Asian Community Mental Health Services

Asian Health Services

Oakland, California

Cohort III

Asians Coming Together (ACT) for Health Integration Project

Overview

- Co-location Model: (1st floor: AHS Primary Care office & 2nd floor: ACMHS Behavioral Health Clinic).
- Year-to-date, serves 242 SMI adult clients in 9 API languages (Cantonese, Mandarin, Vietnamese, Cambodian, Korean, Mien, Tagalog, Japanese, Burmese) by 24 Care Managers.
- Project Team:

	Project Admin Team	Integrated Patient Care Team
ACMHS	Project Director	Wellness Coordinator
(Behavioral Health)	Project Coordinator/ Electronic Health Record Manager	Peer Wellness Coach
	Data Specialist	Psychiatrists
	Research Interns	Care Managers
	Project Evaluator	
AHS	Director of Clinical Operations	Primary Care Provider/Nurse Care Manager – NP
(Primary Care)	Associate Director	Primary Care Provider - MD
	Members Eligibility	Health Coach/Medical Assistant
	Billing Assistant	Dietician

- Wellness Activities: Art Club, Exercise/Walking Group, Chinese Water Color Art Group, Cambodian Wellness, Mien Support Group, Zumba, Family Tai Chi, and Healthy Food Choice Group as part of our Health and Nutrition Series.

Accomplishments & Successes

Improved Partnerships

- First ever formal working relationship between two agencies serving mutual clients in 40 years of history.
- Improved understanding of each other's care philosophy, work flow, admission criteria and business model.
- Increased formal and informal communication about mutual clients' care among primary care and behavioral health providers.
- Lay the foundation for further exchange between two agency's leadership on continuing collaboration.

Improved Patient Care & Coordination

- Co-location (in the same building); designated PCP office and team for the care of Project clients.
- Shorter interval between appointments; shorter waiting time for initial appointment with PCP.
- Integrated Care Case Conference on at least 8 clients/month, attended by Psychiatrists, PCP, Care Manager & Wellness Coordinator.
- Integrated Care Plan discussion informed by Wellness Report Card tool.

Implementation of Electronic Health Record System

- PCP & BH Appointment Coordination made possible by permitting PCP access to BH's Electronic Health Record (EHR) System.
- Prescribed psychotropic medications info and lab results accessible through BH EHR's e-prescription and e-lab functions.
- Based on patient interview, clients are happier with the care.

Increased Workforce Capacity

- Transforming behavioral health client care culture gradually. Not case managers, but Care Managers.
- Increased Behavioral Health providers' knowledge, comfort level and willingness to work with clients on their physical health care via Case to Care Manager training, Integrated Care Case Conferences, Wellness Program and Wellness treatment goals.
- Primary Care providers more informed and understanding of the SMI clients and their integrated care's needs.

Increased Collection and Utilization of Health and Service Data for Planning

- NOMS – quality of life survey; Health Indicators summary report.
- Wellness Report Card (Health Indicators); on average two report cards per client per year.
- PCP & BH visits: service utilization, no show, cost analysis.

Accomplishments & Successes

Increased Utilization and Impact of Wellness Program

- Providers have increased appreciation of benefits of Wellness Programs for client care. Increased referral of clients to Wellness Program, resulting in an increase of 50% attendance for some Wellness groups. 75% of Project participants have developed Wellness goals in their BH treatment plan.
- Foci of our Wellness Programs are: community connection among API monolingual clients, acquiring healthy eating and healthy living skills/habits.

Increased Peer Involvement

- Transforming agency culture to include Peers in our Workforce. Create a Peer Wellness Coach position; recruit a peer to be a Wellness group instructor.
- Sponsored three peers to be trained and certified as WHAM facilitators; and one certified as WRAP facilitator. Developed and implemented a peer facilitated Korean WHAM Group
- Consumer Advisory Board (CAB) was found. Increased membership from 5 to now 10.
- Quarterly Wellness Newsletter published for consumers and by consumers – 4 issues published so far.
- Adopted CAB's ideas to improve facility and make it more welcoming.

Increased Community Partnership

- Entered MOU with a neighborhood church that has a kitchen to conduct our Wellness groups
- Recruited bilingual students from University of California, Davis & University of California, Berkeley to assist in Wellness activities and translation of health education materials.
- Partner with community wellness providers and instructors to spread the Wellness Life Style messages through Wellness Program and Events.
- Co-sponsor with Alameda County Behavioral Health Care Services and other agencies to host the annual 10x10 County Wellness Fair.
- Join the Bay Area PCI Grantee Network to learn and support one another's Integrated Care service delivery and culture change.

Contribution to availability of bilingual health materials and tools

- Translated NOMS into Chinese, Korean, Vietnamese & Cambodian languages.
- Translated WHAM curriculum into Korean and English

Challenges

Partnership

- Insufficient leadership buy in; FQHC partner has own operational, financial and workforce challenges.
- Rigidity and resistance in changing the existing system and practice e.g. FQHC admission and insurance criteria,
- Crisis & Opportunity: 50% staff turn over rate in both Admin & Patient Care team over the 4-year grant period.

Cultural and Linguistic Diverse Immigrant SMI Population – Multiple Challenges for Care Coordination

- Project Enrollment Challenge – clients do not want to switch their PCP providers. Any change is difficult.
- Language & cultural-match Integrated Care Team Providers for 9 Asian Pacific Islanders languages client groups - very challenging. The roles and functions of bilingual behavioral health care managers are critical for the bridge, much more than any regular Integrated Care Team's care managers.
- Integrated Care Model – We implement the co-location model during the 4-year grant, which has been better than the former collaboration model but still not conducive enough for the heavy coordination efforts required for the bilingual Care Managers to link clients and assist them keep the appointments and follow through the doctor's advices. Based on our experience, we believe we should adopt the Same-location Integrated Care Model so to address more effectively our unique client engagement challenges that are tied to their immigration history, traditional belief about healing practices, cultural and linguistic barriers.

No Show Rate

- Average no show rate: >20%. Started a shared system for appointment scheduling coordination in June 2014 to address.

Patient Care Resources

- Very inadequate public dental care insurance/resources – negatively affects client's quality of life, complicates health conditions and increase their mental stress.

Outcomes

Interview Quotes:

a. Patient: "My mother is preparing more nutritious food such as salad, oatmeal, fish, orange, at home. During group activities, she is there to urge me to concentrate on the activities at hand."

b. Family Member: "My daughter becomes more active during the day at home so that she does not sleep excessively and no longer gains more weight."

c. Care Manager:

"Through this program, clients are able to practice self advocacy. We recognize minute improvements and point out to them so they see it as their strength. It allows them to have their own voice."

"Gradual improvements, understanding the patients. The PCI office is more sensitive to our clients than the main (FQHC) site. With the sensitivity of the patients, there are more client engagements within the PCI office and patience is given to the patients…"

As of July 15, 2014	Outcome Improved (Percent change)	
NOMS Indicators	ACMHS	Overall PCI Pgms
"Healthy Overall"	**39%**	25%
"Functioning in Everyday Life"	**57%**	32%
"Having a Stable Place to Live"	**32%**	12%
"Being socially connected"	**25%**	18%

* only negative outcome is the use of tobacco products showing an increase of 6.5% for ACMHS vs a reduction of 4.5% for the overall PCI programs

As of July 15, 2014	Outcome Improved		Remain at Risk		No longer at Risk	
H Indicators	ACMHS	Overall PCI Pgms	ACMHS	Overall PCI Pgms	ACMHS	Overall PCI Pgms
Blood Pressure - Combined	18%	19%	**13%**	29%	**19%**	17%
Triglycerides	**65%**	39%	28%	28%	**14%**	11%
HDL Cholesterol	**54%**	38%	**11%**	22%	7%	8%
LDL Cholesterol	**54%**	41%	15%	17%	**15%**	10%
BMI	45%	43%	**49%**	74%	8%	5%
Waist Circumference	40%	40%	**49%**	74%	8%	5%
HgbA1c	34%	35%	**57%**	49%	5%	8%

* other Health Indicators have similar level of outcome as overall PCI Pgms

Moving Forward

1. Explore same location and other viable integrated care service delivery models. Keep abreast of the national development especially that of Behavioral Health Care Home.
2. Identify steps to reduce no show rate for BH and PCP appointments to less than 10% in order to make any program sustainability discussion meaningful and implementation possible.
3. Identify resources to sustain Wellness Program to activate life style changes and mindful on what outcome data to collect.
4. Continue the integrated care case conferencing and consider expanding to include other PCPs of our FQHC partner who treat ACMHS' SMI clients.
5. API Immigrant Population and SMI Population Health data is sparse but important for program planning and identification of service gaps. Plan to collect vitals and lab results of every adult client in the Behavioral Health clinic for baseline data.
6. Increase the role and functions of Peer specialist in integrated care delivery.
7. Experiment the proactive efforts of having bilingual BH care managers, who see clients more often than a PCP provider, lead in coordinating the scheduling of BH and PCP appointments on the same day.
8. Explore with FQHC partner steps to implement electronic exchange of client care info now that both parties have installed an Electronic Health Record system.
9. Expand Consumer Advisory Board to include family representatives.

Words of Wisdom:
Don't Do What We Did/or What I Wish We'd Done Differently

Model of Integration

- Explore the same location model seriously before ruling that out.
- Consensus early on if the Integration Project only includes participants who will switch their PCP provider to the one in the Project.
- Leadership buy in.

Sustainability factor

- Thought about sustainability from Day One of the Grant; ask for technical support on how to do budgeting more wisely and utilizing cost analysis model.
- Use sustainability consideration to drive the discussion and decision on workflow, data collection, cost analysis, capacity building, workforce development etc.
- Deal with no shows early on. Revenue generation and balancing the book ultimately determines what sustainable services will look like.

Capacity building

- More cross trainings between the primary care & behavioral health to build both sides' capacity to work with this vulnerable population in the integrative setting.
- More trainings around billings for the integrated care work especially how to do clinical documentation to meet behavioral health side's medical and service necessity criteria.
- Transform staff to not only know, but also appreciate and practice wellness so that they can model that with their clients, instead of just "preaching it out."

Project Team: Roles & Functions

- More integration team building activities in the first 6 months to understand the program and our integrated care team roles; set clear expectations of role functions; staff training and networking.
- Get family and significant others' involvement early on so that our SMI clients have the support at home and have partners in their road to recovery.

Words of Wisdom:
Don't Do What We Did/or What I Wish We'd Done Differently

Interventions

- More peer resources on doing wellness group with SMIs. The peer support model seemed to make a great impact on client's motivation to make changes for better health.
- Implementation of both Primary Care and Wellness Program at the same time, more effective in engaging clients to stay in the Project.
- Translate educational materials in client's languages to make possible full understanding.
- Have a large consistent venue for Wellness Activities.

Community Impact

- Work with managers at board and care homes to impact on the food choices that they are making in serving our clients.
- Get more community involvement from Day One. Spread the word about our integration through the media so that different sectors such as faith community, businesses, health providers, pharmacies and other entities will want to get involved and be part of the movement.

Data Collection

- Better understanding of H indicators collection process, so that there will be less missing baseline data, which reduces the number of valid cases for future comparison.
- Planning time around the sharing of patient information, what is possible and what is not; what are the type of information that will help in client care and treatment planning.
- Define early on what outcome data we want to gather through Wellness activities.

Words of Wisdom: Tips for Success

1. Despite not meeting our original numbers, we all felt we have grown tremendously in understanding the power of integrating the mind and the body for holistic health and the multi-discipline teamwork and infrastructures that can support that goal.

2. When we watched our clients transformed from being in the socially isolated, withdrawn and disconnected state to one of seeing a little sparkle in their eyes, smiles on their faces; when they are taking baby steps to try new things like eating organic fruits and vegetables, doing Tai Chi, Zumba and Yoga; when they are doing more and feeling more…..we are right there next to them in partnership. It is the most rewarding feeling. It's like "if you build it, they will come."

3. Celebrate each day with little victories, like when our clients are achieving short term goals. Share that success to inspire others, with family and friends.

4. Celebrate clients' cultures and language as their valuable assets and strengths. Use cultural celebrations, holidays and important milestones to share stories and reinforce their unique histories, backgrounds, gifts and contributions to the community and to the group. Have providers and others learn and understand each others' cultures, health beliefs and practices. Honor diversity, cultural meanings and rituals.

5. Use each month as a special month for health promotion so providers, clients and the community members can focus on that theme and work together to spread the message, educate and learn from each other.