The first 6 months of our journey…..

Whole Health Clinical Group is a non-profit organization in Milwaukee, Wisconsin serving individuals living with serious mental illness, medical conditions, trauma, addiction, and have many deterrents of health such as, homeless, poverty and access requiring case management.

WHCG is part of Cohort VIII and in the very beginning stages of model implementation, and evidence based practice of our data collection.
Objectives

- Describe how Whole Health Clinical Group (WHCG) integrated practice is moving the dial
- Define population health management
- Identify key protocols to use in clinical practice
- Describe how WHCG are implementing a plan to impact the health indicators

Individuals living with SMI: As we know?

Shorter life expectancy of mortality 25yrs earlier than the average population

- *The World Health Organization (WHO) reports that cardiovascular disease, including coronary heart disease, atherosclerosis, hypertension and stroke, is one of the leading causes of death among individuals with SMI.*
- *Higher than expected rates of Type II diabetes, respiratory diseases, and infections such as HIV, hepatitis and tuberculosis.*
Cardiovascular Disease is Primary Cause of Death in Persons with Mental Illness

Cardiovascular Disease Risk Factors

<table>
<thead>
<tr>
<th>Modifiable Risk Factors</th>
<th>Estimated Prevalence (%) and Relative Risk (RR)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Schizophrenia</td>
</tr>
<tr>
<td></td>
<td>Bipolar disorder</td>
</tr>
<tr>
<td>Metabolic syndrome</td>
<td>37-60%, 2-3 RR</td>
</tr>
<tr>
<td></td>
<td>30-49%, 2-3 RR</td>
</tr>
<tr>
<td>Dyslipidemia</td>
<td>25-69%, 5 RR</td>
</tr>
<tr>
<td></td>
<td>23-38%, 3 RR</td>
</tr>
<tr>
<td>Hypertension</td>
<td>19-58%, 2-3 RR</td>
</tr>
<tr>
<td></td>
<td>35-61%, 2-3 RR</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>10-15%, 2-3 RR</td>
</tr>
<tr>
<td></td>
<td>8-17%, 1.5-3 RR</td>
</tr>
<tr>
<td>Smoking</td>
<td>50-80%, 2-3 RR</td>
</tr>
<tr>
<td></td>
<td>54-68%, 2-3 RR</td>
</tr>
<tr>
<td>Obesity</td>
<td>45-55%, 1.5-2 RR</td>
</tr>
<tr>
<td></td>
<td>21-49%, 1-2 RR</td>
</tr>
</tbody>
</table>


Disparities: Rates of Non-treatment

WHCG principles guiding integration:

- Supporting the whole-person through Person-Centered Approaches.
- Consistent collaboration & communication with care team and participant.
- Enlisting a trusting relationship is essential.
- Reducing the stigma and discrimination of individuals with mental health.

Location + Collaboration = Integration

<table>
<thead>
<tr>
<th>Minimal Collaboration</th>
<th>Basic Collaboration from a Distance</th>
<th>Basic Collaboration Onsite</th>
<th>Close Collaboration/Partly Integrated</th>
<th>Fully Integrated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separate systems</td>
<td>Separate systems</td>
<td>Separate systems</td>
<td>Some shared systems</td>
<td>Shared systems</td>
</tr>
<tr>
<td>Separate facilities</td>
<td>Separate facilities</td>
<td>Same facilities</td>
<td>Same facilities</td>
<td>Consumers and providers have same expectations of system(s)</td>
</tr>
<tr>
<td>Communication is rare</td>
<td>Periodic focused communication; most written</td>
<td>Regular communication; occasionally face-to-face</td>
<td>Face-to-Face consultation; coordinated treatment plans</td>
<td>In-depth appreciation of roles and culture</td>
</tr>
<tr>
<td>Little appreciation of each other's culture</td>
<td>View each other as outside resources</td>
<td>Some appreciation of each other's role and general sense of large picture</td>
<td>Basic appreciation of each other's role and cultures</td>
<td>Collaborative routines are regular and smooth</td>
</tr>
<tr>
<td></td>
<td>Little understanding of each other's culture or sharing of influence</td>
<td>Mental health usually has more influence</td>
<td>Collaborative routines difficult; time and operation barriers; Influence sharing</td>
<td>Conscious influence sharing based on situation and expertise</td>
</tr>
<tr>
<td>&quot;Nobody knows my name. Who are you?&quot;</td>
<td>&quot;I help your consumers.&quot;</td>
<td>&quot;I am your consultant.&quot;</td>
<td>&quot;We are a team in the care of consumers&quot;</td>
<td>&quot;Together, we teach others how to be a team in care of consumers and design a care system.&quot;</td>
</tr>
</tbody>
</table>

Where does WHCG fall?
What do we need to do as PCPs?

• Build a relationship which supports integration of communication across the team.
• Understand the importance of participant setting personal goals and let that drive the treatment decision
• Role of the practitioners
  • Direct Care
  • Collaboration
  • Population Based Care
  • Education
  • Leader

Strategies for promoting participation in treatment

• Longer clinic visit times
• High no show rates
• Bundle services on the same day
• Address complex medical needs related to co-occurring conditions
• Understand the target population
  • Self-Learning, stages of change, trauma, wellness and recovery.
  • Understanding the importance of Psychopharmacology
  • SAMHSA/CIHS Primary Care Provider 5 modules
WHCG Lab/Pharmacy Onsite

- One shop
- Increases adherence to treatment plan
- Collaboration
- Increased access to services
- Reduces delays in treatment
- Pharmacist onsite for clinical consultation and part of the PBHCI team

Barriers to Providing Primary Care to SMI Population

**Cultural**
- Mental health staff and patients not used to incorporating primary care as part of job
- Psychiatric staff feel time pressure to address screening, vital signs and may feel “out of scope” for specialty

**Financial**
- Limited funding
- Different billing structures
- High no show rates, takes extra time
- Psychiatric providers not provided resources such as Medical Assistants

**Motivational**
- Lack of perceived need for care
- Lack of motivation as part of negative symptoms of schizophrenia

**Organizational**
- Devoting space, time, and money
- Specialists do not cross boundaries
- Different languages
- Behavioral health EHRs may lack capacity to track physical health indicators
- Not perceived as part of the Mission

**Physical Location**
- Proximity is crucial to success
- Same building is best
- Space limitations
WHCG Strategies to Barriers

• Practice Space
• Communication
• Screening
• Team Huddles
• EHR-eClinicalWorks Provider to Provider communication (P2P)
• Wellness Recovery Program
• Integrated Treatment plan

WHCG Moving the Dial

• Collecting H-Indicators
  • Baseline
  • Reassessment plan
• Impacting health outcomes
  • Evidence-Based Practices (EBP)
  • Treatment Protocols and Clinical Pathways
  • Treatment Engagement
  • Tracking Health Outcomes
Collecting and Monitoring Data

Health indicator data
- Higher obesity rate
- High percentage of smoking
- Metabolic syndrome

Reassessment
- Re-evaluate current processes-Quality Improvement plan
- Evaluate change in patient’s behavior
- Assessing patient centered goals
- Meeting PBHCI goals
Health-Evidence Based Practices

- Million Hearts (Hypertension/Tobacco)
- Eighth Joint National Committee (JNC 8) Hypertension Guidelines
- American Heart Association (AHA)/American College of Cardiology (ACC) Joint Cholesterol Guidelines 2013
- American Association of Clinical Endocrinologist (AACE)/American College of Endocrinology (ACE) file:///Users/Robinsro0812/Documents/aace_algorithm_slides (1).pptx

Treatment Protocols
Treatment protocols and best practice approaches

- TOBACCO PROTOCOL
  - file:///Users/Robinsro0812/Library/Mobile Documents/com~apple~CloudDocs/Tobacco-Cessation-Protocol.pdf
  - /Users/Robinsro0812/Documents/smoking cessation (2)[1].docx

- SBIRT PROTOCOL
  - file:///Users/Robinsro0812/Library/Mobile Documents/com~apple~CloudDocs/SBIRT PROTOCOL .docx

- HYPERTENSION PROTOCOL
  - file:///Users/Robinsro0812/Library/Mobile Documents/com~apple~CloudDocs/Hypertension-Protocol1.pdf
  - file:///Users/Robinsro0812/Documents/HTN Protocol.docx

- DIABETIC PROTOCOL
  - file:///Users/Robinsro0812/Documents/dm protocol .docx
Implementing Protocols

- Educating Staff
- Efficient Workflows
- Chart Prep/Pre-Visit Planning
- Case managers attending appointments with patients

Treatment (Engagement)

- No-Show protocol for primary care staff to follow- to impact no-show rates
  - file:///Users/Robinsro0812/Documents/No-Show-Management.pdf
- Wellness Recovery Program
- Frontdesk staff
- Internal Evaluator
- Open Access Scheduling
  - Leaving 15 minute appointment slots open for acute care/walk-in appointments
Population Health

“Population health management is a collection of provider (MD, NP, PA) supervised interventions, implemented for populations defined by a healthcare need or condition, that help patients and caregivers optimize care, prevent future complications, and maximize opportunities for wellness.”

Six Steps of Population Health Management

1. Population Identification/Definition
2. Health & Risk Assessment
3. Risk Stratification
4. Targeted Interventions
5. Engagement for Behavior Change
**Best Practices-Monitoring Population Health Data**

- Collecting Analytics
- Aggregate and Segment Your Population Data
- Coordinate Care Across the Continuum with Visualization
- Understand Your Risks
- Proactively Manage Patient Relationships

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**Tracking Health Outcomes**

- The utilization of Health Information Technology
- Utilization of Population Health Registries to subgroup population
- Quality IT team member
In Data we trust…

Health Indicator

- BMI - Obesity/overweight rate within the SMI population
- Percentage of smokers and risk factors related to Breath CO readings
- Screening diabetics using the HbgA1c results (borderline or confirmed diabetics)
- Lipid Panel - Risk factor for cardiovascular disease

H-Indicators of WHCG Participants

- **HDL cholesterol**: Approximately one-third (32.4%) of the clients had HDL levels that fell into the “at risk” range at baseline (i.e., <40), while 67.6% had levels that fell into the “normal” range (i.e., ≥41). (N=34)
- **LDL cholesterol**: Approximately 10% (8.8%) of the clients had LDL levels that fell into the “at risk” range at baseline (i.e., ≥130), while 91.2% had levels that fell into the “normal” range (i.e., <130). (N=34)
- **Triglycerides**: Approximately 40% (38.2%) of the clients had triglyceride levels that fell into the “at risk” range at baseline (i.e., ≥150), while 61.8% had levels that fell into the “normal” range (i.e., <150). (N=34)
**H-Indicators of WHCG Participants**

- **BMI:** Approximately two-thirds (66.7%) of the clients had BMIs that fell into the “at risk” range at baseline (i.e., ≥25), while 33.3% fell into the “normal” range (i.e., <25). (N=33)

- **Waist Circumference:** Approximately 45% (46.9%) of the clients had waist circumferences that fell into the “at risk” range at baseline (i.e., ≥102 for men; ≥88 for women), while 53.1% fell into the “normal” range (i.e., <102 for men; <88 for women). (N=32)

- **Breath CO:** Approximately 45% (43.3%) of the clients had breath CO levels that fell into the “increased risk” or “at risk” ranges at baseline (i.e., ≥7), while 56.7% fell into the “low risk” range (i.e., <7). (N=30)

- **HgbA1c:** Approximately 40% (40.6%) of the clients had HgbA1c levels that fell into the “at risk” or “high risk” range at baseline (i.e., ≥5.7), while 59.4% fell into the “normal” range (i.e., <5.7). (N=32)

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**A WHCG Participant’s Experience…**

51 year old Hispanic male, uncontrolled diabetes, paranoid schizophrenia, metabolic syndrome, referred to and utilizing nursing services/home health care, referred to diabetic educator, provided with diabetic education information, collaborating with behavioral health team, medication reconciliation and adjustment

Baseline: LDL 50

- HDL 27
- A1c 10.2
- Breath CO 4(Former Smoker)
## Risk From Baseline Decreased

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Decrease (%)</th>
<th>Count (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Blood Labs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LDL Cholesterol</td>
<td>44</td>
<td>1107</td>
</tr>
<tr>
<td>Tri-glycerides</td>
<td>25</td>
<td>1826</td>
</tr>
<tr>
<td>HDL Cholesterol</td>
<td>25</td>
<td>1349</td>
</tr>
<tr>
<td>Diabetes labs</td>
<td>19</td>
<td>2411</td>
</tr>
<tr>
<td><strong>Mechanical Indicators</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>39</td>
<td>6137</td>
</tr>
<tr>
<td>Breath CO</td>
<td>16</td>
<td>4481</td>
</tr>
<tr>
<td>Waist Circumference</td>
<td>10</td>
<td>6410</td>
</tr>
<tr>
<td>BMI</td>
<td>6</td>
<td>10362</td>
</tr>
</tbody>
</table>