SAMHSA-HRSA
CENTER for INTEGRATED
HEALTH SOLUTIONS

Health Indicators: Moving the Needle

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integration.samhsa.gov

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 then the average population

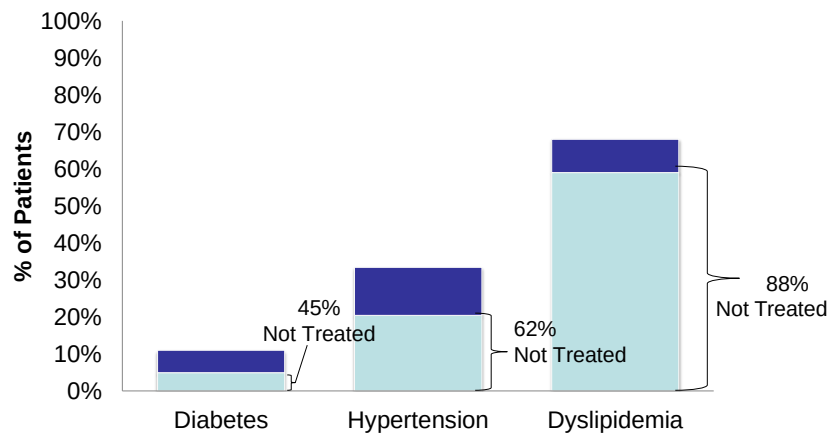
- ***The World Health Organization (WHO) reports that cardiovascular disease, including coronary heart disease, atherosclerosis, hypertension and stroke, is one of the leading causes of death among individuals with SMI.***
- ***Higher than expected rates of Type II diabetes, respiratory diseases, and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

Cardiovascular Disease is Primary Cause of Death in Persons with Mental Illness

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

De Hert M, et al. World Psychiatry. 2011 Feb; 10(1): 52–77

Disparities: Rates of Non-treatment



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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

Integration

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

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
    - http://www.integration.samhsa.gov/workforce/primary-care-provider-curriculum

WHCG Lab/Pharmacy Onsite

- One STOP 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

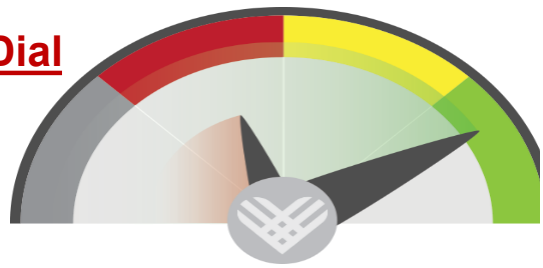
Organizational
- Devoting space, time, and money
- Specialists do not cross boundaries
- Different languages
- Behavioral health EHRs may lack capacity to track physical health indicators
- Not perceived as part of the Mission

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
6. Evaluation of Outcomes/Impact

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

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

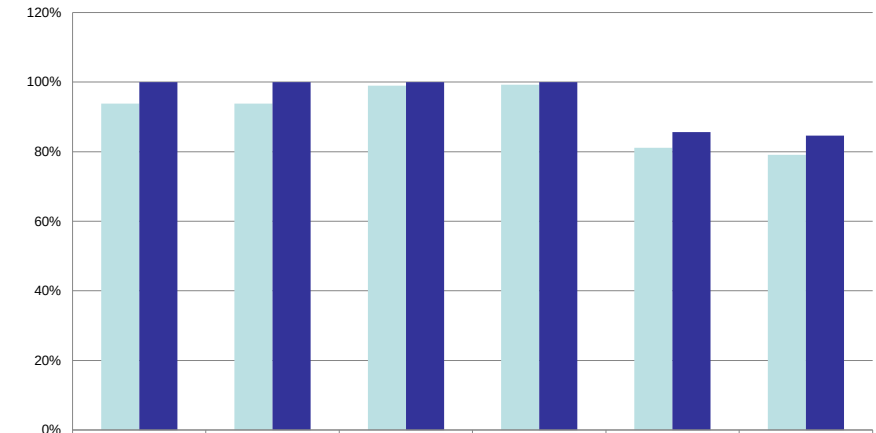
- **BMI:** Approximately two-thirds (66.7%) of the clients had BMIs that fell into the "at risk" range at baseline (i.e., ≥25), while 33.3% fell into the "normal" range (i.e., <25). (N=33)
- **Waist Circumference:** Approximately 45% (46.9%) of the clients had waist circumferences that fell into the "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)

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

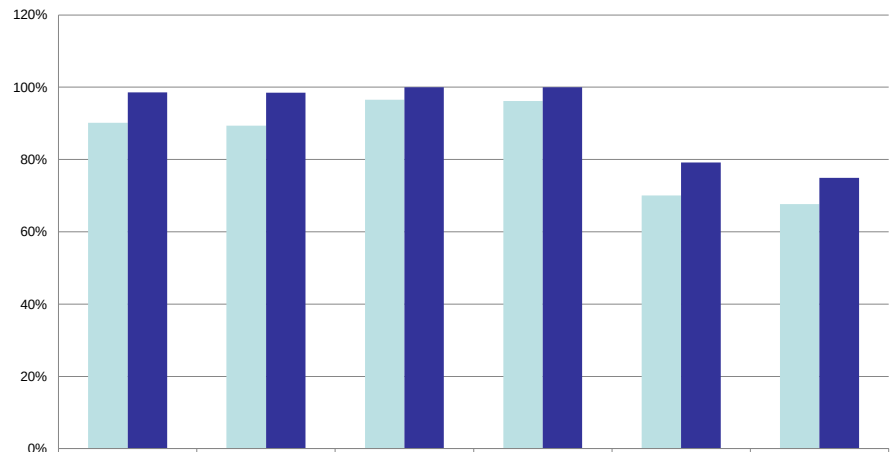
Baseline: LDL 50
HDL 27
A1c 10.2
Breath CO 4(Former Smoker)

Region 5
% H indicator Data Entered at Baseline
(N= 26 of 27)



	Blood Pressure	BMI	Waist Circumference	Breath CO	Diabetes Labs	Cholesterol
Average	94%	94%	99%	99%	81%	79%
Median	100%	100%	100%	100%	86%	85%

All Regions
% H Indicator Data Entered at Baseline
(N= 115 of 121)



	Blood Pressure	BMI	Waist Circumference	Breath CO	Diabetes Labs	Cholesterol
Avg	90%	89%	97%	96%	70%	68%
Median	99%	98%	100%	100%	79%	75%

Risk From Baseline Decreased