Integration of Mental Health, Physical Health, and Wellness Services in Mental Health Setting

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Objectives

• Increase awareness of health challenges for individuals diagnosed with severe and persistent mental illness
• Explore a model of integration of primary care and wellness into community mental health services
• Understand the role of Peer Wellness Coaches in working with people with serious mental illness
• Examine outcomes of physical health indicators as a result of “reverse integration”
Why Integration?

• People with serious mental illness and addictions who utilize publicly funded services die, on average, 25 years earlier as a result of untreated chronic health conditions.

• Cascadia BHC is working to increase consumer health by integrating primary care into community mental health with peer delivered wellness supports.

• Our goal: achieve the triple aim of healthcare reform.
It’s Not Easy

Primary Care

Mental Health
Oregon Partnership for Health Integration (OPHI)

- Outside In primary care is integrated onsite into Cascadia’s programs
- Care coordination by Cascadia’s Nurse Care Manager
- Health and wellness services provided by Cascadia’s Peer Wellness Coaches
- Evaluation partner is Portland State’s RRI
- Use of population based data to inform treatment services
Target Populations

**Outpatient Clinics**
- Multnomah County
- Clackamas County
- SPMI population
- No PCP or not a strong relationship with PCP

**Supportive Housing**
- Chronic homelessness
- History of difficulty engaging in services
- SPMI population
- No PCP or not a strong relationship with PCP
GOALS

- Lower BP
- Normal HgA1c
- No tobacco
- Lower BMI/wt
- Great MH!
Data Collection

- Process for data collection
- Baseline data for all grantees
  - NOMs interview
  - Mechanical vitals
  - labs
- Reassessments
- Incentives
- Individual & population data
- Health disparities reporting
# Health Outcomes

<table>
<thead>
<tr>
<th>Health Indicator</th>
<th># of Cases</th>
<th>At-Risk Baseline</th>
<th>At Risk 2nd Interview</th>
<th>Outcome Improved</th>
<th>No Longer at Risk</th>
<th>Outcome Remained at Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP- total</td>
<td>87</td>
<td>32.2%</td>
<td>32.2%</td>
<td>19.5%</td>
<td>12.6%</td>
<td>19.5%</td>
</tr>
<tr>
<td>Waist Circum.</td>
<td>67</td>
<td>67.2%</td>
<td>59.7%</td>
<td>47.8%</td>
<td>11.9%</td>
<td>55.2%</td>
</tr>
<tr>
<td>BMI</td>
<td>77</td>
<td>84.4%</td>
<td>79.2%</td>
<td>53.2%</td>
<td>9.1%</td>
<td>75.3%</td>
</tr>
<tr>
<td>Breath CO</td>
<td>64</td>
<td>43.8%</td>
<td>42.2%</td>
<td>28.1%</td>
<td>4.7%</td>
<td>39.1%</td>
</tr>
<tr>
<td>HgbA1c</td>
<td>27</td>
<td>29.6%</td>
<td>25.9%</td>
<td>14.8%</td>
<td>3.7%</td>
<td>25.9%</td>
</tr>
<tr>
<td>HDL</td>
<td>30</td>
<td>30.0%</td>
<td>30.0%</td>
<td>16.7%</td>
<td>0.0%</td>
<td>30.0%</td>
</tr>
<tr>
<td>LDL</td>
<td>29</td>
<td>24.1%</td>
<td>27.6%</td>
<td>20.7%</td>
<td>3.4%</td>
<td>20.7%</td>
</tr>
<tr>
<td>Triglycerides</td>
<td>26</td>
<td>30.8%</td>
<td>38.5%</td>
<td>7.7%</td>
<td>3.8%</td>
<td>26.9%</td>
</tr>
</tbody>
</table>
## Service Outcomes

<table>
<thead>
<tr>
<th>NOMs</th>
<th># of Cases</th>
<th>Positive at Baseline</th>
<th>Positive at 2\textsuperscript{nd} Interview</th>
<th>Outcome Improved</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Overall</td>
<td>59</td>
<td>32.2%</td>
<td>47.5%</td>
<td>25.4</td>
<td>47.4</td>
</tr>
<tr>
<td>Functioning in everyday life</td>
<td>60</td>
<td>21.7%</td>
<td>38.3%</td>
<td>53.3%</td>
<td>76.9%</td>
</tr>
<tr>
<td>No serious psychological distress</td>
<td>60</td>
<td>45.0%</td>
<td>58.3%</td>
<td>21.7%</td>
<td>29.6%</td>
</tr>
<tr>
<td>Retained in community</td>
<td>59</td>
<td>84.7%</td>
<td>88.1%</td>
<td>10.2%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Had a stable place to live</td>
<td>60</td>
<td>58.3%</td>
<td>75.0%</td>
<td>16.7%</td>
<td>28.6%</td>
</tr>
<tr>
<td>Attending school/work</td>
<td>60</td>
<td>13.3%</td>
<td>15.0%</td>
<td>5.0%</td>
<td>12.5%</td>
</tr>
<tr>
<td>No involvement with criminal justice system</td>
<td>59</td>
<td>98.3%</td>
<td>98.3%</td>
<td>1.7%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Socially connected</td>
<td>59</td>
<td>37.3%</td>
<td>44.1%</td>
<td>44.1%</td>
<td>18.2%</td>
</tr>
</tbody>
</table>
Care Teams

- Multidisciplinary
- Care coordination to ensure continuity of care across systems
- Single record for all services
- Multi-agency care and discharge planning
- Health education
Primary Care Team
Nurse Care Manager

• Coordinates care among providers
• Triages non-emergency situations
• Program development and implementation

• Facilitates education and skill building for clients
• Provides training and on-site support for Peer Wellness Coaches
Peer Wellness Specialists at Cascadia

- OPHI
- Project Respond
- Housing Outreach Team
- Health Commons Grant
- Forensics Assertive Community Treatment
- Firefly
- Standing Stone
- Plaza
- Supported Education
- Villebois
Peer Wellness Coaching

“We are working to improve the quality of care and overall health of OPHI participants.”

- Supports participants in setting, tracking, and achieving health goals
- Ensures participants have access to the tools they need to work towards health and wellness goals
- Identifies strategies to support better integration of physical and behavioral healthcare with providers
- Supports participants in accessing community resources, including benefits
- Provides traditional peer support services
Peer Wellness Coach Practice

- Outreach and engagement
- Intake and enrollment
- Measure vitals
- 1:1 and group services
- Traditional peer support
- Collaboration and coordination
- Wellness boards/health promotion
# Quick Guide: Physical Health Indicators

<table>
<thead>
<tr>
<th>HEALTH MEASUREMENTS</th>
<th>TERM</th>
<th>“AT RISK” RANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>blood pressure (systolic/diastolic)</td>
<td>mmHg</td>
<td>≥130 (S) / ≥85 (D)</td>
</tr>
<tr>
<td>waist circumference</td>
<td>cm</td>
<td>&gt;102 (M) / &gt;88 (W)</td>
</tr>
<tr>
<td>body mass index</td>
<td>BMI</td>
<td>≥25</td>
</tr>
<tr>
<td>breath CO (carbon monoxide)</td>
<td>ppm</td>
<td>≥10</td>
</tr>
<tr>
<td>HDL cholesterol</td>
<td>mg/dL</td>
<td>&lt;40</td>
</tr>
<tr>
<td>LDL cholesterol</td>
<td>mg/dL</td>
<td>≥130</td>
</tr>
<tr>
<td>triglycerides</td>
<td>mg/dL</td>
<td>≥150</td>
</tr>
</tbody>
</table>

### Physical Health Indicator Explanations

- **blood pressure**: systolic blood pressure is measured after the heart contracts and is the top number; diastolic blood pressure is measured when the heart is at rest and is the bottom number
- **waist circumference**: waist circumference measurement helps determine abdominal fat which is associated with an increased risk of heart disease, diabetes, some cancers and even early death
- **body mass index (BMI)**: BMI is a number calculated using a person’s weight and height and can be an indicator of body fatness; BMI does not measure fat directly, but is a screening tool to identify possible weight problems and to determine if they pose a health risk (BMI = kg/m²)
- **breath CO (carbon monoxide)**: carbon monoxide is a colorless, tasteless and odorless gas that is highly poisonous (cigarette smoke can contain high levels of CO); CO Poisoning symptoms include: fatigue, headaches, dizziness, weakness, nausea & vomiting
- **HDL cholesterol**: high-density lipoprotein (HDL) cholesterol is a combination of fats (lipids) and proteins in which lipids are transported in the blood; HDL cholesterol is the “good” cholesterol that may lower the risk of coronary artery disease
- **LDL cholesterol**: low-density lipoprotein cholesterol is referred to as the “bad” cholesterol because elevated levels of LDLs are associated with increased risk of heart disease
- **triglycerides**: triglycerides are the main ingredient in vegetable oils and animal fats, and are also produced by low physical activity, cigarette smoking, being overweight, high carbohydrate diet and excess alcohol intake

### How can I lower my risk?

In general, maintaining a healthy weight, eating nutritious food, being physically active and not consuming tobacco all contribute to decreased risk of developing disease.
Health and Wellness Groups

- Learning About Healthy Living (tobacco cessation)
- LOTUS (Lifestyles Overcoming Troubles Utilizing Supports)
- Art, Jive, and Mo!
- My Life, My Health
- Weight Management for Wellness and Recovery
- Living Well (Stanford’s Chronic Disease Self Management program)
- Physical activities (walking, yoga, chair exercises)
Moving Forward

- Service delivery model for capacity and sustainability
- Behavioral health home designation
- Data exchange and disease registry
- Clinical pathways
Success Stories
Dr. Rieke is awesome! She hooked me up with everything I needed, and took care of me. It was casual, and easy. You all should get with this program. It was awesome!
The support that I get is amazing and it gives me hope. I also enjoy how I can relate to someone who has gone through similar things. She’s always there for me and I believe she really cares.
Feedback from Clients...

You [OPHI] have changed my life. I'm so grateful that this program came to Cascadia. I can see that this program will help me make real changes with my health.