Total Wellness

A SAMHSA 4-year, grant-funded program

Integrating primary care and behavioral health services

Improving health outcomes of the SMI population
Principles

- Wellness group model
- Standardized practice across clinics
- Improved access for on-site clients
- 1:1 individualized care
- Client support, education, advocacy
- Address cultural and linguistic needs
- Outcome oriented
What We Offer

- Services 5 days a week
- 2 clinic locations:
  - Central county
  - South county
Client Outcomes

- Improvement in
  - Blood pressure, HgbA1c, cholesterol control
  - Weight loss
  - Social Connectedness
  - Decreased use of acute services

- Increased use of outpatient primary care and specialty care
Client Outcomes: Health

Bar chart showing the percentage of outcomes improved for Blood Pressure, BMI, HgbA1c, HDL, LDL, and Triglycerides.
Client Outcomes: Social

- Attending school or employed:
  - Baseline Positive: 27.30%
  - Second Interview Positive: 35.80%

- Were socially connected:
  - Baseline Positive: 51.40%
  - Second Interview Positive: 64.20%
Program Outcomes: Financial

Acute/Inpatient vs Outpatient Charges

- **Inpatient/Acute Charges**: $2,223,083 in 2010-2011, $1,662,966 in 2011-2012
- **Outpatient Charges**: $534,973.00 in 2010-2011, $785,693.00 in 2011-2012
Who We Are

- **Project Director** overseeing the PBHCI grant
- **Unit Chief** assuring daily operations of Total Wellness
- **Primary Care Supervising Physician**
- **Primary Care Nurse Practitioner**
- **Nurse Care Managers** providing care collaboration and coordination between BHRS and primary care
- **Community Health Planner** providing health education services, coordinating activities and groups
- **Health Education Associate** providing nutrition and health education services
- **Community Worker** and contracted **Wellness Coaches** assisting in enrollment and delivery of wellness activities
- **TW Consultant** on part time contract
- **Data Analyst Assistant** contracted to help with enrollment and data collection
- **Primary Care Medical Assistants & Patient Service Assistant**
Nurse Care Managers

- Assess and evaluate the client’s holistic needs
- Create an integrated Total Wellness plan
- Select wellness services
- Act as primary liaison with all health providers
- Bridge BHRS and primary care communication
- Assure behavioral health and health issues are addressed
- Provide health and psychiatric education
- Provide medication reconciliation and support
Peer Coaches

- Motivate based on sharing lived experience
- Run wellness support groups
  - Ash Thinkers, Ash Kickers, WRAP, Well Body, Walking Group
- Provide 1:1 coaching support
- Provide resources and education
- Provide transportation to and from medical appointments
- Have ongoing contact with and provide support to clients
Collaboration: Nurses & Coaches

- Collaborative decision making
- Coordinated appointment scheduling
- Shared spreadsheets, calendars, weekly check-ins
- Common office spaces, joint meetings
- Shared referrals
Preparation: Nurses

- Master’s degree in Psychiatric Nursing
- Knowledge of behavioral health needs of the SMI and co-occurring disorders and associated medical issues
- Ability to address complex care needs
- Comprehensive biopsychosocial assessment and care
- Coordination of mental health and other medical services
- Knowledge of principles of psychiatric rehabilitation and recovery
- Openness to innovative healthcare approaches
- Flexible, nonjudgmental, and collaborative
Preparation: Coaches

- Participate in orientation and Wellness trainings
  - Brief Action Plan
  - University of Colorado’s Peer to Peer Tobacco Cessation and Well Body program training
  - WRAP training or experience in WRAP planning
- Biweekly community worker meeting
- Empathy, compassion, humility
- Effective use of self: Willingness to share their stories
- Organizational and office skills
- Basic knowledge of behavioral health
- Ongoing support
- Openness to learn new things and new health care model, and work with staff of different disciplines
Challenges

- Multiple databases, different labs across the county
- Coordination with county medical clinics
- Difficult follow-up due to multiple reasons:
  - perceptions about healthcare
  - psychiatric, substance use, medical, socioeconomic, cultural issues
  - housing instability
  - logistic issues
- Culturally capable workforce and wellness offerings
- Ongoing efforts to bridge the two health systems
Key Learnings

Importance of:

- Establishing standards of care
- Clarification of roles and expectations
- Development of integrated protocols and workflows
- Coordinated appointments between BH, PC, TW
- Warm hand-offs during referrals
- Ongoing outreach, engagement, alliance building