NATIONAL COUNCIL for Mental Wellbeing

CCBHC-E National Training and Technical Assistance Center

CCBHC Optimizing Data Learning Series

June 20, 2023

CCBHC-E National Training and Technical Assistance Center

Funded by Substance Abuse and Mental Health Services Administration and operated by the National Council for Mental Wellbeing

Acknowledgements and Disclaimer

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Logistics

- **Please rename yourself so your name includes your organization.**
  - *For example:*
    - Blaire Thomas, National Council
  - *To rename yourself:*
    - Click on the **Participants** icon at the bottom of the screen
    - Find your name and hover your mouse over it
    - Click **Rename**
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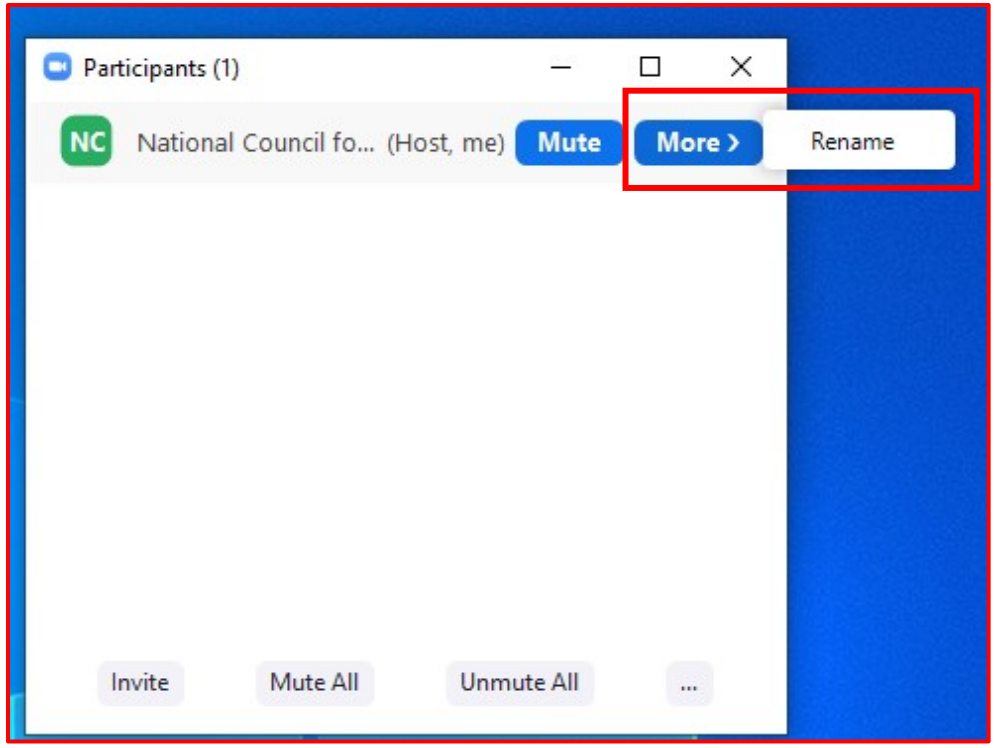

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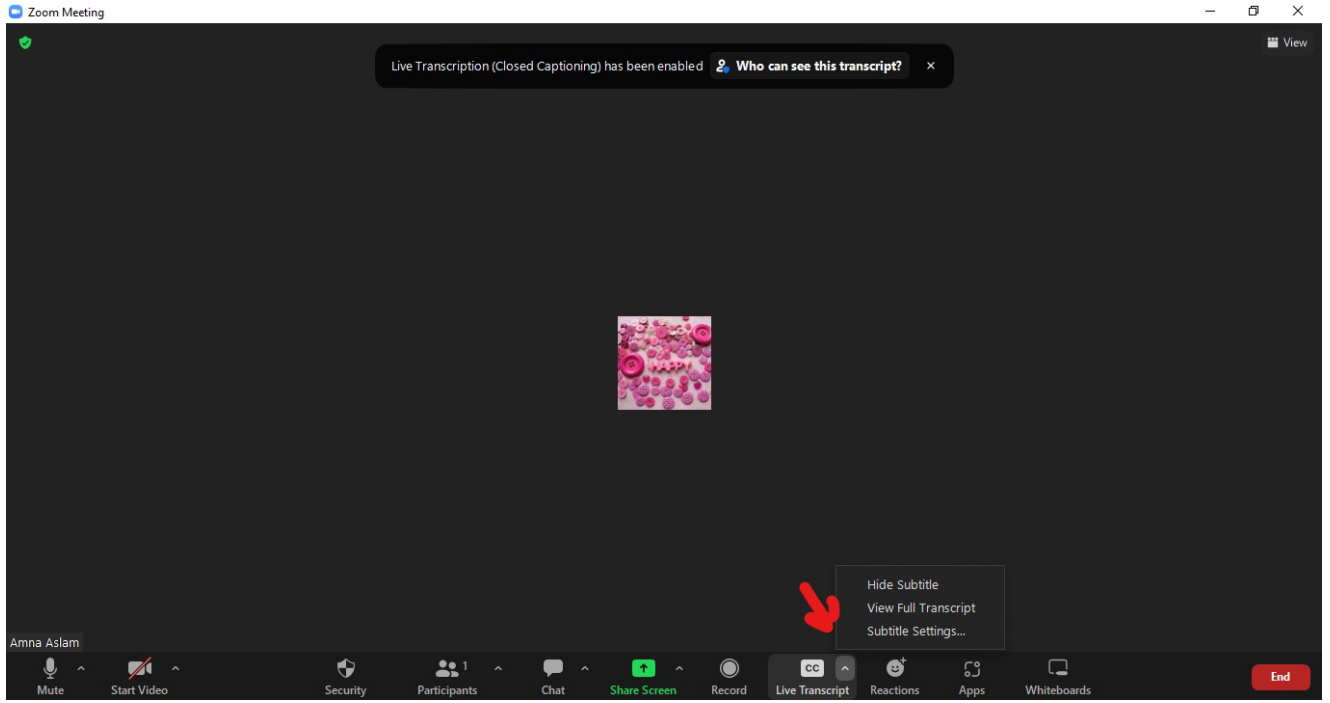

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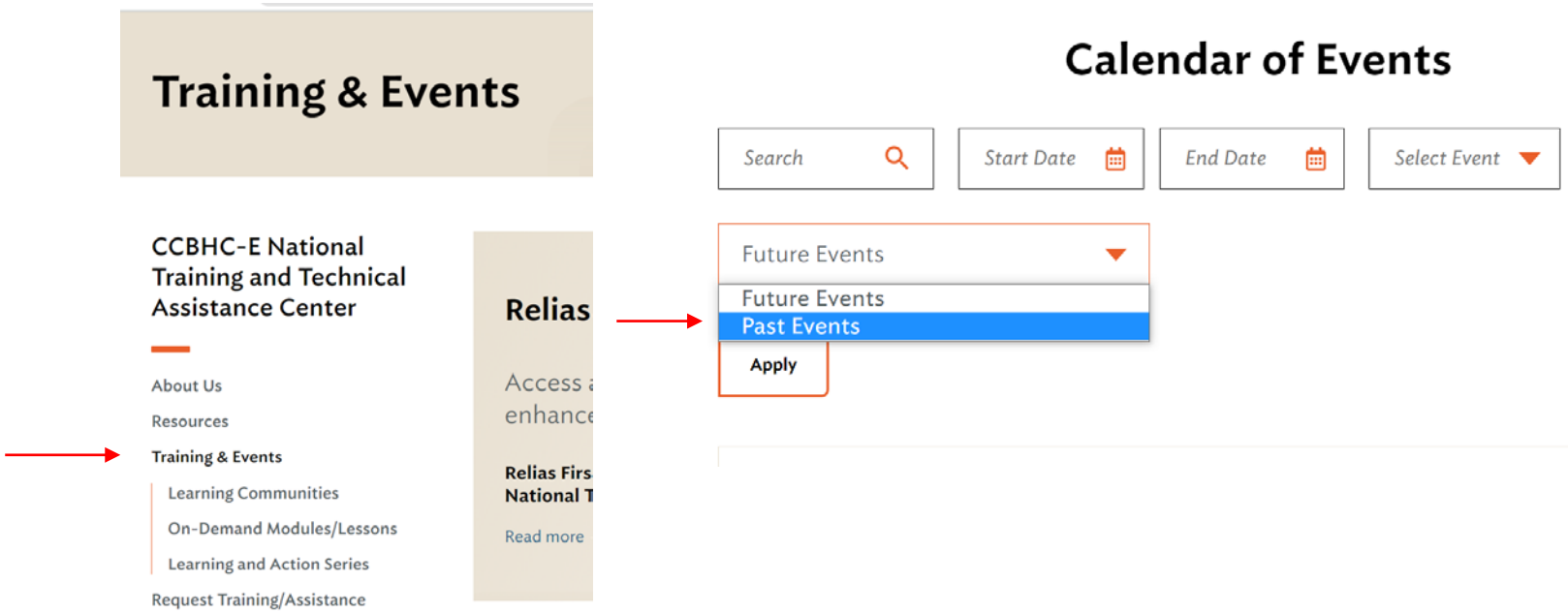
Today's Session: Slides and Recording

Slides and the session recording link will be available on the CCBHC-E NTTAC website under "Training and Events" > "Past Events" within 2 business days.



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Today's Agenda

- Review Purpose of Optimizing Data Learning Series
- Discuss How to Integrate Data to Address Chronic Disease Management, Increase Health Literacy, and Improve Health Outcomes
- Provide Case Example
- Group Discussion

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CCBHC Advanced Optimizing Data Learning Series

Purpose

Designed for CCBHC grantees interested in learning about the advanced principles of leveraging data to advance consumer health outcomes, the four-session CCBHC Advanced Optimizing Data Learning Series will explore applying data to identify disparities, operationalizing data to expand screening, and integrating data to improve practice activities.

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Learning Series Topics

Date	Topic	Summary
May 16	Application of Data	Provide overview of National Standards for Culturally and Linguistically Appropriate Services (CLAS) and discuss how to use data to identify and address disparities.
June 20	Integrating Data Systems	Increase knowledge of data to support chronic disease management and identify opportunities for improved health outcomes.
July 18	Operationalizing Data	Increase understanding of screening tools and opportunities to address social determinants of health.
August 15	The Role of Data in Practice Improvement	Provide overview of measurement-based care (MBC) and discuss how to build organizational readiness to implement MBC.

Your Learning Series Team

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Consultant and Subject Matter Expert

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Director

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Project Manager

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Project Coordinator

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Today's Presenters

Leigh Fischer, MPH
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Principal, TriWest Group

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Senior Director, Quality and Population Health, Cascadia Health

TriWest Health + Human Service Evaluation + Consulting

Cascadia HEALTH

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Why Address Chronic Diseases?

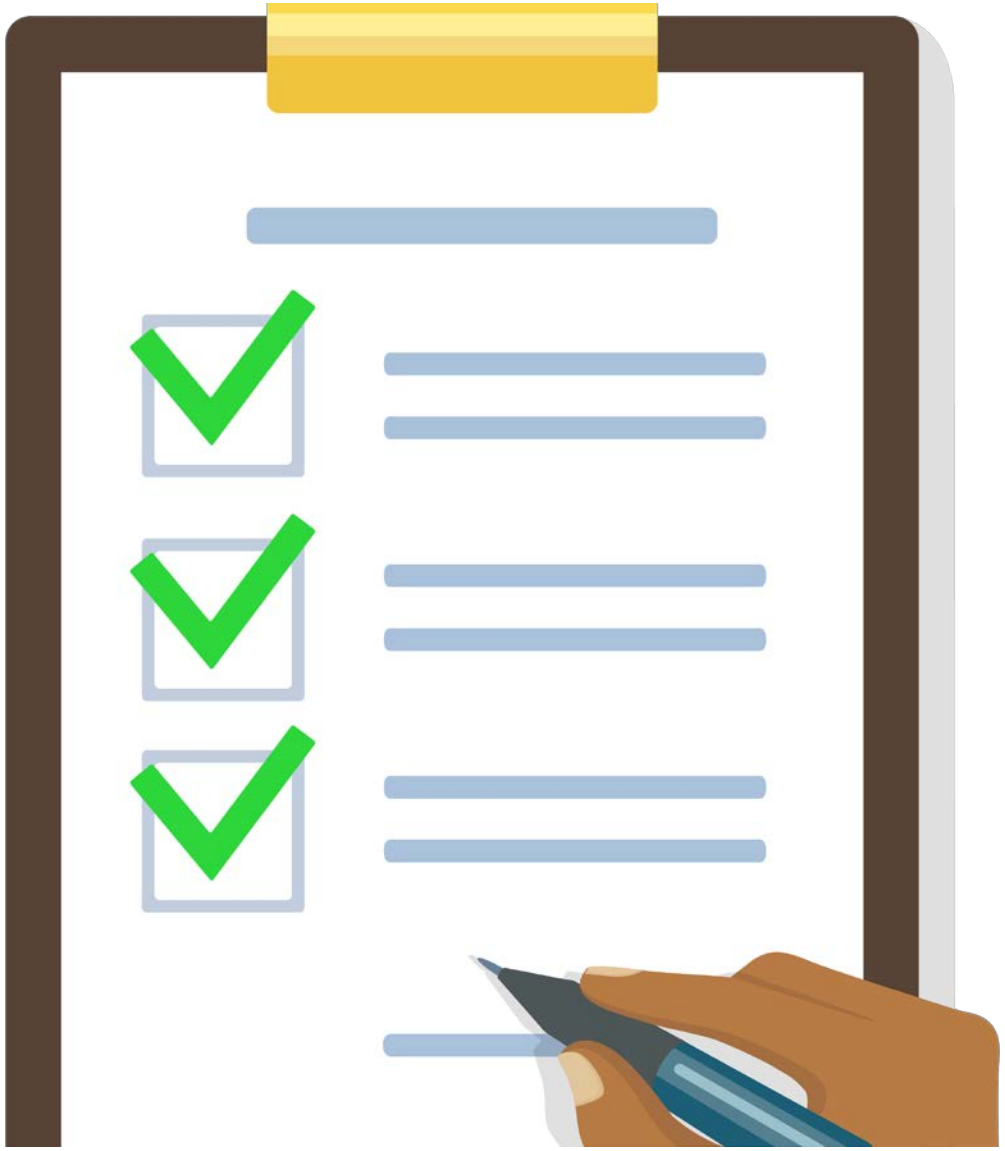
- Adults with SMI experience higher rates of diabetes, lung disease, cardiovascular disease, and other medical conditions
- Adults with SMI have a significantly reduced life expectancy
- Untreated chronic conditions lead to increased emergency room visits, inpatient stays, nursing home admissions, and healthcare costs
- Risk factors include inadequate physical activity and poor nutrition; smoking; side effects from antipsychotic medications; and lack of access to health care services

CCBHC’s Role in Chronic Disease Management

- Screen to identify people at risk
- Monitor health conditions
- Care coordination with external health providers, including referral and follow-up
- Assess for health-related social needs

Screening for Chronic Conditions

- Identify people with chronic diseases
- Ask about physical health symptoms
- Establish systems for collection and analysis of laboratory samples



Monitoring and Managing Chronic Conditions

- Ensure individuals have access to primary care services
- Ongoing laboratory testing and physical measurement of health status indicators
- Coordinate care and track appointments with primary care and specialty health providers
- Promote positive health behaviors and lifestyles

Data Sources

- Electronic health records (EHRs)
- EHRs integrated with laboratory and pharmacy systems
- Health information exchange (HIE) with behavioral health and physical health systems
- Claims data

Tools and Technologies

- Clinical decision support tools (e.g., alerts; prompts; documentation templates)
- Predictive modeling
- Chronic disease registries
- Patient/client portals that provide education and resources to help individuals self-manage chronic conditions
- Telehealth
- Remote monitoring devices

Getting Started

- Collect data on physical health indicators and screening results
- Use data to stratify individuals into risk categories
- Select interventions appropriate for each risk category
- Provide education and resources related to health behaviors and disease self-management
- Formalize care coordination agreements and processes with primary care, pharmacy, and specialty providers
- Establish a continuous quality improvement plan

EBP Example: Integrated Illness Management and Recovery (I-IMR)

- Designed for people with SMI who have chronic medical conditions
- Includes 1) training of self-management skills; and 2) care coordination and counseling on lifestyle changes by a nurse
- Weekly sessions delivered individually or in groups over 8 months
- Studies show improvements in:
  - Psychiatric illness self-management
  - Diabetes self-management
  - Use of hospitalization
  - COPD self-management
  - Community functioning

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Common Barriers

- Billing and reimbursement for integrated programs
- Workforce limitations (e.g., staff shortages; limited capacity; limited buy-in)
- Competing priorities
- Limited access to or knowledge of data, technology, and tools to manage chronic diseases
- Low health literacy among people receiving services and CCBHC staff

Increasing Health Literacy

- Ensure health care services and resources are accessible
- Increase the communication skills of staff and other health providers
- Decrease the level of complexity of health information
- Make data collection interactive, e.g.,
  - Explain screening questions and why they matter
  - Explain health information and options
- Use person-centered approaches and tools, e.g.,
  - Patient/client portals that include person-centered health education materials and disease self-management resources
  - Shared decision-making

Case Example: Integration of Data Systems to Support Chronic Disease Management

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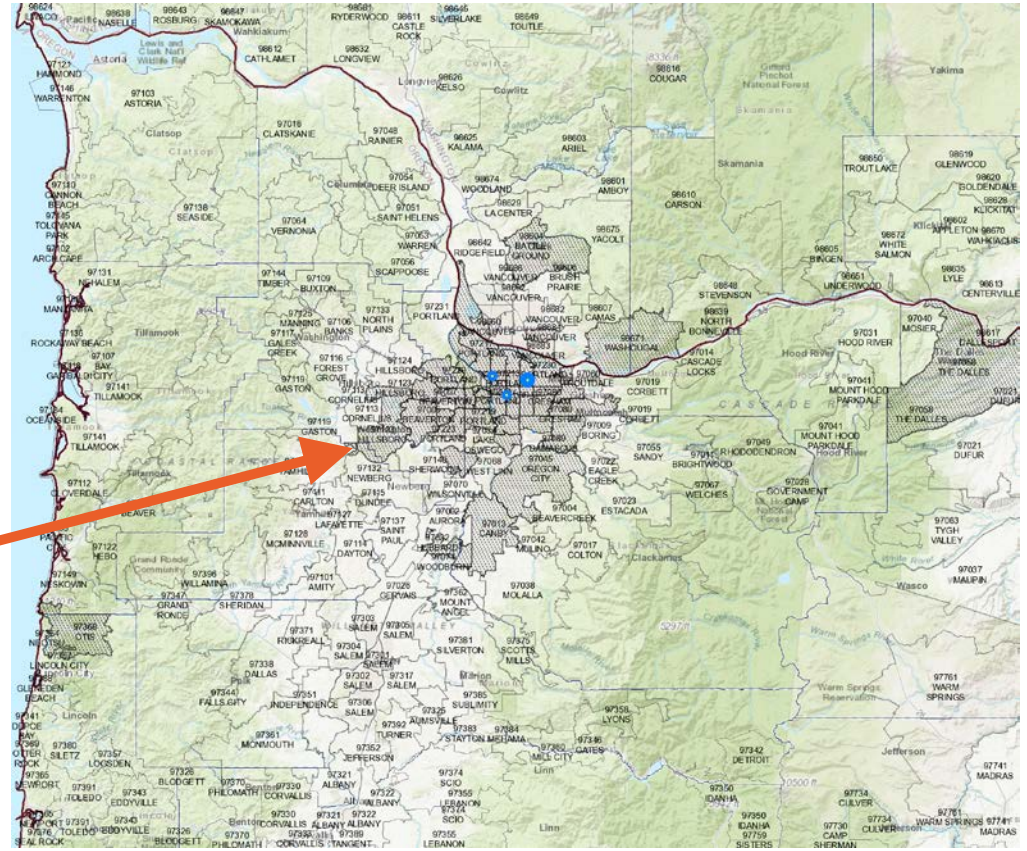
Cascadia Health



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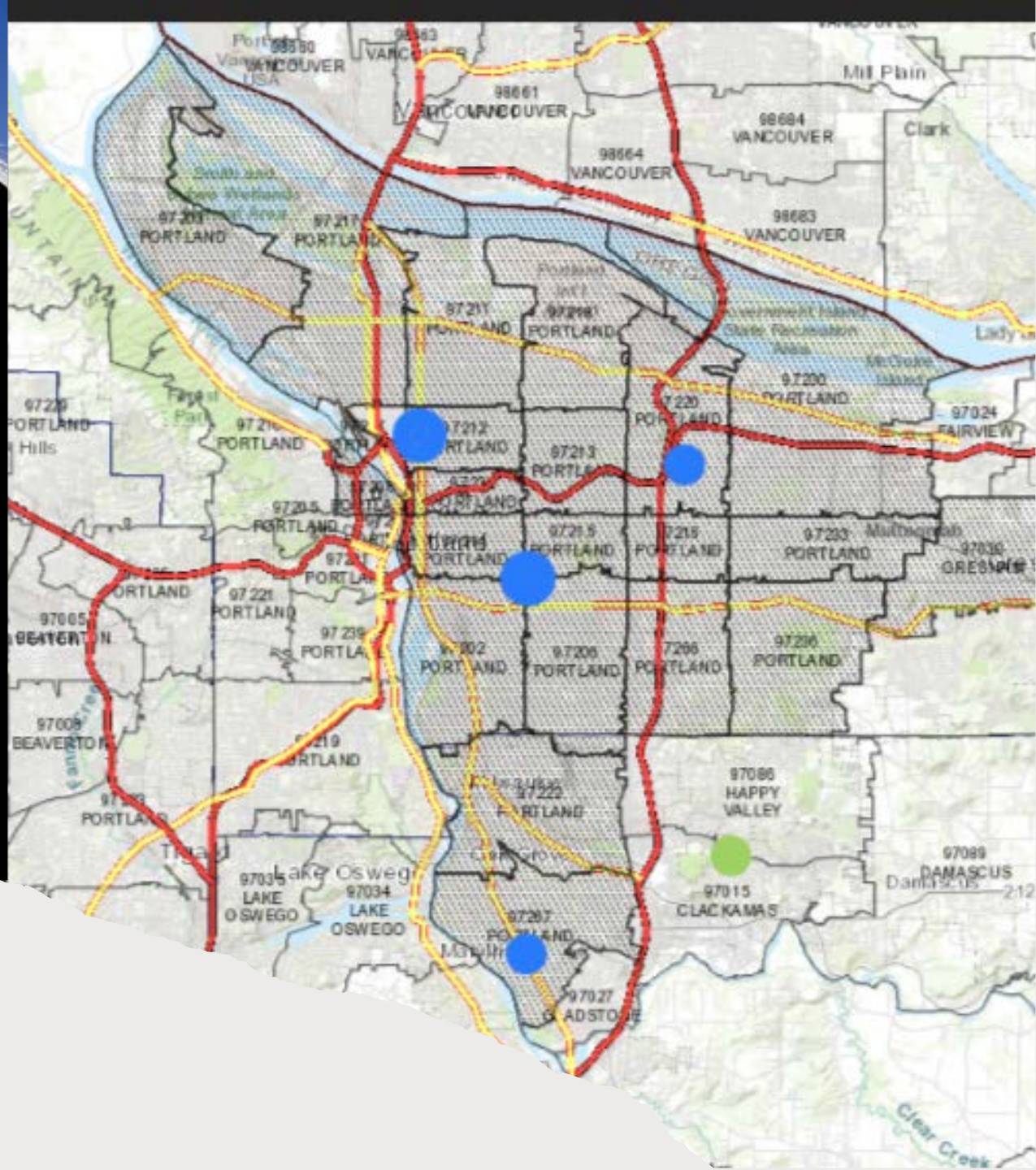
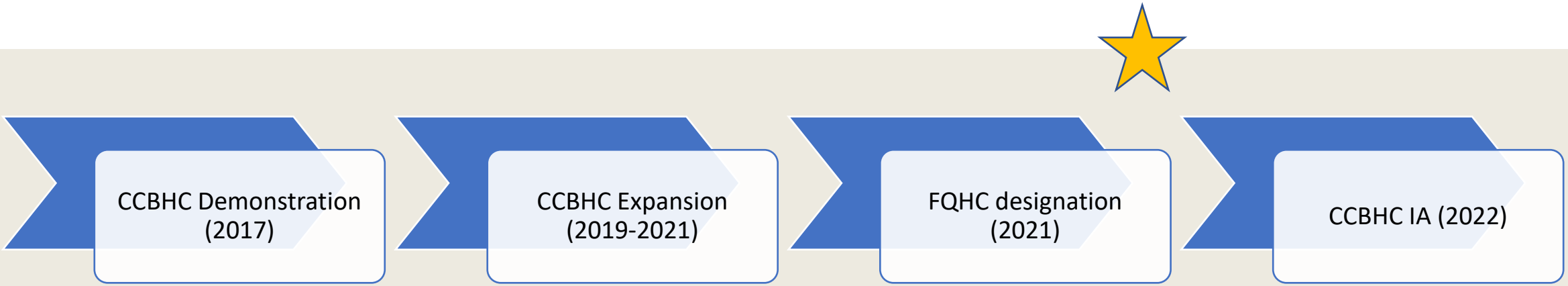


Cascadia Health, zoomed

MISSION

Cascadia Health delivers whole health care – integrated mental health and addiction services, primary care, and housing – to promote hope and support the well-being of the communities we serve.

Transformation – Cascadia Behavioral Healthcare to Cascadia Health



Developing a Culture of Data

Data woes: Real world speedbumps

Data validity (or lack thereof)

Early stages of development

Limited clinical capacity

Limited buy-in or understanding

Strategies overview

- Build muscles around using data slowly and consistently
- Identify early adopters and data savvy partners
- Make the data useful
- Pair population health work with data and health literacy
- Unsustainable is okay
- Get creative
- Engage staff
- Celebrate success

Discovery phase

Why do people go to the emergency department (ED)?

A key indicator of population health

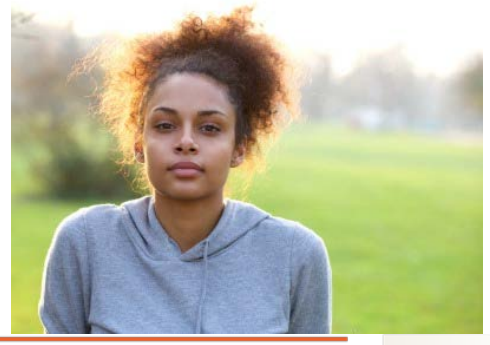
A proxy for health status

Achievement of quadruple aim

Models of ED utilization

Does ED utilization vary by important individual or healthcare-level factors?

- Demographics
- Socioeconomics
- Health
- Engagement in healthcare



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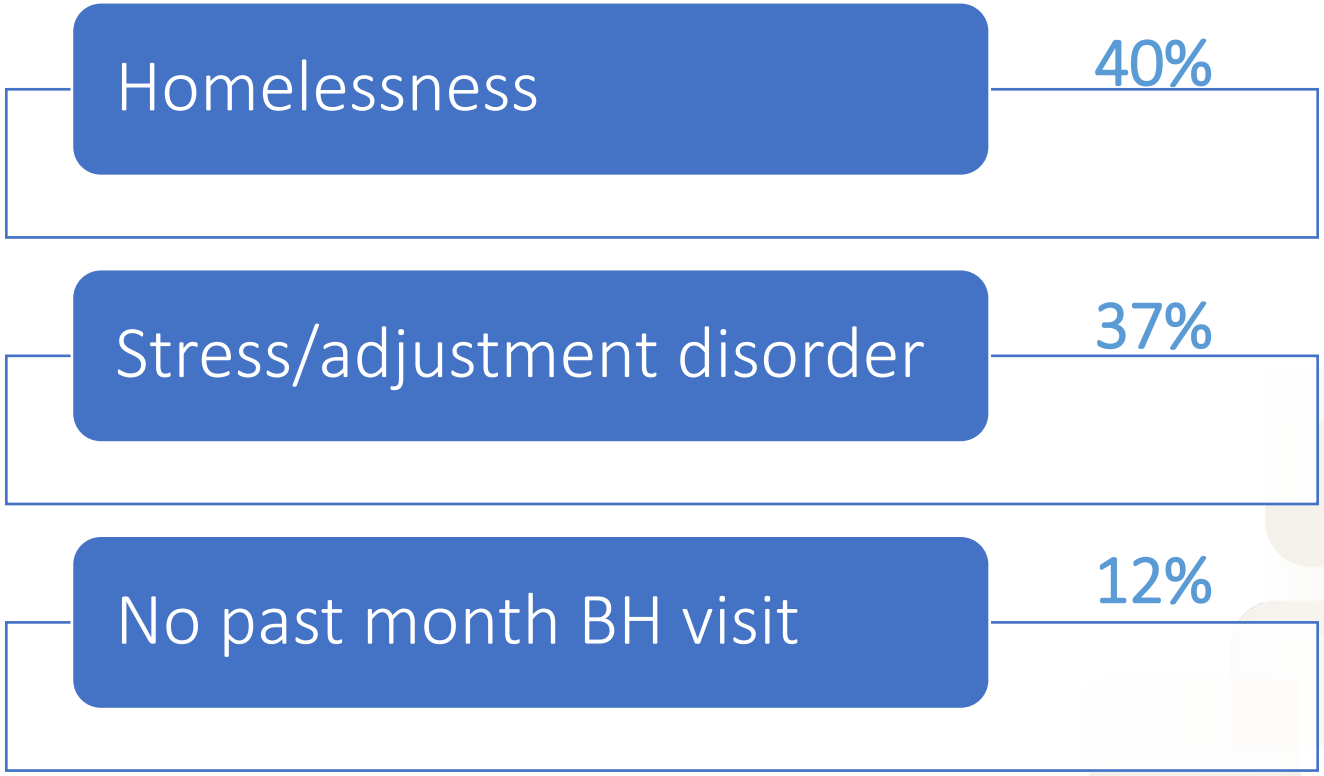
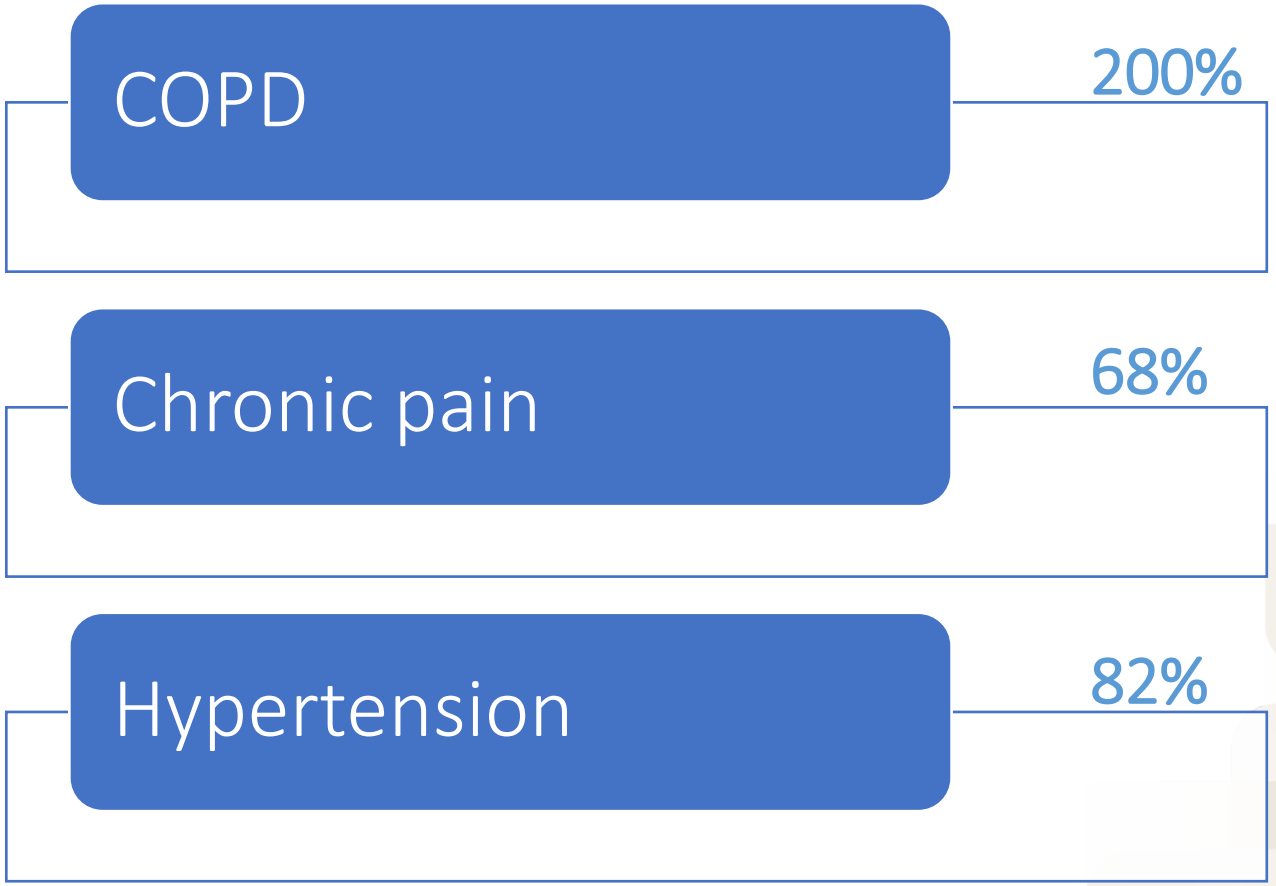
BH drivers

Where do we focus resources?



Physical Health drivers

These can be successfully addressed in an outpatient community setting!



Houselessness continues to be a significant[1] predictor for increased ED visits

On average, unhoused clients went to the ED more than twice as often as housed clients.

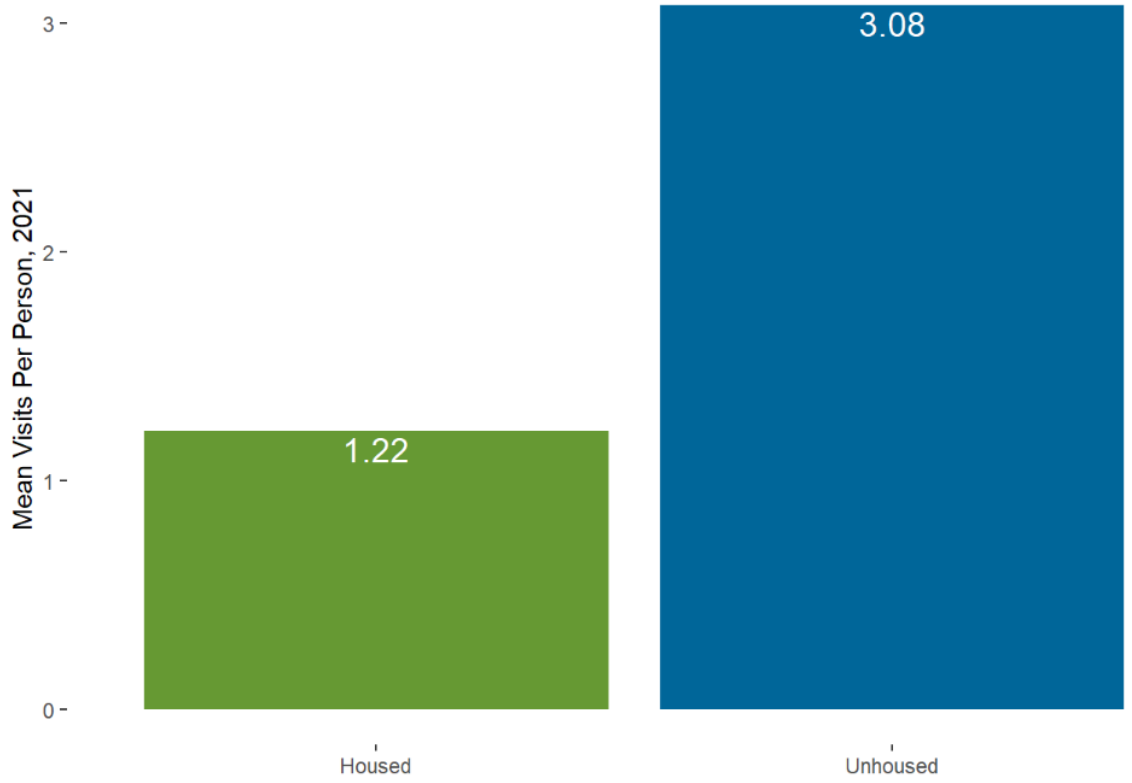


Figure 9. Data include all encounters among clients with an ED visit in 2021. Data on housing status may not be current.

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CASCADIA BEHAVIORAL HEALTHCARE
WHOLE HEALTH CARE™

Multnomah County Urgent Care Locations

Urgent Cares are different in their insurance practices and appointment requirements.
Call first to check hours, walk-in options, and confirm insurance. Calling to confirm insurance can help make sure you can receive care at that location and prevent unnecessary medical bills!

FOR KAISER PLANS:
The following three Urgent Cares in Multnomah County accept OHP - Healthshare Kaiser and Medicare Kaiser Senior Advantage Plans.

URGENT CARE	CONTACT		Medicaid / OHP Accepted	Medicare Accepted		BUS LINES
North Portland						
Kaiser Permanente - Interstate Urgent Care	3500 N Interstate Ave Portland, OR 97227	(503) 813-2000	ONLY OHP Kaiser Plan	ONLY Kaiser specific Medicare Plan	Overlook	4, 35, 24
Southeast Portland						
Kaiser Permanente - Care Essentials	3060 SE Hawthorne Blvd Suite 1 Portland, OR 97214	(855) 235-0491 Appointment Only	ONLY OHP Kaiser Plan	ONLY Kaiser specific Medicare Plan	Richmond	15,14
Cascadia Plaza Urgent Walk In Clinic	Plaza Health Center 4212 SE Division St Portland, OR 97206	(503) 674-7777	**Yes to ALL. Services are free.**		Richmond	2, 66, 75

FOR CAREOREGON, LEGACY HEALTH/PACSOURCE, OHSU, AND PROVIDENCE PLANS:
The following Urgent Cares may be available to these insurance plans - see Medicaid and Medicare columns for details.
Remember, Kaiser Plans not accepted at these locations

URGENT CARE	CONTACT		Medicaid / OHP Accepted	Medicare Accepted		BUS LINES
Northwest Portland						
Providence Express Care - Pearl District	1025 NW 14th Ave Portland, OR 97209	(888) 227-3312 Appointment Only	Yes	Yes	Pearl District	24, 26
AFC Urgent Care NW Portland	25 NW 23rd Pl Portland, OR 97210	(503) 305-6262	Yes	Must have Medicare A&B or Medicare Adv	Goose Hollow	24, 26, 77

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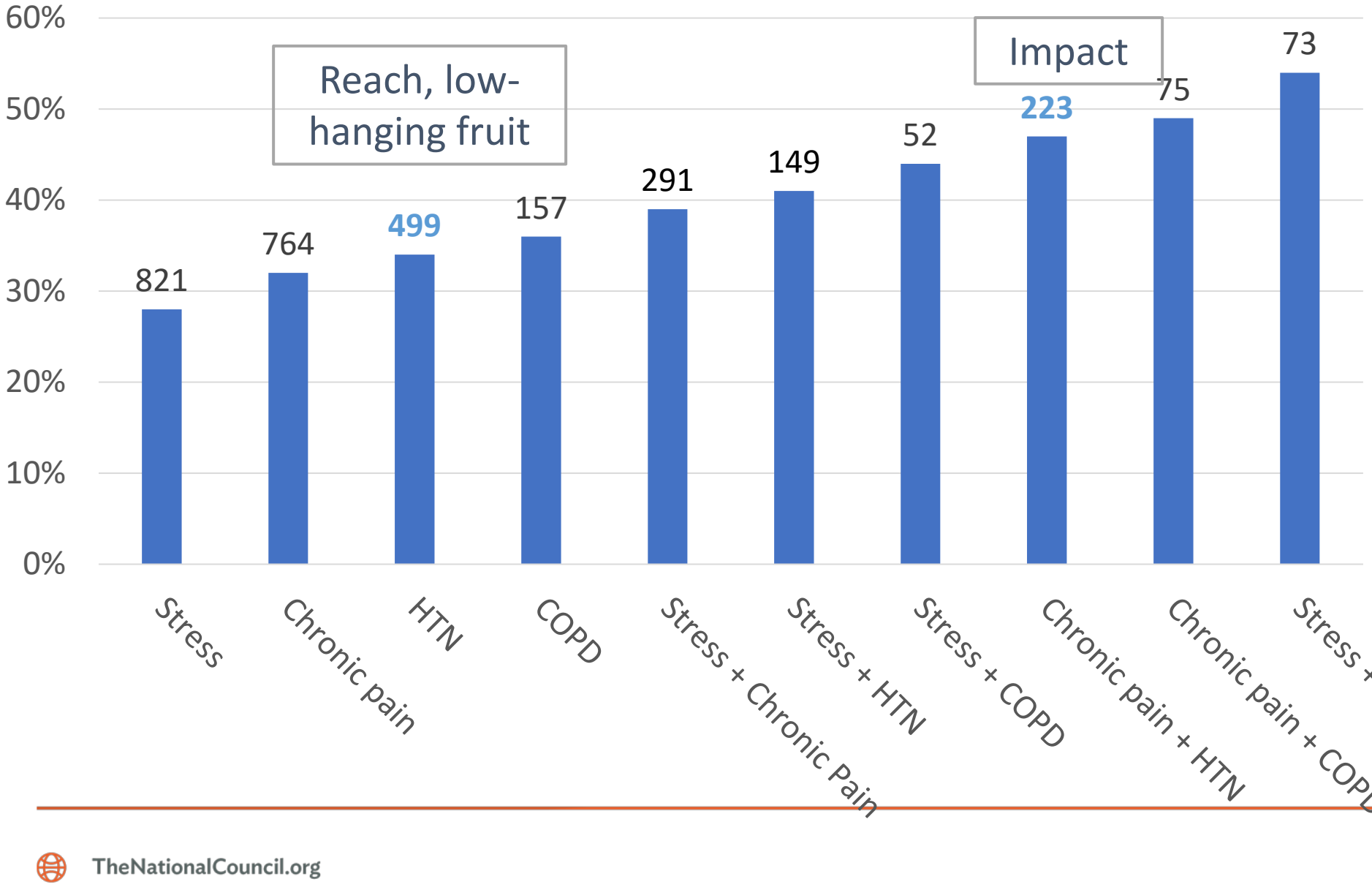
Probability of Any Emergency Room Visit, Past 10 Months



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Prioritization: Finding the sweet spot

Hypertension	Chronic Pain + Hypertension
COPD	Chronic Pain + COPD

IMPACT →

EFFORT →

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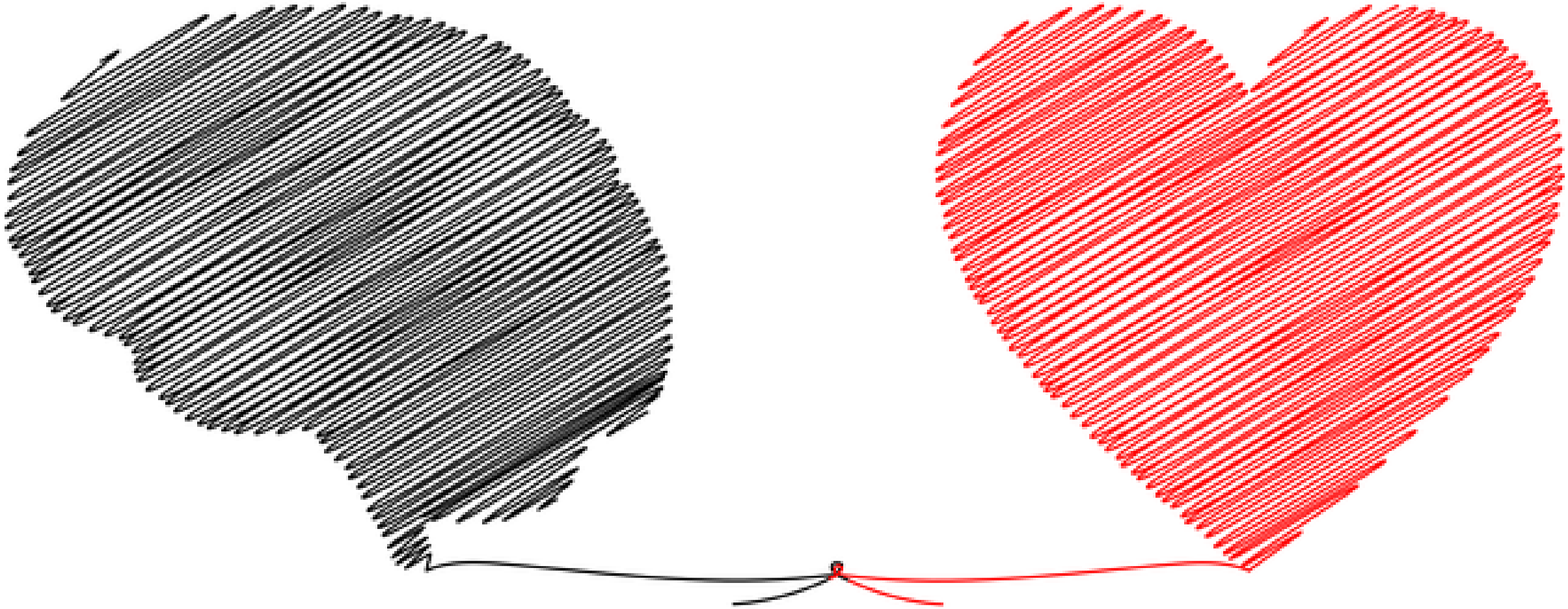


Health (and data) literacy

Examples

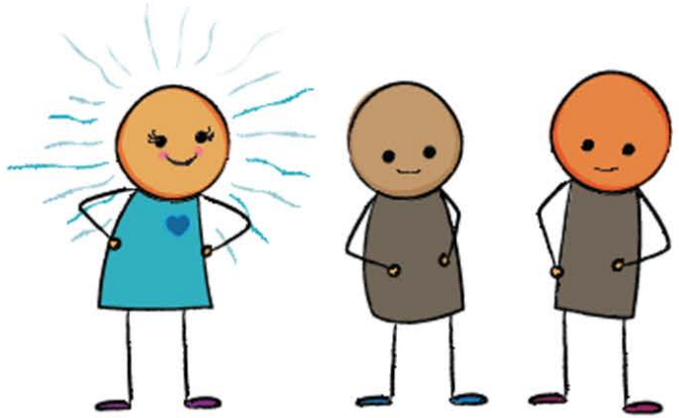
Health and data literacy is for clients/patients and for staff

Than those without a mental health concern.

Yet, only

1/3

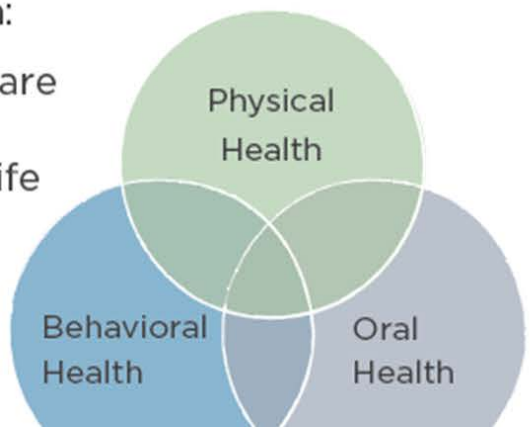
of this populaton receives treatment for diabetes.

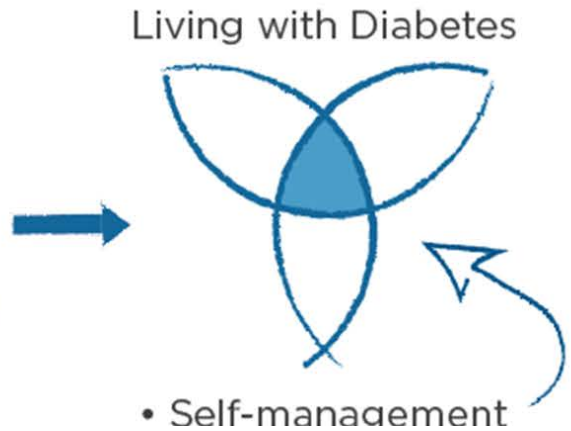


THE SOLUTION:

Integrated Healthcare can:

- Increase access to care
- Enhance quality of care and quality of life
- Contain costs





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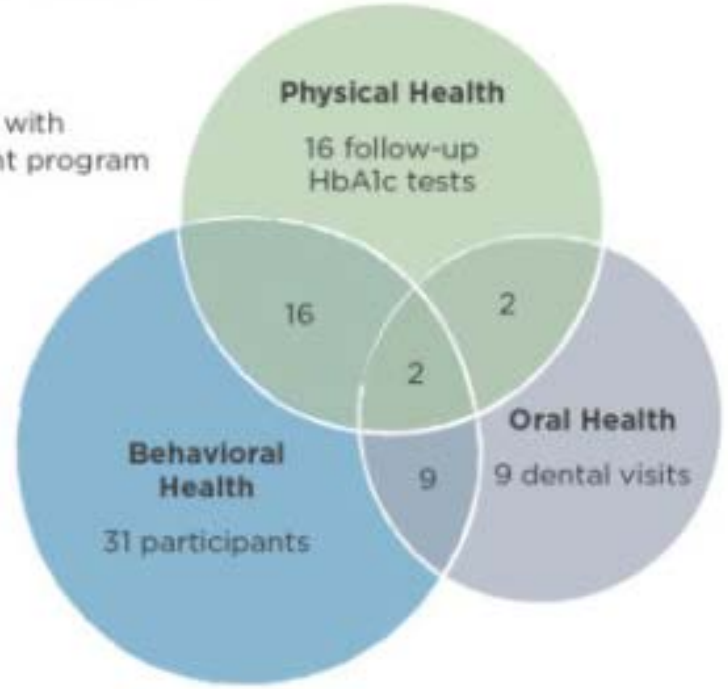
THE EVIDENCE:

Cascadia Behavioral Healthcare Living with Diabetes Pilot

31 Clients engaged in Living with Diabetes self-management program



PHYSICAL HEALTH:

60% Follow-up rate of HbA1c testing

BEHAVIORAL HEALTH PROVIDERS:

62% Felt that their client(s) was engaged in the program

92% Reported that their clients had a positive attitude about the program

Asked clients about

ORAL HEALTH CLIENTS:

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DIABETES (TYPE 2)

Type 2 Diabetes, the most common type of diabetes, is a disease that occurs when a person's blood glucose (sugar) is too high. Glucose is the main source of energy for our body and comes mainly from food. Insulin, a hormone made by the pancreas, helps glucose get into the body's cells to be used for energy.

RISK FACTORS

- Ages 45+
- Pre-diabetes
- Smoking
- High blood pressure
- Obesity or overweight
- Physical inactivity
- Family history of diabetes

SIGNS & SYMPTOMS

- Strong thirst
- Increased hunger
- Fatigue
- Frequent urination
- Dry mouth
- Weakness
- Blurred vision
- Unintended weight loss

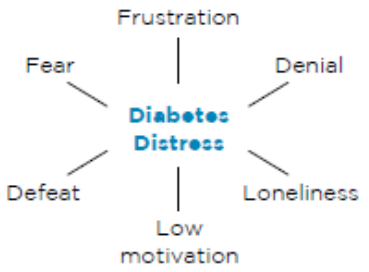
COMPLICATIONS

- Heart diseases (cardiovascular)
- Eye damage (retinopathy)
- Nerve damage (neuropathy)
- Kidney damage (nephropathy)
- Dental health problems
- Slow healing
- Skin infections

DIABETES DISTRESS

Managing diabetes can be overwhelming and these feelings can cause distress. To cope:

- Pay attention to feelings
- Talk with a health care provider
- Talk with trusted family and friends
- Talk to other people with diabetes
- Do one thing at a time
- Take time to do things that are enjoyable
- Go out in nature



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ROUTINE CARE

EVERY DAY

- Foot check
- Diabetes medicines
- Blood sugar checks
  - Before meals: 80 to 130 mg/dl
  - 1-2 hours after meals: Below 180 mg/dl

EVERY CLINICAL VISIT

- Review diabetes management plan
- Weight check:
  - Underweight: BMI below 18.5
  - Healthy Weight: BMI 18.5-24.9
  - Overweight: BMI above 25
- Complete foot exam
- Blood pressure check:
  - Healthy blood pressure: below 120/80
  - Early high blood pressure: between 120/80 and 139/89
  - High blood pressure: 140/90 or higher

TWICE EACH YEAR

- A1C test:
  - No diabetes: under 5.7
  - Pre-diabetes: 5.7-6.4
  - Diabetes: over 6.5

ONCE EACH YEAR

- Cholesterol test
- Complete foot exam
- Dental exam to check teeth and gums
- Dilated eye exam to check for eye problems
- Flu shot

KEEP THE NUMBERS IN CHECK

- Exercise 150 minutes each week
- Follow a balanced diet of vegetables, fruit, carbs, and protein
- Minimize sugary and high fat foods
- Control portion size

Even just a small amount of **WEIGHT LOSS** can reduce A1C by up to one full point

10 MINUTES of walking after meals can help control post-meal blood sugar by up to 22%

LEARN MORE

Managing Diabetes:
cdc.gov/diabetes/managing

Blood Pressure:
cdc.gov/bloodpressure/about.html

Obesity:
cdc.gov/obesity/adult/defining.html

CASCADIA PRIMARY CARE

To enroll in primary care services, call **(503) 674-7777** or speak with your Cascadia provider for more information.

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Are you adding dental checkups to your routine diabetes care?

Diabetes and oral health are connected!

If you have diabetes, making oral health part of your routine care can help keep your body healthy. Have you seen your dentist this year? Just like foot, eye and blood sugar exams, you should visit your dentist, too.

A two-way street

When you keep your teeth healthy, your overall health is better. When you take care of your diabetes, your oral health may improve. There are risks, too: **Gum disease can make diabetes worse, and diabetes can increase the risk of gum disease.** This is why dental checkups are so important!

Questions to ask yourself

When was my last visit to the dentist?

Do I know how diabetes affects my teeth and gums?

Do I have any concerns about my oral health?

Do I know why a healthy mouth is an important part of my diabetes management?

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TOBACCO & BEHAVIORAL HEALTH

Did You Know?

2-3x

People with a behavioral health condition use tobacco at 2-3 times the rate of those without such conditions.[1]

However, many individuals with a behavioral health condition want to and are able to quit or reduce their use of tobacco.[2]

50%

Individuals with behavioral health conditions account for nearly half of all tobacco-related deaths each year.[3]

Major causes of death among people with behavioral health conditions are tobacco-related cancer, heart disease, and lung disease.[3]

40%

40% of Cascadia clients endorse tobacco use. The percentage is much higher for clients enrolled in ACT, SUD, Community Solutions, or Residential programs.

Research suggests that individuals who concurrently treat addiction to nicotine and other substances are 25% more likely to sustain their recovery.[4]

8x

On average, clients will spend about 8 times the number of minutes per year with their mental health provider compared to their physical health providers.

How Can You Help?

TheNationalCouncil.org

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1. SAMHSA. (2012). *The NSDUH report.* www.samhsa.gov/data/sites/default/files/spot104-cigarettes-mental-illness-substance-use-disorder/spot104-cigarettes-mental-illness-substance-use-disorder.pdf
2. University of Colorado Anschutz Medical Campus School of Medicine. (2017). *DIMENSIONS: Tobacco free toolkit for healthcare providers: behavioral health.* dbhids.org/wp-content/uploads/2017/03/Tobacco-Free-Toolkit-for-Health-Care-Providers-Supplement.pdf.
3. CDC. (2020). *What we know: Tobacco use and quitting among individuals with behavioral health conditions.* www.cdc.gov/tobacco/disparities/what-we-know/behavioral-health-conditions/index.html
4. Prochaska, JJ, Delucchi, K, Hall, SM. (2004). *A meta-analysis of smoking cessation interventions with individuals in substance abuse treatment or recovery. Journal of Consulting and Clinical Psychology.* 72(6):1144-56.

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TOBACCO CESSATION

People with behavioral health concerns...

Benefit from quitting

People with behavioral health conditions are nicotine-dependent at 2-3x the rate of those without such conditions. Since individuals with behavioral health conditions use tobacco at greater rates, they experience greater tobacco-related illness and mortality.[1]

Want to quit

Many people with behavioral health conditions want to quit or reduce using nicotine products, but may face extra challenges in successfully quitting and may benefit from extra support.[1]

Can quit

People with behavioral health conditions can successfully quit using nicotine products. Substantial evidence shows that tobacco cessation works.[2]

Provider's Role

- Providers can use **motivational interviewing** to support self-efficacy and enhance motivation to quit. Just starting the conversion is an important step that can lead to quit attempts.
- Providers can **support behavior changes** and help people recognize triggers, develop coping skills, and make lifestyle changes.
- Providers can **link people to care**, including **referring** people to community resources or the Quit Line.

Stages of Change

When an intervention matches a person's readiness for change, it is more likely to increase their motivation for change.[3]

Stage	Definition	Intervention
Pre-contemplation	Unaware or unwilling to change: • Currently using tobacco • Not considering quitting in the next 6 months	• Motivate client to consider quitting • Provide education about the hazards of nicotine
Contemplation	Ambivalent, but considering change: • Currently using tobacco • Considering quitting in the next 6 months • Not ready to quit in the next 30 days	• Motivate client to consider quitting • Discuss pros and cons • Provide education about the hazards of nicotine

Brief Tobacco Intervention

5A's: A brief tobacco intervention recommended by the U.S. Public Health Service Clinical Practice Guideline.[5,7]

ASK about tobacco use:

"Do you currently smoke or use other forms of tobacco?"

ADVISE the client to quit/reduce in a personal, non-judgmental way:

Considerations: Offer advice, don't impose it; ask permission first; support decision making; inquire about the client's thoughts

ASSESS readiness for change:

"Are you interested in quitting tobacco?"

ASSIST the client in reducing use or quitting:

IF READY FOR CHANGE: Provide brief counseling and connect to medication (if appropriate). Refer clients to other support resources, such as the Oregon quit line.

IF NOT READY FOR CHANGE: Encourage clients to consider quitting by using personalized motivational messages. Let them know you are there to help them when they are ready.

ARRANGE for follow up:

Follow up regularly with clients who are trying to reduce/quit.

5R's: Based on the theories of motivational interviewing, the following strategies were developed to enhance motivation to quit tobacco.[4]

RELEVANCE: Find specific reasons why quitting is personally relevant to the client.

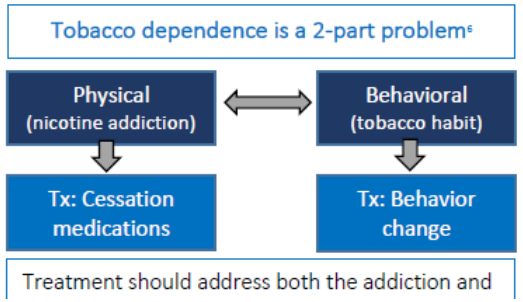
RISKS: Consider the potential negative consequences of a client's tobacco use, both acute and long-term.

REWARDS: Identify the potential benefits of quitting tobacco use that are specific to the client.

ROADBLOCKS: Think through the barriers the client might face when quitting, and how they might be addressed.

REPITITION: These strategies should be repeated each time the client visits the provider. Clients should also be reminded that most people make several quit attempts before they are successful.

Treatment Planning



Quit Resources

- Oregon Quit Line 1-800-QUIT-NOW
- Oregon Quit Line Spanish 1-855-DEJELO-YA
- Oregon Native Quit Line 1-800-QUIT-NOW (Press 7)
- Asian Smokers Quit Line, asiansmokersquitline.org
- Nicotine Anonymous, nicotine-anonymous.org
- Quit For Life, quitnow.net or 1-866-QUIT-4-LIFE (English and Spanish)
- BecomeAnEx becomeanex.org
- Health insurance plan specific resources

Data sharing through regular reports

- Consistency
- Increased familiarity with data
- Allows staff to act on their own timeline

PLAZA HEALTH CENTER – OCTOBER 2021

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WHOLE HEALTH CARE™

HIGHLIGHTS

CLIENT CHARACTERISTICS

WHAT DO THE DATA TELL US?

- At least **60%** of clients have **both** physical and behavioral health concerns.
- The **most common** behavioral health diagnoses amongst Plaza clients are **trauma/stressor-related disorders** and **depressive disorders**, both of which are also **associated with higher ED utilization**.
- The **most common** physical conditions amongst Plaza clients are **chronic pain** and **hypertension** (high blood pressure).

WHAT CAN WE DO?

- Cascadia clients typically spend more time with their behavioral health providers than their physical health providers. Counseling can be a powerful resource for people striving to **manage multiple conditions.**
- The high prevalence of trauma-related disorders underscores **Cascadia's focus on trauma-informed care.**
- People with trauma/stressor-related disorders and chronic pain often have additional complex physical and behavioral healthcare needs. **Targeted interventions** might include **tracking a panel of clients** to ensure any care gaps are met or offering a **chronic pain group.**

METRICS

WHAT DO THE DATA TELL US?

- There are **disparities by race and age** amongst the **39%** of Plaza clients endorsing the **use of nicotine** products.

WHAT CAN WE DO?

- **Increasing focus on nicotine/tobacco cessation** efforts could be especially impactful for younger people and people who identify as either Black, American Indian, or 2+ races.

PHYSICAL HEALTH

WHAT DO THE DATA TELL US?

- Most clients have high BMI.
- Most clients have **elevated or high blood pressure.**
- Amongst MH OP clients with at least 1 past year ED visit, **20% had 2+ visits in the past month**. ED utilization is **higher** for **unhoused individuals** and people with PTSD/severe stress, MDD, psychotic disorders, bipolar disorders, and anxiety.

WHAT CAN WE DO?

- For clients with weight-related goals, behavioral health providers can provide **non-stigmatizing care** and help individuals

Persistent (Chronic) Pain

Persistent (chronic) pain is the most common cause of disability worldwide. Over 100 million Americans suffer from persistent pain, and individuals with persistent pain make up as much as 58% of all physician visits. It is considered a major health issue due to its pervasiveness and its ability to impact individual's health and wellness across multiple domains, including mental health, relationships, financial stability, social functioning, and overall quality of life. As treatment and understanding of persistent pain has evolved, it has become increasingly clear that persistent pain is heavily impacted by psychosocial factors and an integrated healthcare approach is often needed.

The following are a few resources for supporting individuals living with chronic pain. If you are looking for something specific and do not see it here, please contact PopHealth at pophealth@cascadiabhc.org for support.

Population Health Research & Innovation
Integrated Healthcare
Diabetes
Tobacco Cessation
Oral Health
Persistent (Chronic) Pain

▸ Cascadia's LMS Module: Assessment & Management of Pain

▸ Using an ACT Toolkit

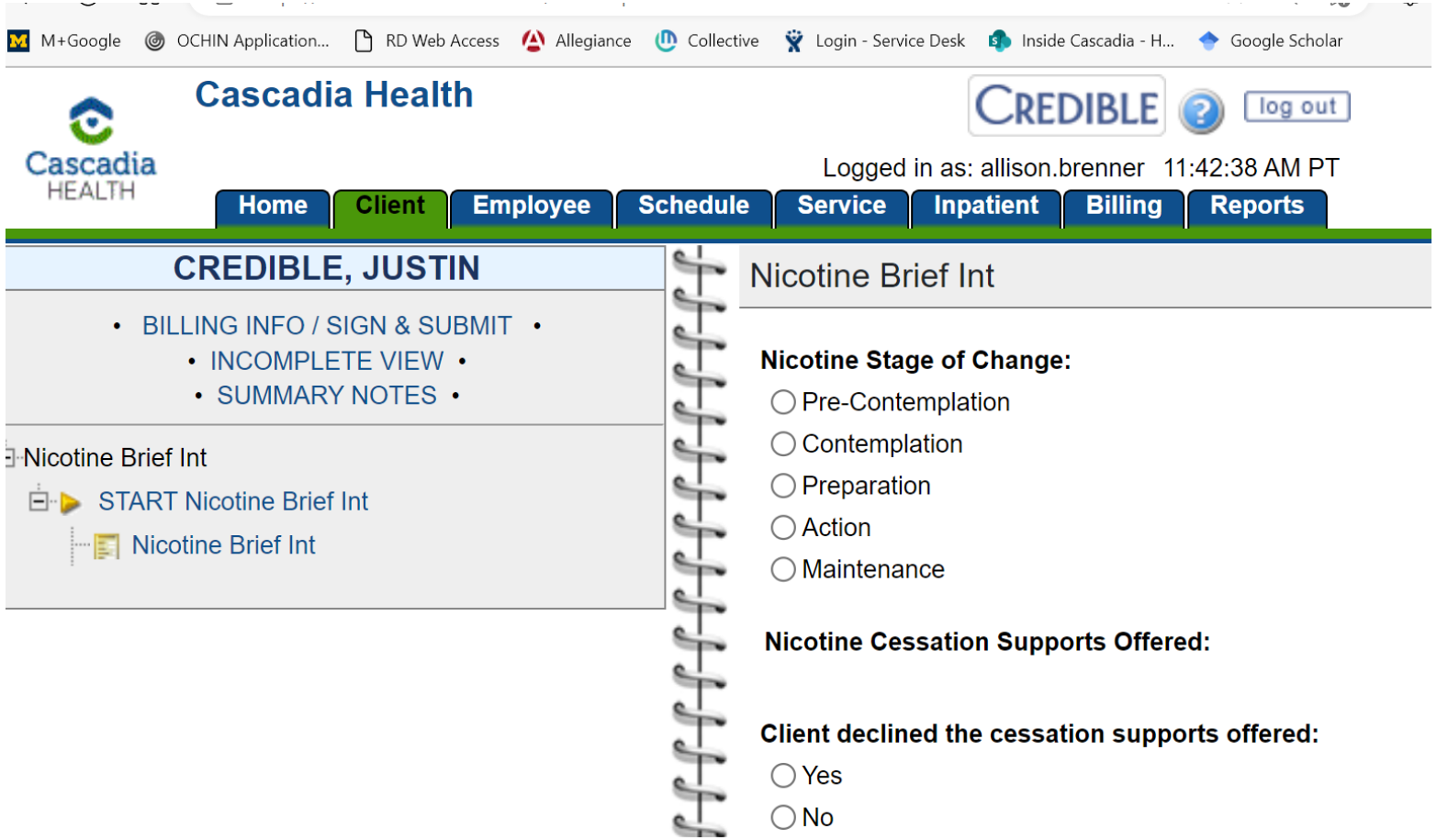
▾ Psychology Tools: Pain (Acute Pain & Chronic Pain)

Psychology Tools: Pain (Acute Pain & Chronic Pain)

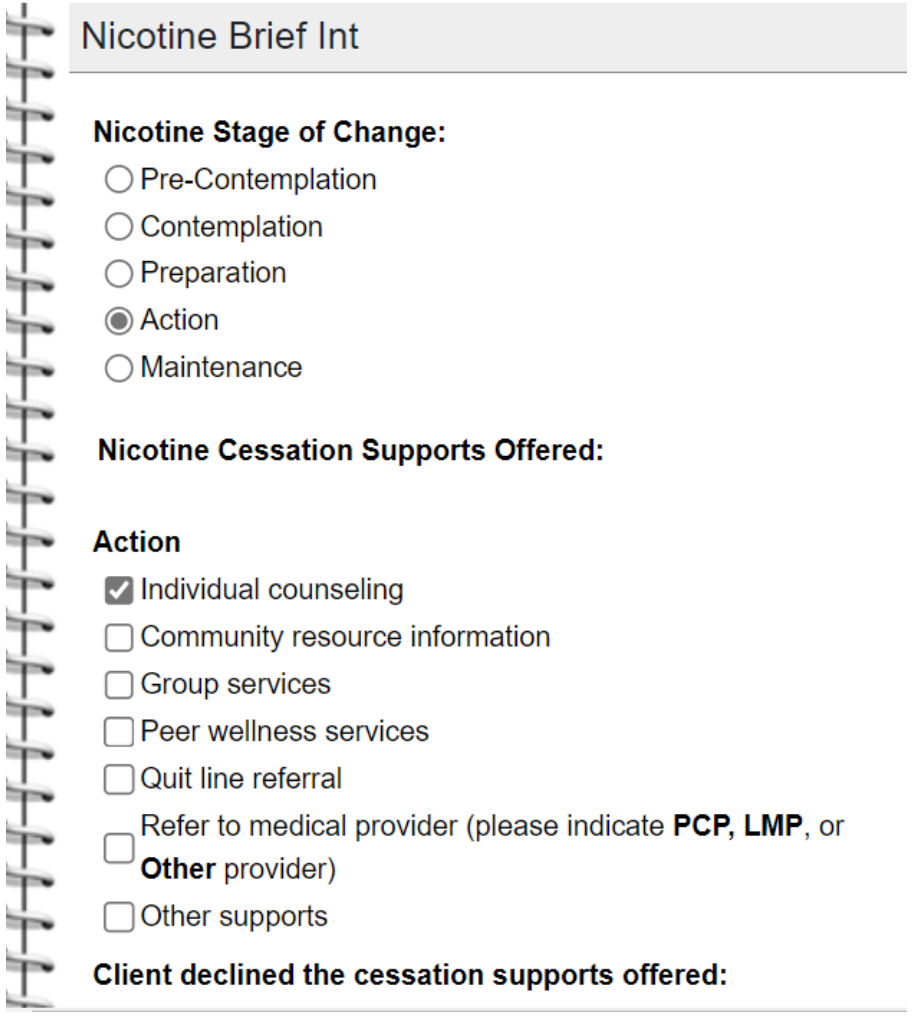
Provides an array of worksheets, tracking logs, audio relaxation tools, mindfulness exercise, informational handouts, and more.

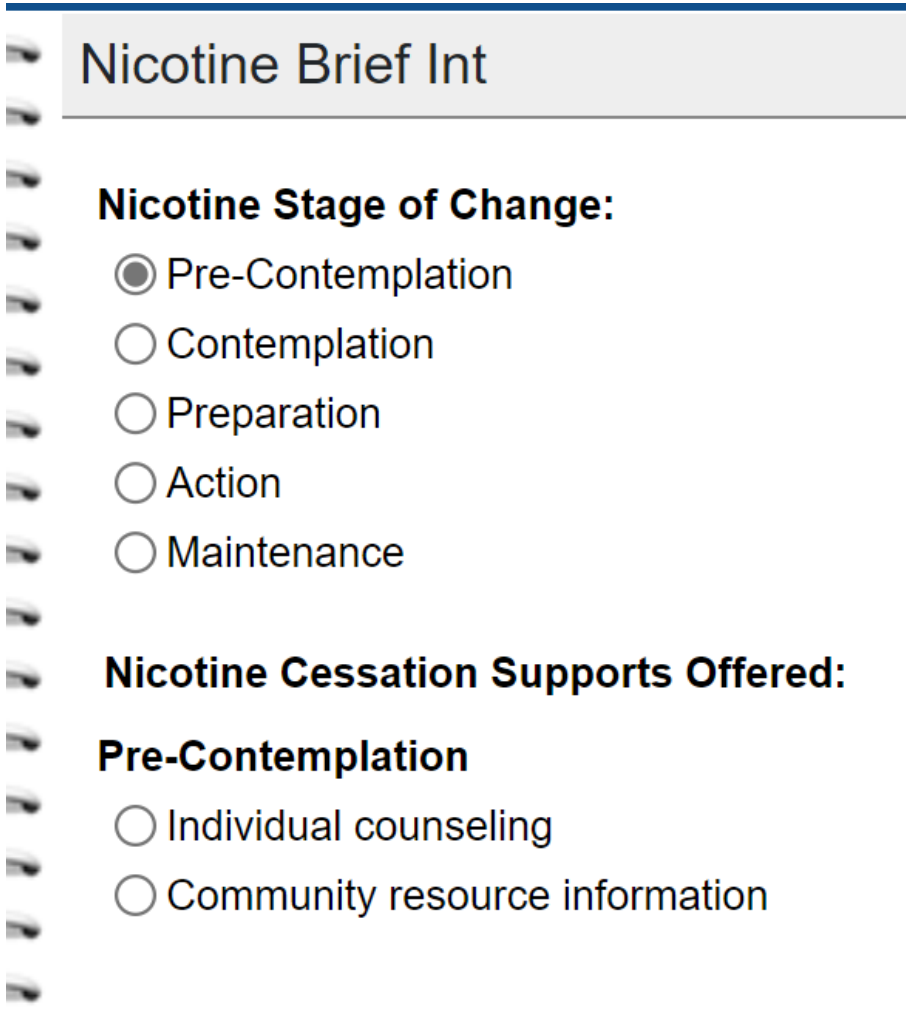
Chronic Pain CBT Worksheets & Handouts | Psychology Tools

Build interventions and data collection into the EHR

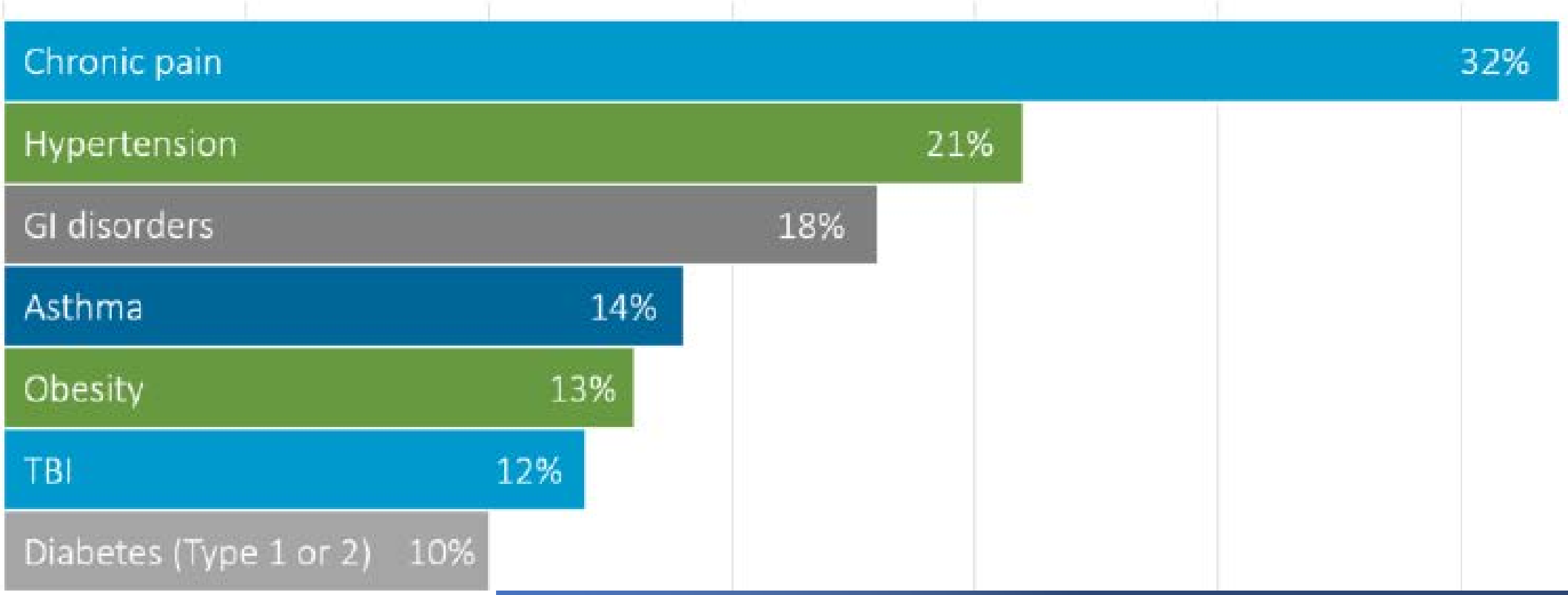


Referral options based on stage of change





- The **most common** physical conditions amongst Plaza clients are **chronic pain** and **hypertension** (high blood pressure).
- People who experience chronic pain often have additional complex physical and behavioral healthcare needs. **Targeted interventions** might include offering a **chronic pain group** or **tracking a panel of clients** to ensure any care gaps are met.



Example: Data-informed peer review

Goal: Engage in effective and efficient peer review process

- Data driven
- Not duplicating processes
- Engages clinical staff
- Imbedded quality improvement

Of patients with diagnosed hypertension, **81.6%** have a current BP reading

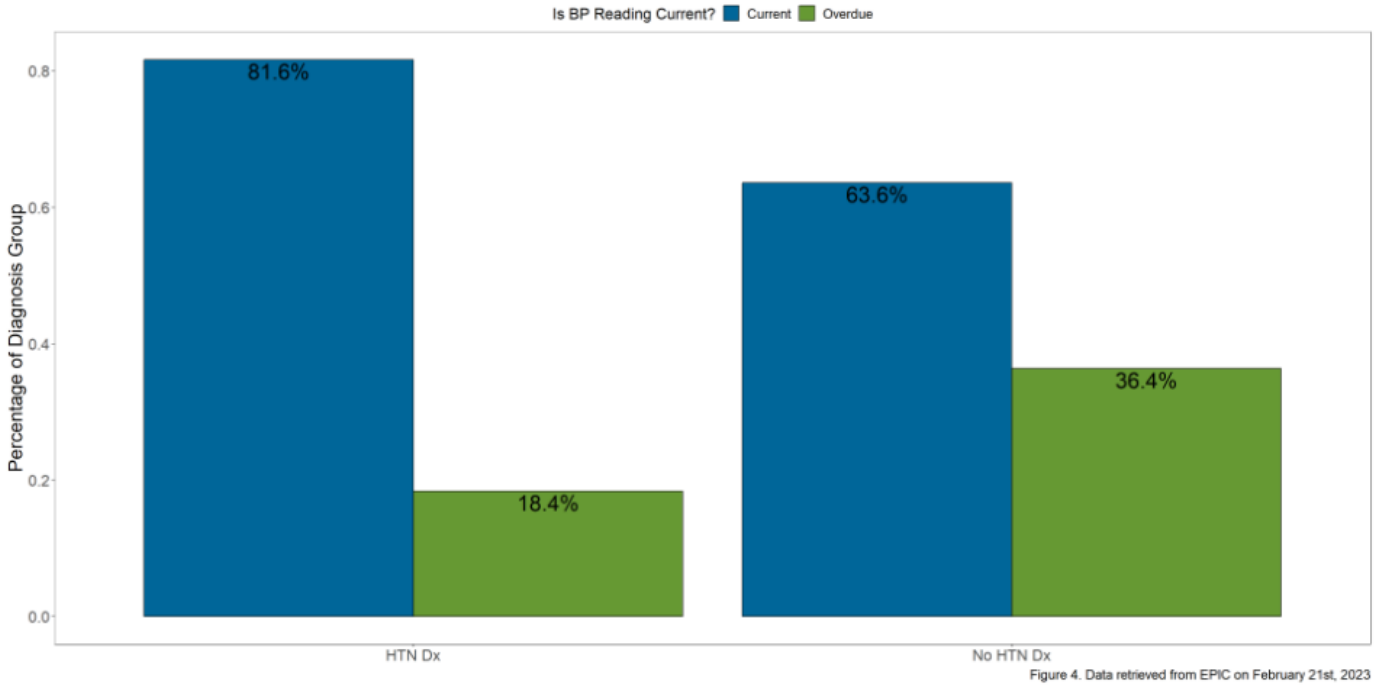


Figure 4. Data retrieved from EPIC on February 21st, 2023

Identify need for improvement in health prevention

Discussion: Sharing with Your Peers

- What lessons have you learned in using data to support chronic disease management?
- What data sources do you use to monitor health outcomes? Are these sources integrated?
- How are you increasing health literacy?
- What remaining questions do you have?

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Closing

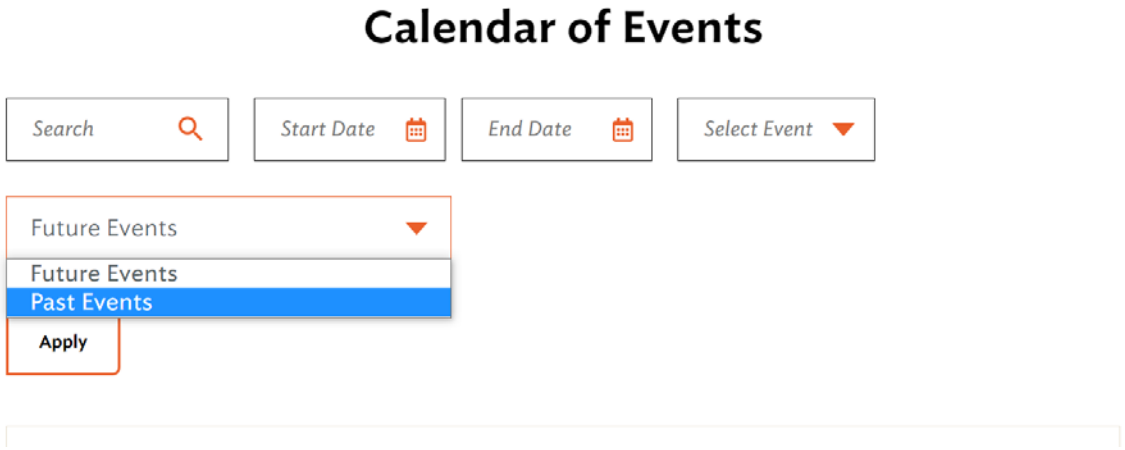
Next Session: *July 18, 2023 - Operationalizing Data (3pm – 4:30pm ET)*: Increase understanding of screening tools and opportunities to address social determinants of health.

NATIONAL COUNCIL for Mental Wellbeing

Thank You!

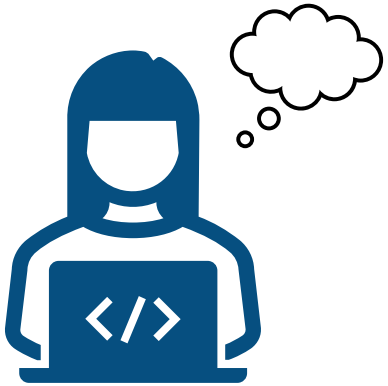
Thank you for attending today's event.

Slides and the session recording link will be available on the CCBHC-E NTTAC website under "Training and Events" > "Past Events" within 2 business days.



Your feedback is important to us!

Please complete the brief event survey that will open in a new browser window at the end of this meeting. Your input helps us improve our support offerings and meet our SAMHSA data metrics.



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