with services and requests for new services. The treatment team discusses the feedback in aggregate at monthly meetings.

### **Pennyroyal**

Hopkinsville, Kentucky

*Blood Pressure (33% improvement. PBHCI average is 18%)*

- At grant inception, Nurse Care Managers (NCM) trained behavioral health staff on the definitions and wellness interventions for H Indicators. Training materials were from CIHS, CDC, and condition-specific groups (such as the American Heart Association). The NCM uses multiple materials to convey the same information. This reinforces the message and keeps the training interesting.

- Each consumer has multiple one-on-one health education interviews with a NCM. During this meeting, the NCM reviews their baseline and current H-indicators, offers praise for effort and explores ways to improve. If a patient has not shown progress across multiple meetings, the NCM will explore alternate ways to achieve health goals.
- Pennyroyal is able to provide consumers with many medications for \$4 each. Many retail pharmacies have several hypertension drugs they offer for this cheap, and providers keep up-to-date on which drugs are discounted on each pharmacy's website. Antibiotics, asthma, arthritis, heart, diabetes, cholesterol, gastrointestinal and thyroid medications are also frequently available at this price.

### **Postgraduate Center for Mental Health**

New York, New York

*BMI (61% improvement. PBHCI average is 44%)*

- Each new wellness program is piloted for eight weeks. After eight weeks, the program is reviewed to determine if the class met predetermined weight-loss goals and consumer satisfaction goals. One example of consumer feedback affecting wellness programming was a suggestion to move wellness programs to the afternoon to allow morning clinical appointments followed by afternoon wellness programming.
- Consumer health data is reviewed at weekly team huddles. Consumers with missing or alarming health data are given priority during the discussion. For individuals with missing health data, a staff person is assigned to schedule an appointment to obtain the data. For individuals with alarming health data, the team discusses how to encourage the person to engage with relevant wellness classes and treatment protocols.
- Clinicians regularly review health data with consumers. The health data is used as a motivational interviewing tool to encourage the consumer to become more wellness-focused. The clinician will use the consumer's health indicators and a schedule of wellness programs to guide the conversation.

### **San Francisco Department of Public Health**

San Francisco, California

*BMI (56% improvement. PBHCI average is 44%)*

- Each month, the clinical team and project steering teams review the change in service data over time. Service metrics include enrollment, reassessment, no shows, time between enrolling and first appointment, and percent of consumers who have seen a primary care physician in the previous seven months. During the review of these metrics, team members will discuss the current trend for each metric and what they believe is causing the trend. The team will then devise a plan to improve the numbers for that particular metric.
- Care coordinators receive a bi-weekly list of appointments, lab needs, health status and a record of each wellness class attended by the consumer. This information is reviewed as a team to discuss missing data, changes in health status (both positive and negative), and scheduling.
- Consumers review their health data in a one-on-one meeting with their health coach on a monthly basis. During these conversations, the health coach explains the definition of the health information and discusses how engagement with wellness programs and their primary care physician can lead to positive health outcomes.

## San Mateo County Health System

San Mateo, California

*FBS (51% improvement. PBHCI average is 32%)*

*Cholesterol (58% improvement. PBHCI average is 38%)*

- Weekly team huddles incorporate data from the patient health registry. Behavioral health and primary care staff members review individual health data (health indicators and NOMS) and formulate health coaching plans. The initial focus of these meetings is new enrollees. Based on health data, the new enrollee is ranked according to health needs as low, medium or high. After stratifying new enrollees, the team reviews absentee and high-risk consumers.
- Consumer-level data is available to consumers in real-time and is shared by a clinician in the form of an individual consumer dashboard. Nurse Care Managers review the health dashboard with the consumer. During these discussions, the consumer will create action steps designed to achieve their health goals. These conversations also validate progress made by consumers, which motivates them to continue following through on their health goals.
- As an ongoing quality improvement initiative, the project director and the project coordinator sit in on different wellness groups to observe the facilitators running these groups. Based on these observations, areas of improvement are identified to better engage consumers in groups' participation and discussion, to improve groups' effectiveness, as well as to tailor the curriculum to meet the needs of the SPMI clientele. Modifications included adding exercises/activities/messages so as to reinforce "repetition" and hence increasing receptivity by consumers, using more visual aids to highlight a wellness message (e.g. a tar display showing the amount of tar in lungs for smoking six cigarettes a day), and restructuring group activities to have better flow.

## South Carolina Department of Mental Health

Columbia, South Carolina

*Breath CO (65% improvement. PBHCI average is 29|%)*

- Wellness classes are informed by evidence-based programs. For tobacco cessation, consultation was provided by Chad Morris and BHWP. During the consultation, BHWP trained staff members in the [Well Body](#) and [Tobacco Free](#) wellness program. Other evidence-based wellness programs include [NEW-R](#), [Solutions for Wellness](#) and [Learning About Healthy Living](#).
- Behavioral health clinicians use this training, combined with motivational interviewing, to determine the consumer's readiness to change. Once a consumer is ready to quit, they set a quit date, incorporate nicotine replacement therapy, teach relaxation exercises and provide education about cost savings and health improvements that result from quitting tobacco use.
- Regular use of the breath CO monitor has helped initiate conversations about quitting tobacco. The CO monitor is used at least every six months, but many consumers like to use it more often when they successfully cut down on smoking. Even consumers who are not engaged in tobacco cessation classes have shown improvement in breath CO as a result of using the monitor on a regular basis.
- Nicotine replacement products such as patches, gum and lozenges are provided to consumers once they are ready to quit.

## Washtenaw Community Health Organization

Ypsilanti, Michigan

*BMI (56% improvement. PBHCI average is 44%)*

*Fasting blood glucose (51% improvement. PBHCI average is 32%)*

- On a monthly basis, the clinical team reviews the outcomes dashboard. This dashboard shows service indicators and change in health status for the entire PBHCI population and for each care manager's caseload. The most important service indicator is the amount of contact with the disease management team during the preceding twelve months. The team reviews these indicators to promote conversation between clinicians about different methods used to promote behavior change in individual consumers.
- Consumers have access to their health data through an online portal. Each consumer is trained to access the portal, and there are computers available in the waiting room to use for this purpose. The portal shows the individual's health status, medications, upcoming appointments and treatment plan goals.
- All peers are Certified Peer Support Specialists (CPSS) through Michigan Department of Community Health, and this certification must be obtained within six months of being hired into a peer position. All CPSS have lived experience in the mental health system, and certification is obtained through a weeklong training and passage of an exam. CPSS are paid positions as members of the PBHCI team, where their role is to support the consumer in making changes/choices to improve their overall health. CPSS meet with consumers individually and also teach wellness classes throughout the week on topics like goal setting, recreation, and tobacco treatment. CPSS's take consumers to appointments, food banks, walk with them at the mall, help them grocery shop and sometimes just listen to them. The peers have been an asset to the program because they have "been" where the consumers are and can relate to the everyday struggles of living with a mental illness and can also share their own obstacles and successes in making changes to their physical health, be it increasing exercise, eating better or quitting smoking.

## Conclusion

Beyond discovering what practices outlined can be replicated in your organization, there are three key takeaways to note about PBHCI high achievers.

They are:

- Successful organizations have regular communication between clinicians and consumers, and between behavioral health and primary care staff, about wellness programming and each consumer's health status. These organizations are using the consumer's current health status as a springboard for motivational interviewing conversations that promote the importance of wellness programming.
- Successful programs also share individual and aggregate health data with clinicians. Sharing individual data on a daily or weekly basis promotes care coordination for all patients. Sharing aggregate data on a weekly, monthly or quarterly basis promotes quality improvement conversations among clinicians.
- These organizations employ continuous quality improvement cycles for their wellness programs. Feedback is provided by consumers and clinicians to aid in the improvement process.

If you would like to discuss how to implement these approaches in your integrated health setting, including how to connect with a high-performing site, contact Aaron Surma, Quality Assurance Associate, at 248.345.6535 or [Aarons@theNationalCouncil.org](mailto:Aarons@theNationalCouncil.org).

*\*Grantee interviews were completed in 2014 using health outcome data from grant inception through December 2013.*