



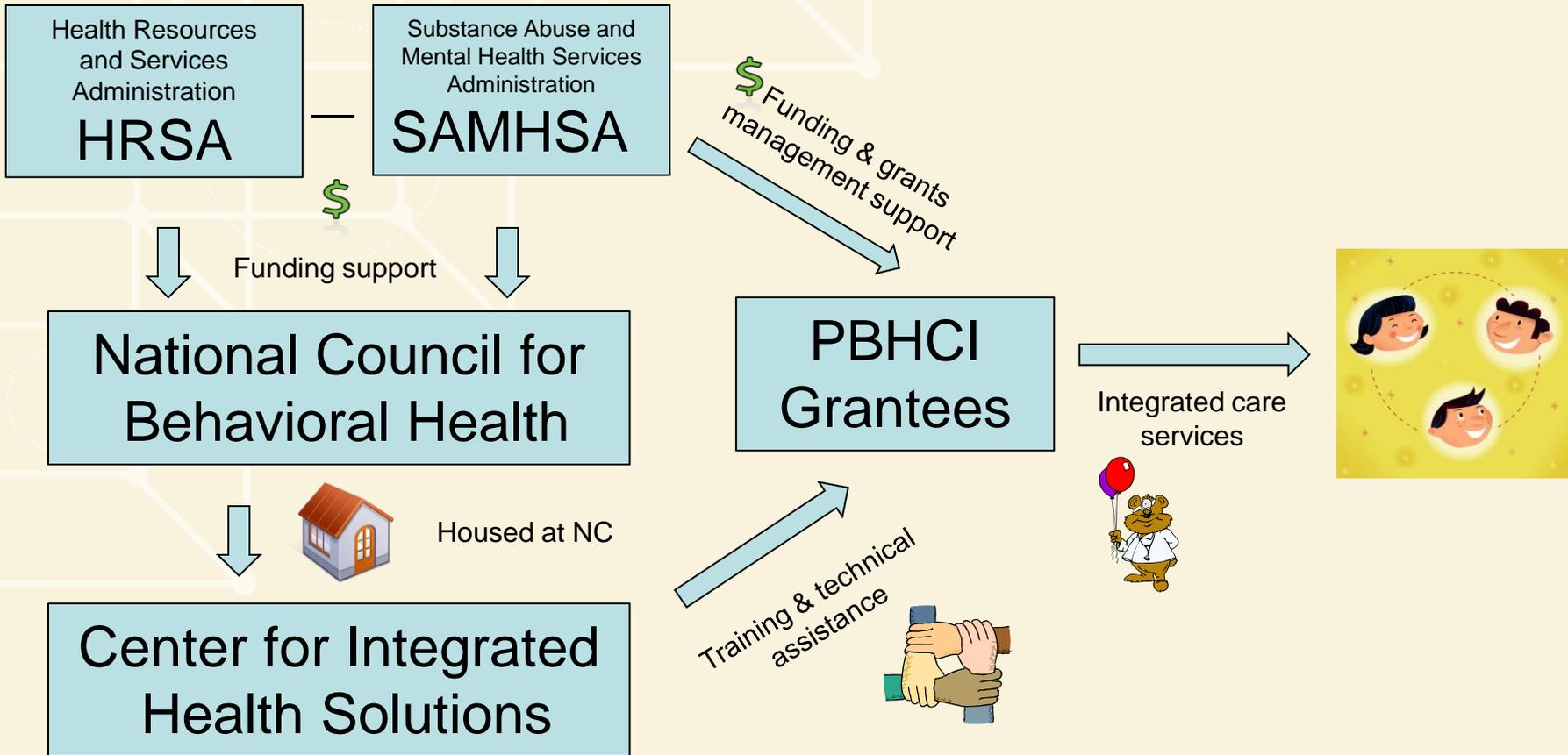
SAMHSA-HRSA Center for Integrated Health Solutions

Midwest Learning Community In-Person Meeting

January 31, 2013 – February 1, 2013



Connecting the dots...



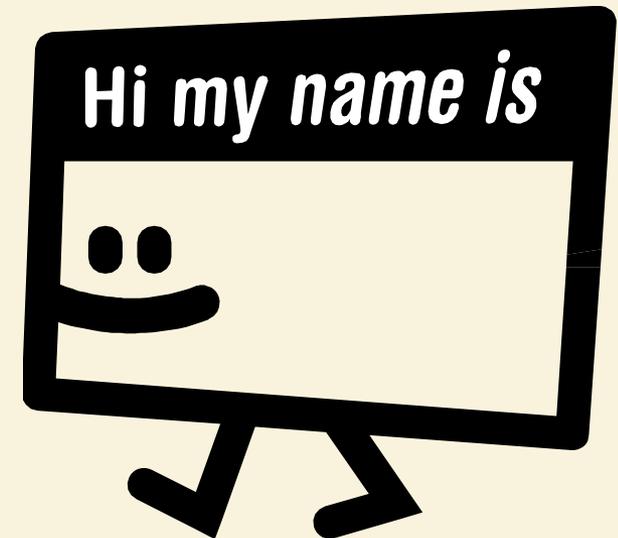
So Tell Us About Yourself...

Each person:

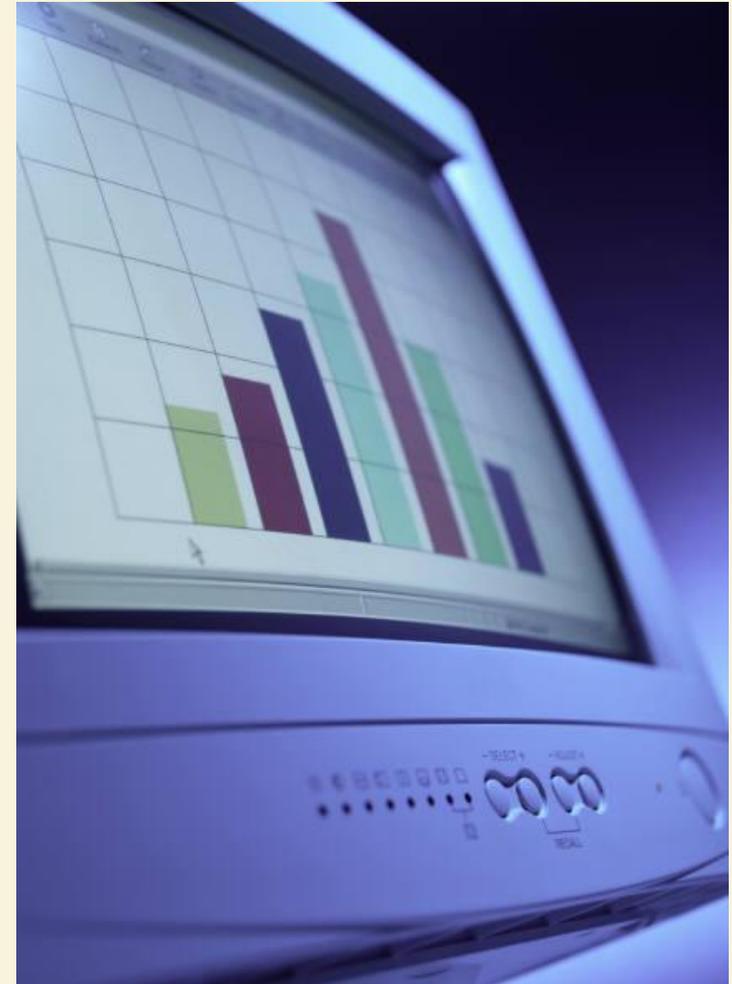
- ✓ **Who you are**
- ✓ **What you do (PBHCI role)**

Each project director (or grantee spokesperson):

- ✓ **Where you are**
- ✓ **What cohort you are in**
- ✓ **What you have achieved in the last 6 months, OR**
- ✓ **What your immediate plans are**



Meeting Theme:
Using Health Information
to Improve Client Care





TRILOGY

BEHAVIORAL HEALTHCARE

HELPING PEOPLE DISCOVER SELF, PURPOSE AND COMMUNITY

**Strategic Use of Population-Based Information
(groups of patients with similar chronic health
problems) for Improving Health**

How Do Health Registries Work?

Presenter: Fred Rachman

**Strategic Use of Population-Based Information
(groups of patients with similar chronic health
problems) for Improving Health**

**RAND Data: An Example of
Population Management**

Presenter: Roxanne Castaneda



Behavioral Health is Essential To Health



Prevention Works



Treatment is Effective



People Recover



Findings: PBHCI Preliminary Follow-up Evaluation Report



Providers Seen from Enrollment to End of First Year

- **Percent of clients seeing Primary Care Provider: 75.6%**
 - This means that for Cohorts I and II, 75.6% of clients had seen a Primary Care Provider at least once by the end of their first year enrolled in PBHCI.
 - Target: 100%

Physical Health Service Utilization from Enrollment to End of First Year

- Percent of Clients Using Screening/Assessment Service:
83.7%

- This means that for Cohorts I and II, 83.7% of clients had a physical health screening/assessment performed at least once by the end of their first year enrolled in PBHCI.
- Target: 100%

Substance Use Service Utilization from Enrollment to End of First Year

- **Percent of Clients Using Screening/Assessment Service: 57.3%**
 - This means that for Cohorts I and II, 57.3% of clients had a substance use screening/assessment performed by the end of their first year enrolled in PBHCI.
 - Target: 100%
- **Percent of Clients Using Referral Service: 6.9%**
 - This means that for Cohorts I and II, 6.9% of clients were given a referral to a substance use provider by the end of their first year enrolled in PBHCI.
 - FYI: 22.0, 27.2% of clients are using illegal substances or binge drinking, respectively

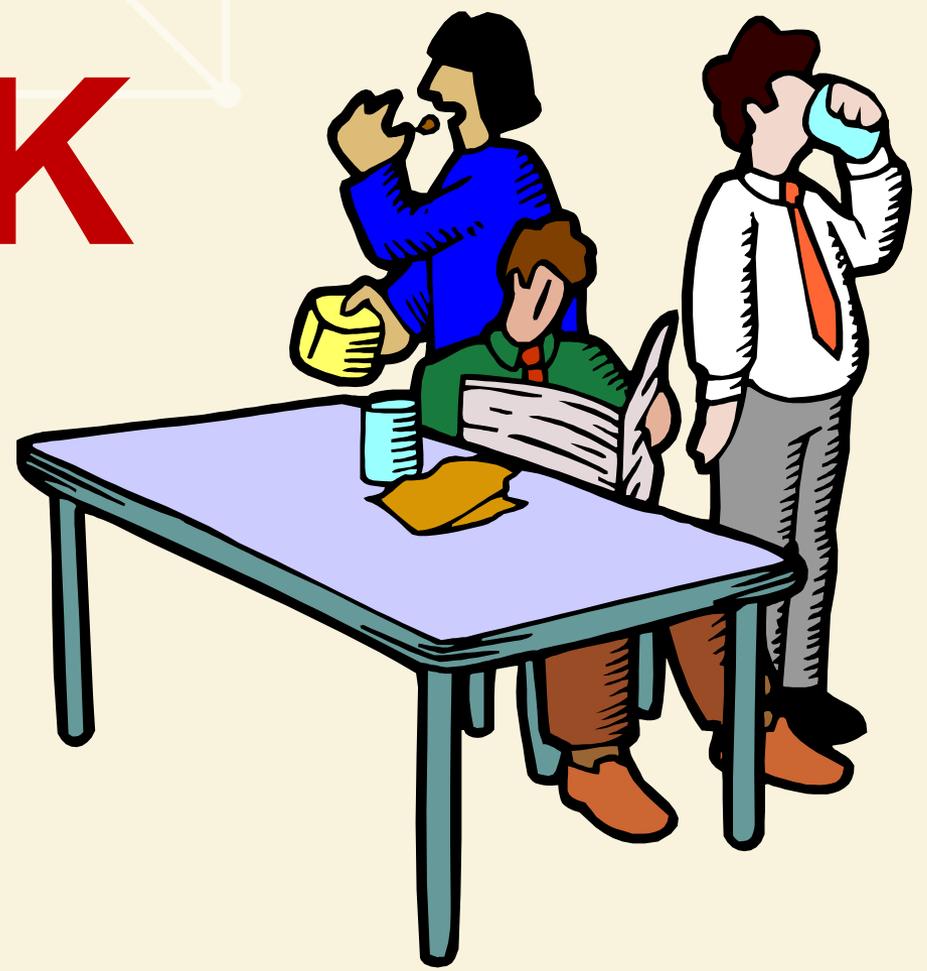
Wellness Service Utilization from Enrollment to End of First Year

- **Percent of Clients Using Any Wellness Service: 70.3%**
 - This means that for Cohorts I and II, 70.3% of clients used any wellness service at all by the end of their first year enrolled in PBHCI.
- **Percent of Clients Using Smoking Cessation: 23.7%**
 - FYI: 61.3% percent of clients are smokers
- **Percent of Clients Using Wellness Education: 46.3%**
- **Percent of Clients Using Exercise: 23.4%**

Quality of Care for Physical Health Conditions

- Patients with diabetes that received education services related to diabetes, nutrition, cooking, physical activity, or exercise within 1 year of enrolling in PBHCI: 66.5%
 - Target: 100%
- Patients with hypertension that received education services related to hypertension, nutrition, cooking, physical activity, or exercise within 1 year of enrolling in PBHCI: 55.2%
 - Target: 100%
- Patients identified as tobacco users who received cessation intervention during the two-year measurement period: 28.6%
 - Target: 100%

BREAK



Strategic Use of Population-Based Information (groups of patients with similar chronic health problems) for Improving Health

How We Use Health Information

Presenter: Sandra Stephenson & Phyllis Panzano

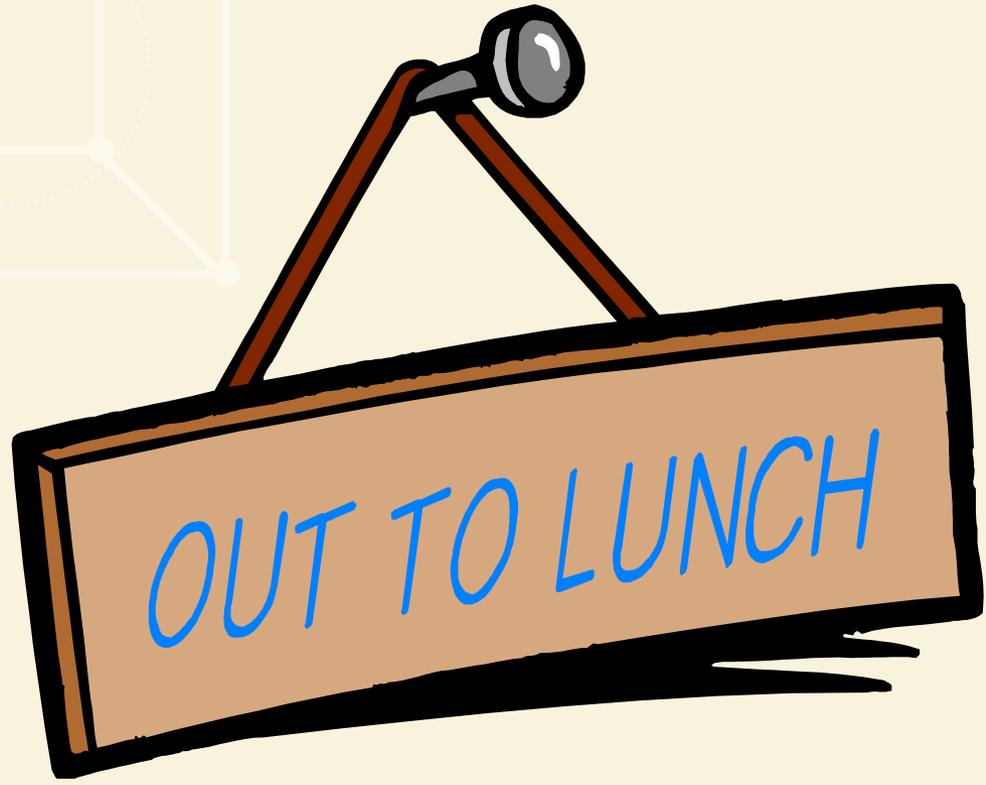


Strategic Use of Population-Based Information (groups of patients with similar chronic health problems) for Improving Health

Team Discussion



- Do we have health indicator reports from our EHRs or a separate registry?
- Do we have the ability to case manage subsets of clients?
- Do we change interventions if groups of clients are not improving? (e.g. diabetes)
- What can we start to implement or improve upon in our population management systems?



How an Individual Moves through the Service System

Presenter: Greater Cincinnati Behavioral Health Services (GCB)
“Holistic Health Project- Cincinnati”

Jeff O’Neil, M Ed, PCC



GCB At A Glance...

Our Mission... *"To assist persons with mental illness and related barriers to lead productive and fulfilling lives."*

A Provider of Comprehensive Services To Adults and Young Adults with Severe and Persistent Mental Illnesses

40+ year service history

Supported by local MH levy funding, Mental Health Board, grants and insurance reimbursement (Medicaid, Medicare)

4,500 served annually with 300 total Staff

Achieving Our Mission...

By Providing Comprehensive Services:

Psychiatry

Nursing

Case Management

PBHCI, Primary Care, Pharmacy

Assertive Community Treatment (ACT)

Counseling

Vocational

Residential / Housing

Specialized Programs with: Courts, Jails, Hospitals Programs,
Homeless, Youth, Deaf Services

PBHCI: “*Holistic Health Project –Cincinnati*”

Grant Year 3

A Partnership Model:

- Behavioral Health / Federally Qualified Health Center
- GCB and The HealthCare Connection

Sustainability Planning: Moving to Ohio Health Home
Status in 2013

Our client background: Mary

- Age 56
- Caucasian
- Female
- Diagnosis of Bi-Polar Disorder; severe
- Hx of sexual abuse by father
- Serious neglect by mother
- No Substance use issues
- No PC connection but some obvious health risks (overweight, poor nutrition), non-smoker

Initial Engagement in the PBHCI Service

- Grant year 1; just getting started
- Client was receiving traditional Case Management and Psychiatry services from GCB
- Client was Not referred to the project by the MH Case Manager!
- Client was engaged by the project Nurse Care Manager by a “warm hand-off” from the Psychiatrist while in the MH services clinic
- Project services were explained to client; client requested services (NCMs were trained in Motivational Interviewing!)

Initial Engagement in the PBHCI Service (cont'd)

- Orientation and Consent was completed
 - NOMs baseline completed at same visit
 - NCM collected basic vitals, direct data input
 - Folder of info went to Admin Coordinator for enrollment and data entry
 - Appointment set with client for continued assessment and PBHCI services
- *(Sometimes more services occur at first initial engagement)
- Initial Communication to the CM (MH) by the NCM

Assessment Process

- NCM collected initial health history and presenting problem information
 - Primary care status assessed (Y or N)
 - Referred to onsite Primary Care; seen in same week
- PC reviewed initial referral and NCM's initial info.
 - PC conducted further health screening, labs, dx, tx plan, etc
- Client also reviewed in Grand Rounds
- Communication feedback loop to CM and all involved
- CM Coordinated / updated the Care Plan
- A two-way arrow...

Client H indicators / Additional Health Issues:

PBHCI Nurse Care Manager and Primary Care were responsible for conducting health indicators / health measures

PBHCI Admin. Coordinator responsible for collecting the health data from GCB and PC systems and entering into TRAC

Client H indicators / Additional Health Issues (cont'd):

(Start) April 2011:

- 165 lbs, 5'4", BMI 28
- BP 145/85
- Cholesterol 218
- Triglyceride 145
- HDL 49
- LDL 140
- Glucose 136, fasting

April 2012:

- 148 lbs, BMI 25
- BP 105/65
- Cholesterol 180
- Triglyceride 129
- HDL 63
- LDL 94
- Glucose 111, unknown

Medications

- BH Meds: Wellbutrin, Zoloft, Buspar, Ambien
- Pravastatin and Trilipix (cholesterol)
- Metformin and Lantus Solostar (diabetes)
*has significantly decreased
- Lisinopril (hypertension)

Individualized Care Planning Design

- CPing process operates on the premise that the BH staff take responsibility to coordinate overall healthcare needs
- GCB's Care Plan calls for maximum 3-4 broad life goal areas with many more supporting & detailed objectives
 - *GCB Requirement for one goal area to address physical health issues*
- Care Manager responsible for coordination to ensure all health needs were incorporated into the GCB Care Plan; Communication key!
- Individual providers (PC, etc) contain more detailed, specific treatment planning information in their service

Individualized Care Planning

A. Primary Care Services:

- Frequency: every 6-8 weeks
- PC Provider: Began with the in-house PC, The HealthCare Connection (FQHC) but now sees an outside PC
- Focus: Managing / reducing diabetes symptoms, preventive care, both psychiatric and physical health medications

Individualized Care Planning

B. Behavioral Health Service

- Frequency: very minimal contact
 - Has graduated from Care Management to Recovery Facilitator as step-down but time-limited and approaching graduation from all GCB services
 - Current Focus: Coordination of wellness services, transition from client to peer, graduate from PBHCI
 - Attending Therapy
- *Ability to have psych meds coordinated by outside PC made this more feasible!

Wellness Activities/Services

Client Attended:

- Weight-loss group
- Nutrition group
- Managing My Symptoms group
- Chronic Disease Management – Diabetes group
- WRAP group
- WMR group
- Solutions For Wellness group
- WHAM Training

Progress Monitoring (H indicators and other health conditions)

- Client has now moved to a lower level of care and working with a Recovery Facilitator
- PBHCI Administrative Coordinator and Recovery Facilitator work together to monitor and collect health indicators
- PBHCI Administrative Coordinator manages internal reports and TRAC data / reports
- Internal reports are distributed weekly to CM Teams
- Client is now actively working in the PBHCI project as a Peer Wellness Coach! 😊

Continued Challenges To Address...

Communication between providers
eg: Med Changes

Separate EHR Systems

Care Management / Coordination with outside PC's

MH CMs not yet driving the full process / coordination

Current Care-Enhancing Initiatives...

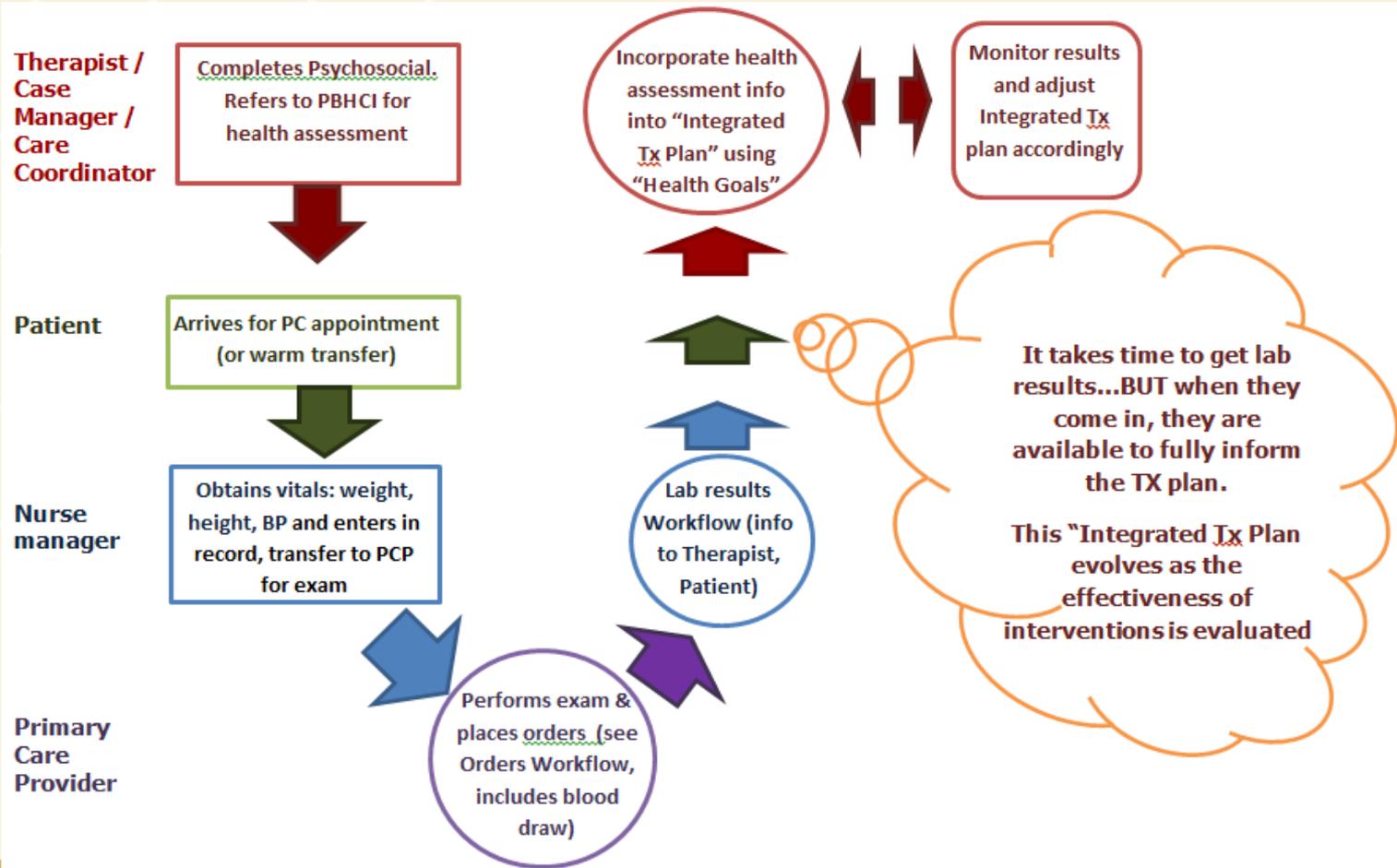
- ✓ EHR implementation, Meaningful Use
- ✓ E-prescribing
- ✓ Tracking PC connection status of all clients
- ✓ CCD/CCR Sharing between GCB and THCC
- ✓ Electronic Labs exchange
- ✓ Health Home Development:
 - A Strengthened Care Management and Care Coordination Model
 - Recruiting More Nurses as CMs
 - Preparing for HIE exchange with MCPs

THANK YOU!!!

Grantee Group Activity: Integrating Health Data in Integrated Assessment & Treatment Plans

Biopsychosocial Assessment and the Integrated Treatment Plan

New Patient > Assess & Refer to PBHCI > See NCM & PCP > BH Includes Section H: Data in Integrated Treatment (Tx) Planning



Do your treatment plans include mental health, health and wellness, and if appropriate, substance abuse goals?

Are your behavioral health treatment plan goals periodically updated when your consumers receive updated health reports (e.g., new lab work)?

Are all PC and BH members of the integrated treatment team (e.g., including therapists, psychiatrists, case managers) working with your consumers to actively support their treatment goals?

BREAK



Team Discussion: How Do You Know That Your Wellness Programs Work?

Why are you implementing your current programs?

How do your current programs align with what your population-based health information suggests are priority issues?

Are your wellness programs working?

Are your wellness interventions supported by the current evidence of effectiveness?

How will your wellness programs be sustained in the long term?

What are your plans for sustaining effective wellness interventions with funding and internal policy changes?

Checklist for Evaluating Health Promotion Programs for Persons with Serious Mental Illness: What Works?

This checklist can be used for comparing health promotion programs. Check all that apply. Each of these features is important to consider in evaluating programs that are (a) most effective and (b) also ready for implementation in real-world settings.

Features Associated with Greater Health Promotion Program Effectiveness

- Program has been specifically designed, evaluated, and proven effective for persons with mental illness
- Program has been proven effective in a randomized trial (RCT study) consistent with establishing an “evidence-based practice”
- Outcomes are reported as clinically significant, not just statistically significant (i.e. outcomes include % or total sample weight loss of at least 5% or more and/or reports on clinically significant change in fitness)
- Program consists of active participation in physical activity and nutrition (not just education, class-room, or passive learning)

Checklist for Evaluating Health Promotion Programs for Persons with Serious Mental Illness: What Works?

- Program includes both physical activity and nutrition components (not just one or the other)
- Program includes a component of physical activity/and or nutrition with coaching or supervision by a person with training in fitness and/or nutrition coaching
- Program includes ongoing self-monitoring by the participant and review by the coach or provider of goals and outcomes (e.g. weight, amount of regular physical activity or exercise, nutrition, etc.)
- Duration of program participation is at least 6 months

Checklist for Evaluating Health Promotion Programs for Persons with Serious Mental Illness: What Works?

Features of Programs Associated with Greater Implementation Readiness

- The program has been implemented at least once outside of the research studies
- The program has been implemented in multiple settings by different agencies outside of the initial research setting
- The program has been implemented and provided without relying on grant funding
- There is an instruction manual for implementing the program designed for providers in real-world settings (not just a research manual)
- Training and implementation technical assistance for the program is available

Action Planning: Tobacco Cessation

Behavioral Health and Wellness Program University of Colorado

Presenter:
Jennifer Hasbrook

BREAK



Grantee Sharing Session

Topics of Interest:

- Consulting process (42 CFR)
- MA's vs. Nurses - conducting office vitals and in relation to billing strategies
- Sustainability planning
- Which grantees are developing non- PBHCI comparison groups for their agencies to evaluate their programs



Meeting Wrap Up

Who came up with a plan for:

- ✓ Implementing a registry?
- ✓ Using a registry to inform wellness activities?
- ✓ Improving the integrated treatment plan?
- ✓ Assessing the effectiveness of wellness programs?
- ✓ Tobacco cessation?



THANK YOU

Please remember to complete your evaluation