CARE INTEGRATION PROGRAM

Fordham-Tremont CMHC
SBH HEALTH SYSTEM
Bronx, NY
COHORT 3

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Background/Partnership History

Fordham-Tremont CMHC is part of SBH Health System, a community-based, patient-friendly health care system serving individuals and families in the Bronx community and surrounding neighborhoods. Fordham-Tremont is a multicultural agency committed to improving mental health and overall quality of life for the diverse residents of the Bronx since 1978. In partnership with the community, Fordham-Tremont CMHC promotes individual and family well-being and social justice through innovative, holistic practices that enhance recovery.

The Care Integration Program (CIP) is designed to promote overall health and wellness for seriously mentally ill adults (SMI)by enhancing primary care and community services. This program promotes wellness activities and the arts to empower clients towards achieving optimal health.

Fordham-Tremont CMHC has partnered with **Union Community Health Center (Union)**, a Federal Qualified Health Center, which is also a part of the SBH Health System. Fordham-Tremont CMHC and Union Community are co-located at two of our sites.

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The Integration Care Model at Fordham-Tremont CMHC

The Model and Services

The Care Integration Program (CIP) utilizes an Integrated Care model that provides clients with holistic care and case management services in a behavioral health setting. We monitor a client's overall health and wellness by facilitating services between behavioral health and primary care, in addition to providing wellness activities to assist clients with their goals in transitioning towards self care.

CIP clients often self refer or are referred by doctors and clinicians within the agency.

- CIP connects clients to medical services at SBH Health System and our FQHC partner, Union Community Health Center as well as medical services in their communities.
- Clients utilize the program as a source of support and guidance towards their goals.
- CIP helps clients navigate social institutions and learn about their rights.

The Care Integration Program team

Patricia Small, Director; Dr. Darrell Wheeler, Evaluator; Judith M Birch, Project Supervisor; Rafaela Santos, Program Coordinator; Elesandel Manlapaz, Nurse Care Manager; Josephine Panford, LPN, Aaron Bruce, Health Educator; Judy Ciacci, Social Worker (for 1 year); Jessica Melendez, Data Specialist; Manuel Cuevas, Peer Counselor; Luz Santana, Peer Counselor

Wellness Activities and Groups

- **Activities/Groups:** Take a Break Tuesdays (Socialization), African and Salsa Classes, Walking Groups, Art Classes, Health Changes, Creativity with a Purpose, Smoking Cessation, Health Promotion, Signs and Symptoms, Meditation

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Measuring Success in Small Steps

Our Wellness curriculum is designed to motivate, empower, reduce isolation and support clients using a small step approach towards reaching their goals. The wellness activities and events at CIP help with these goals and engage clients, reducing the no show rate and more importantly, enlist familial support for the clients.

- Health Promotion groups address relevant issues for clients such as "What is Bi-Polar Disorder?," "Why am I gaining weight?"
- Clients are more proactive about their health and often request that specific topics be discussed during the health promotion groups.
- Clients express interest about their health and share concerns about medical issues with the nurses.
- Clients exhibit increased knowledge of nutrition and overall wellness.
- We were one of the first grantees to have trauma groups like "Healing your Body Image" and "Self Compassion."
- On average improved outcomes in:

  44% BMI
  35% Waist Circumference
  44% HDL
  28% LDL
  42% Tri-glyceride

- Peer led activities such as "Take a Break Tuesdays," salsa classes, and art classes helped reduce anxiety and increase socialization, which in turn helped increase the reassessment rates.
- We host an annual art exhibit consisting of over 250 pieces of artwork created by clients. This year, the 3rd Annual Art Exhibit was held on July 9, 2014.

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Improving Health Outcomes

Services Outcome Measures Then and Now

National Outcome Measures (NOMs)	Number of Consumers	Positive at Baseline	Positive at Second Interview
Functioning: Were healthy overall	224	31.7 %	39.3 %
Functioning: Were functioning in everyday life	233	33.5 %	40.8 %
Functioning: No serious psychological distress	228	46.9 %	60.5 %
Functioning: Were never using illegal substances	234	94.9 %	96.6 %
Functioning: Were not using tobacco products	234	69.7 %	70.1 %
Functioning: Were not binge drinking	234	94.9 %	97.0 %
Retention: Retained in the Community	235	91.1 %	91.9 %
Stability in Housing: had a stable place to live in the community	235	71.1 %	75.3 %
Education and Employment: were attending school regularly and/or currently employed/retired	235	9.4 %	8.1 %
Crime and Criminal Justice: had no involvement with the criminal justice system	234	99.6 %	100.0 %
Patient Satisfaction of Care: client perception of care	231	N/A	96.5 %
Social Connectedness: were socially connected	229	48.9 %	65.1 %

Services Outcome Measures

National Outcome Measures (NOMs)	Number of Consumers	Positive at Baseline	Positive at Second Interview
*Healthy overall (NOMs)	268	35.1 %	39.2 %
*Functioning in everyday life (NOMs)	282	36.5 %	45.0 %
*No serious psychological distress (NOMs)	277	48.7 %	60.6 %
*Were never using illegal substances (NOMs)	283	94.3 %	95.1 %
*Were not using tobacco products (NOMs)	283	67.8 %	70.0 %
*Were not binge drinking (NOMs)	283	95.1 %	97.5 %
*Retained in the Community (NOMs)	284	90.8 %	93.0 %
*Had a stable place to live (NOMs)	283	71.0 %	76.3 %
*Attending school regularly and/or currently employed/retired (NOMs)	283	8.5 %	8.5 %
*Had no involvement with the criminal justice system (NOMs)	283	99.6 %	99.6 %
*Client perception of care (NOMs)	277	N/A	96.8 %
*Socially connected (NOMs)	275	51.3 %	66.5 %

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Improving Health Outcomes

Services Outcome Measures Then and Now

Section H Indicator	Number of Valid Cases	At-risk at Baseline	Outcome Improved
Blood Pressure - Systolic	128	25.0 %	18.8 %
Blood Pressure - Diastolic	128	15.6 %	9.4 %
Blood Pressure - Combined	128	28.9 %	17.2 %
BMI	121	80.2 %	44.6 %
Waist Circumference	107	71.0 %	35.5 %
Plasma Glucose (fasting)	49	51.0 %	46.9 %
HgbA1c	27	66.7 %	29.6 %
HDL Cholesterol	44	27.3 %	47.7 %
LDL Cholesterol	43	27.9 %	34.9 %
Tri-glycerides	44	45.5 %	45.5 %

Section H Indicator	Number of Valid Cases	At-risk at Baseline	Outcome Improved
Blood Pressure - Systolic	171	25.7 %	18.1 %
Blood Pressure - Diastolic	171	15.2 %	10.5 %
Blood Pressure - Combined	171	31.0 %	18.1 %
BMI	163	83.4 %	44.8 %
Waist Circumference	141	74.5 %	35.5 %
Breath CO	108	0.0 %	13.0 %
Plasma Glucose (fasting)	57	50.9 %	40.4 %
HgbA1c	29	65.5 %	31.0 %
HDL Cholesterol	50	22.0 %	44.0 %
LDL Cholesterol	49	26.5 %	28.6 %
Tri-glycerides	50	44.0 %	42.0 %

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3rd Annual Art Exhibit Group Picture

CIP Team photo and with some of the Artist Featured at Annual Art Exhibit on July 9, 2014

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Overcoming the Hurdles

Challenges and the Outcomes

Major challenges at the beginning

- Staffing
  - –We had to use a staffing agency in order to find appropriate candidates
- Buy-in from both the behavioral and primary care
  - Presentations to both staff and clients and finally improved health outcomes were the true selling points

Data Collection, sharing and analysis

- Integrated EMR
  - SBH Health System has a fully operational EMR
- Difficulty in collecting data and generating reports that show client improvement in self care
  - The integrated EMR has resolved many of these challenges because both the behavioral and primary care teams are able to look at a client's medical record

Support from the State and recognition of the need for vital services and the ability to bill

- Peer support services – crucial
  - Licensing for specialist in New York State appear to be on the horizon
- Wellness groups/classes, such as walking groups, art classes
  - The hope is that services/activities be recognized as necessary when treating clients holistically

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Where do we go from here?

Integrated Care at Fordham-Tremont CMHC:

- A centralized intake process that identifies client behavioral and primary care needs .
  - Clients referred for integrated care including clinical services, health screenings and referrals for primary and specialty care.
  - Referral to CIP for program activities and services.
  - Groups held jointly by clinical and primary care staff.
  - Developing a smoking cessation program.

- Sustainability:
  - Billable providers
  - Billable services
  - Retaining health promotion activities , arts and crafts and peer services

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Can we try this again?

How to do it right the first time around.

- Hire key staff on day one; Hire early, hire right!
  - Use a staffing agency, if necessary
  - Hire persons with experience in primary and behavioral health care from the onset.
  - Hire a data person; you will need it!
  - Hire a psychiatric RN or NP early on
- Have administration meetings which include the medical and behavioral staff, as well as the administrative teams from the beginning.
- Keep in mind that the flow of information is vital to true integration.
- Don't put off sustainability until the second year.
- Implement billable services on day one.
- Look at the full array of programs being offered to avoid redundancy in services. Enhance existing services.

Remember, … No idea is too silly…

- Encourage team members and clients to think outside the box and see how it (the idea) can be implemented in a therapeutic fashion.
- Ask and share; why re-invent the wheel?
  - Ask other programs via email and list-serves for forms and documents they have created.
- **Always keep the grant goals in mind.**

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Program Contact Information

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