APPENDIX B Section H Screening

NOMs Section H Missing Data

11/15/2017

Measure	Allegan	PBHCI Benchmark	Difference
BP Systolic	6.7%	10.8%	4.1%
BP Diastolic	6.7%	10.8%	4.1%
Weight	7.1%	10.9%	3.8%
Height	6.4%	11.4%	5.0%
Waist Circumference	8.5%	8.3%	-0.2%
Breath CO	30.0%	10.8%	-19.2%
Plasma Glucose	64.0%	22.3%	-41.7%
HgbA1c	64.0%	22.3%	-41.7%
Total Cholesterol	68.2%	23.9%	-44.3%
HDL	68.2%	23.9%	-44.3%
LDL	68.2%	24.5%	-43.7%
Triglycerides	68.2%	24.0%	-44.2%

NOMs Section H Missing Data

6/27/2018

Measure	Allegan	PBHCI Benchmark	Difference	Direction From Previous Week
BP Systolic	8.5%	10.6%	2.1%	Down
BP Diastolic	8.5%	10.6%	2.1%	Down
Weight	8.0%	10.7%	2.7%	Down
Height	8.0%	11.2%	3.2%	Down
Waist Circumference	13.9%	9.7%	-4.2%	Down
Breath CO	23.0%	12.3%	-10.7%	Down
Plasma Glucose	68.3%	22.2%	-46.1%	Down
HgbA1c	68.3%	22.2%	-46.1%	Down
Total Cholesterol	73.8%	23.7%	-50.1%	Up
HDL	74.0%	23.7%	-50.3%	Up
LDL	73.8%	24.2%	-49.6%	Down
Triglycerides	73.8%	23.8%	-50.0%	Down

APPENDIX B Continued Section H Screening

NOMs Section H Missing Data

11/20/2019

Measure	Allegan	PBHCI Benchmark	Difference	Direction From Previous Week
BP Systolic	6.2%	10.3%	4.1%	Same
BP Diastolic	6.2%	10.3%	4.1%	Same
Weight	6.5%	10.3%	3.8%	Same
Height	5.9%	10.8%	4.9%	Same
Waist Circumference	9.5%	11.3%	1.8%	Up
Breath CO	15.9%	14.0%	-1.9%	Up
Plasma Glucose	35.4%	22.5%	-12.9%	Down
HgbA1c	35.4%	22.5%	-12.9%	Down
Total Cholesterol	39.2%	24.0%	-15.2%	Down
HDL	39.0%	24.0%	-15.0%	Down
LDL	39.4%	24.5%	-14.9%	Down
Triglycerides	39.2%	24.1%	-15.1%	Down

NOMs Section H Missing Data

8/26/2020

Measure	Allegan	PBHCI Benchmark	Difference	Direction From Previous Week
BP Systolic	6.2%	10.5%	4.3%	Up
BP Diastolic	6.3%	10.5%	4.2%	Up
Weight	6.8%	10.6%	3.8%	Up
Height	6.2%	11.0%	4.8%	Up
Waist Circumference	9.9%	11.8%	1.9%	Up
Breath CO	16.6%	14.4%	-2.2%	Same
Plasma Glucose	33.2%	22.7%	-10.5%	Up
HgbA1c	33.2%	22.7%	-10.5%	Up
Total Cholesterol	36.7%	24.2%	-12.5%	Up
HDL	36.5%	24.2%	-12.3%	Up
LDL	36.8%	24.7%	-12.1%	Up
Triglycerides	36.6%	24.3%	-12.3%	Up

IBH ANALYTICS

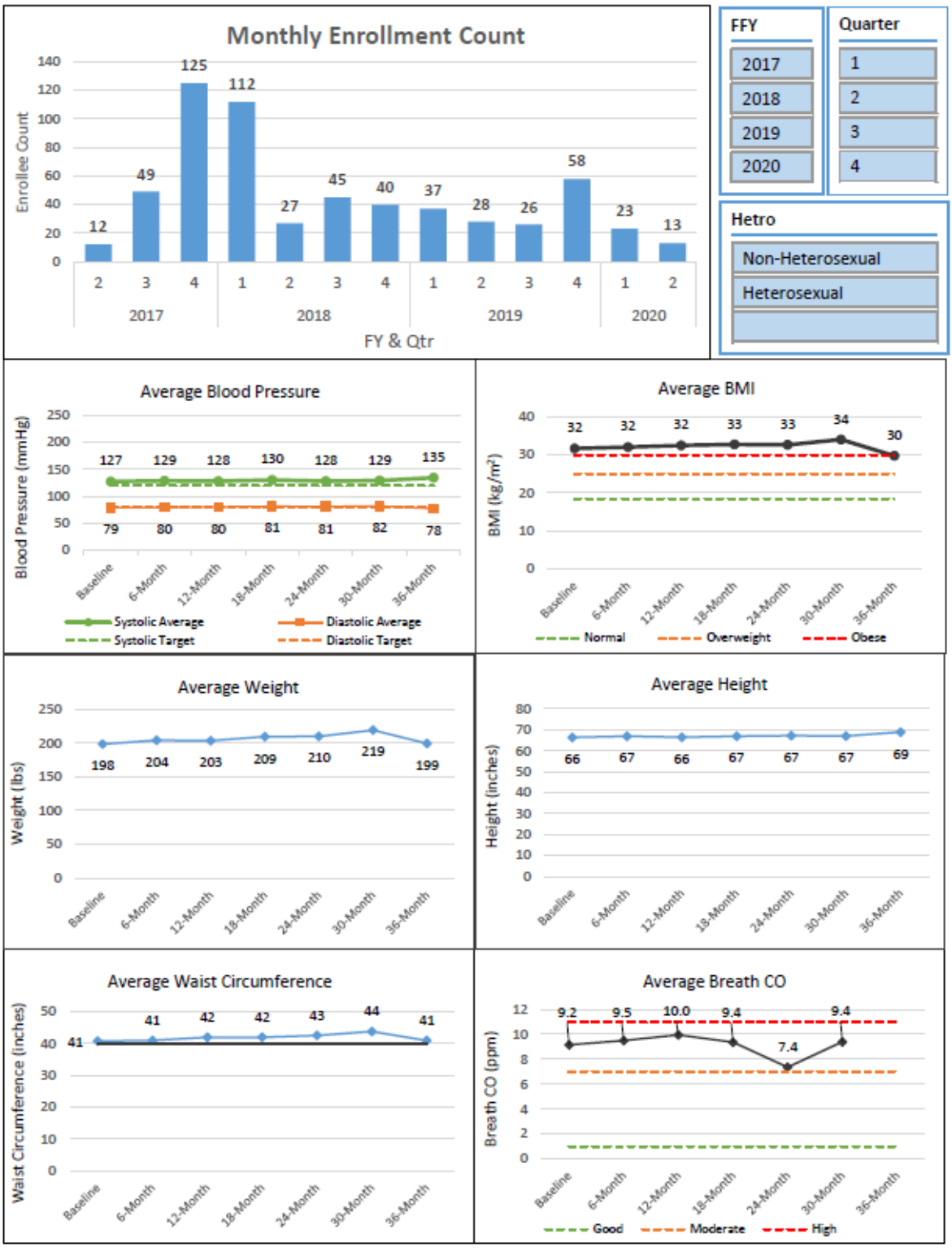
APPENDIX C EBP Programming Activities

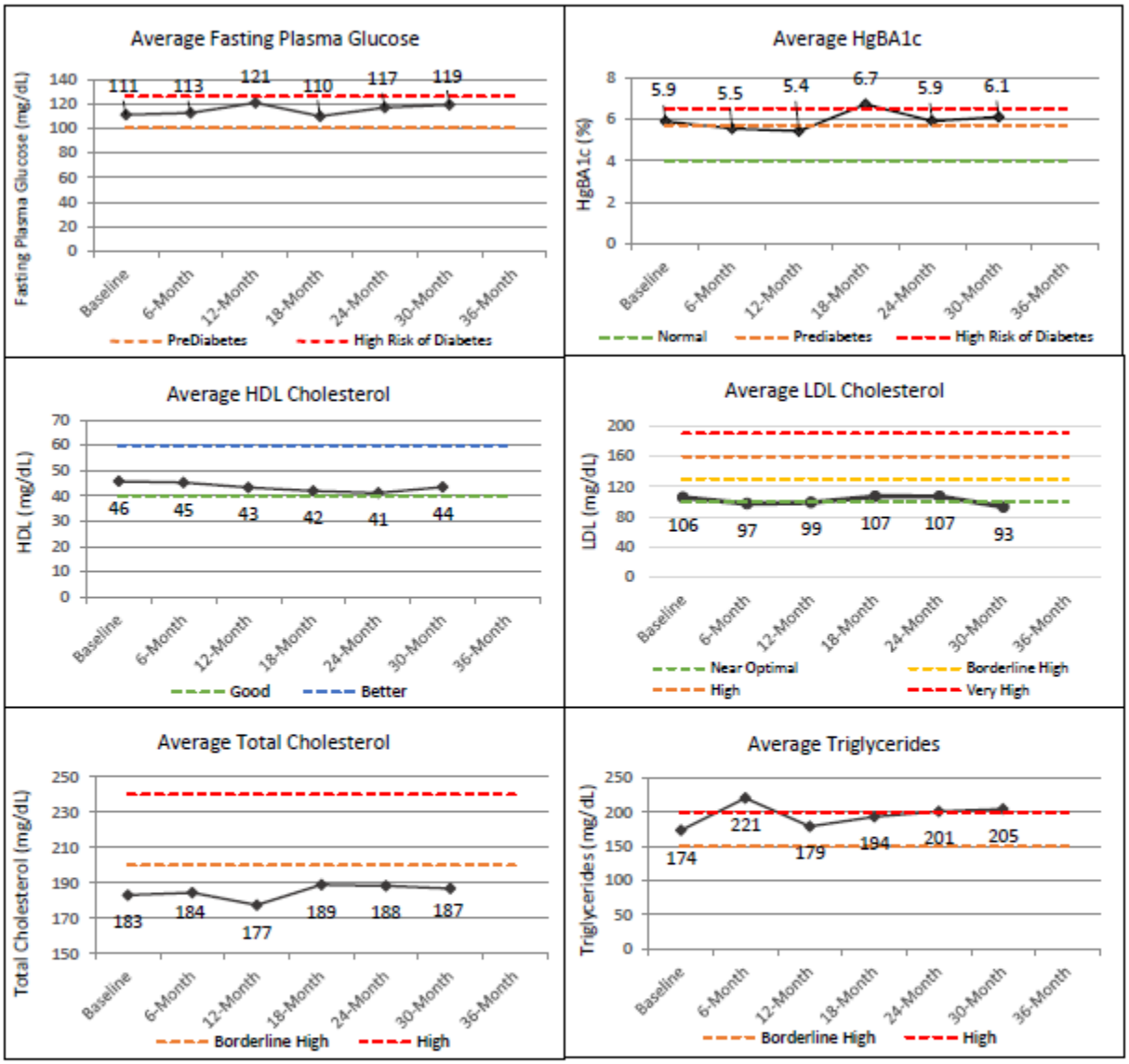
Name of Wellness Activity/ EBP	Staff involved (include peers)	# of Participants	Outcomes
Nutrition/Exercise: STOP light Diet	RN Care Coordinator/Peer Wellness Coach	549 Educational Resources were shared with consumers of services throughout the grant project	Our RN Care Coordinator/Peer Wellness Coach worked with individuals during NOMs screenings to identify needs in nutrition or exercise and help to distribute educational materials or participation in groups to learn more.
Tobacco Cessation: Dimensions	RN Care Coordinator/Peer Wellness Coach/ Certified Peer Support Specialist/ACT Nurse/Nurse Clinic Office Manager	163 Educational Tips to Quit Smoking were handed out throughout the grant project 52 Participants completed training in Dimensions curriculum	Participants described decrease in the habits of smoking, change in their willingness to quit and adherence to cessation medications
Chronic Disease Management (WHAM)	Peer Wellness Coach	22 Individuals completed WHAM programming	WHAM classes occurred each week with consumers entering in at any point according to their motivation for participation and movement towards goals. Weight loss, better eating habits, healthier choices, socialization, and other wellness activities desired by the individuals in the course were outcomes that were successful.
Wellness Recovery Action Planning (WRAP)	Peer Wellness Coach, Certified Peer Support Specialist	7 Individuals completed WRAP programming	WRAP classes occurred each week with consumers participating outside of CMH services as well as those within Mental health treatment court. They complete action plans in order to support their recovery processes and utilized them in daily practice.

APPENDIX D Population Comparison

Section H Comparison of Year 1 to Year 4				
Overall Population				
Health Indicators	**Year 1 Quarter 4**	**Year 2 Quarter 4**	**Year 3 Quarter 4**	**Year 4**
Blood Pressure	127/80	128/78	128/80	130/82
BMI	33	32	32	31
Waist Circumference	41	40	42	40
Breath CO	6.2	11	8.7	6.6
Plasma glucose (fasting)	113	120	118	107
HgbAlc	6.1	5.7	5.5	6.1
HDL cholesterol	42	45	43	46
LDL cholesterol	94	109	107	111
Triglycerides	191	156	192	190

APPENDIX E PBHCI Monthly Dashboard




Average Fasting Plasma Glucose
Fasting Plasma Glucose (mg/dL)
111 113 121 110 117 119
Baseline 6-Month 12-Month 18-Month 24-Month 30-Month 36-Month
PreDiabetes
High Risk of Diabetes
Average HgBA1c
HgBA1c (%)
5.9 5.5 5.4 6.7 5.9 6.1
Normal
Prediabetes
High Risk of Diabetes
Average HDL Cholesterol
HDL (mg/dL)
46 45 43 42 41 44
Good
Better
Average LDL Cholesterol
LDL (mg/dL)
106 97 99 107 107 93
Near Optimal
Borderline High
High
Very High
Average Total Cholesterol
Total Cholesterol (mg/dL)
183 184 177 189 188 187
Borderline High
High
Average Triglycerides
Triglycerides (mg/dL)
174 221 179 194 201 205
Borderline High
High

APPENDIX H: PBHCI Success Stories

2020-03

The integrated health team is proud to announce that the Whole Health Action Management (WHAM) group will have a graduate on 03/4/2020 after completed the program. The client spent weeks working with the certified peer support specialist and has worked towards self-management of individualized health goals. The client will be presented with a certificate of graduation from the integrated health team.

2020-02

A case manager from the MISSION Housing program referred a client to integrated health whom needed assistance with finding a local PCP that accepted Medicaid. The integrated health nurse and Mission case manager completed a joint visit at the client's new apartment and collaborated on getting the client's needs met and offer ongoing medical needs.

2020-01

Coordination of care is occurring often with outside providers in conjunction with our Nurse Care Coordinator and our Family Nurse Practitioner to ensure safety of prescribed medications in our psychiatric clinic due to a change in health status with a pregnancy. Kim Bouchard, our Nurse Care Coordinator called OBGYN offices to establish a care coordination relationship and ensure safety of the consumer with the medications we were prescribing. This interaction occurred within the same day that the consumer was seen in our clinic and the consumer left informed with the information needed for future consultation and follow-up was done timely to ensure adequate instructions were provided to the consumer. We are thankful for the ability of our staff to intercede in necessary consultative conversations within care coordination.

2019-12

A 48-year-old female was transported by the ACT bus to an outpatient appointment with her behavioral clinician. The behavioral health clinician reported to the clinic office after client became progressively confused in her therapy session and the client reported feeling "weird" since riding the bus. The clinic was alerted, and the Integrated Health Nurse responded to the office where the client was found eating jellybeans and alert but abnormally confused. Blood sugar assessment was obtained and indicated the client likely had a hypoglycemic episode from taking insulin prior to getting on the bus and skipping breakfast. The client was monitored in the medical clinic until blood glucose was increased from 97 to 161 and the client reported feeling normal. The client was able to complete the therapy session, while the Integrated Health Nurse collaborated with the client's PCP office via telephone and confirmed client would have an appointment this week to be seen for medication assessment. Education was provided on site and specific instructions were given to the client on how and when to follow up with primary care physician. This client continues to be monitored and offered assistance by the integrated health team.

2019-11

During the month of September, the medical clinic was consulted due to urgent medical needs. ACCMHS employees in multiple departments were able to consult with licensed staff for on-site triaging of clients due to medical problems. One incident involved a 34year-old female being seen in the clinic for a routine medication injection by the ACT Team Nurse. The ACT Nurse obtained vital signs and the client presented with asymptomatic hypertension. The client was seen by ACCMHS' psychiatrist whom referred the individual to her primary care physician for high blood pressure as soon as possible. The ACT Nurse monitored the client following the appointment and became concerned as the high blood pressure did not normalize. The ACT Nurse alerted the clinic staff for a secondary assessment by Kimberly Bouchard RN from the integrated health team. The client was found to be in a hypertensive crisis and was advised to be seen in the emergency department via ambulance for treatment. The client was seen and treated in the emergency department and released on the same day with new medications. The client continues to be monitored by integrated health and the ACT team.

2019-06

Our WHAM programming, Whole Health Action Management has had a great increased percentage in attendance lately. Consumers have been actively involved in making good progress towards healthier decisions in their lives. Consumers are often willing to share their stories and express their current experiences in making changes. The stories, sharing and honesty in the group is very affirming for all those involved. Consumers used to have 2-3 others in the class to relate to and now there are up to 9 participants. The group continues to grow and consumers are learning to make healthier decisions in their lives. We are excited for all those involved in this course and are grateful for the class instructor, John Mills, Certified Peer Support Specialist who is thankful to be a part of this.

2019-02

Behavioral health staff and our integrated care staff have been working more closely together throughout the past few months. Care coordination conversations and warm hand-offs are becoming more of a normal practice throughout the day. In many instances after a behavioral health appointment has finished primary clinicians are

walking their consumers down and introducing them to our staff or showing them to their appointments. On some occasions some case managers, supports coordinators and ACT clinicians have also completed the NOMs assessment with their consumers if the integrated care staff has been unable to make the contact. This allows for more continuity of care and consistent interaction with similar staff members as well. This coordination and communication between our staff have increased the morale for our program as well. Our reassessment rate of consumers coming back for appointments also shows this. We are thankful for the teamwork within the organization that allows us to improve the care of the individuals we serve.

2019-01

Erin, PBHCI's Primary Care Nurse Practitioner, has begun to see patients on a consistent basis. Currently, she has an individual who has come in for multiple visits to help manage their diabetes. The patient has been highly motivated to improve their diet, track their blood sugars, and test new medications. They have completed all appropriate testing in office, and are willing to continue this process in the home. Erin has also supplied this individual with the tools they will need in case of an emergency, and the knowledge to use these emergency kits.

With the continuation of medication management, as well as lifestyle changes, including changes in their diet and exercise, we have great prospects that this consumer will be able to control their diabetes independently

2018-11

PBHCI is excited to announce that WHAM classes have been reinstated this past month. Once a week, participants are encouraged to learn about healthy eating habits, lifestyle changes, and their overall health. Even after only a few sessions, participants are becoming fully involved and dedicated to the program. A member has successfully shared that they have lost 10 pounds in 2 weeks from increased physical activity (bike riding) in association with their WHAM goals. There has been great positive feedback on WHAM provided to the PBHCI staff from both the consumers and therapists about the program positively impacting individual's lives.

2018-10

As we embark on the half-way point of the PBHCI program, a shift in the organizations' culture of embracing PBHCI is coming into focus. Despite agency turnover on the behavioral health side, PBHCI was able to continue to strengthen the relationships between behavioral and physical health. Unofficially, an open-door policy, in addition to formal methods, are used to refer or consult for primary care concerns of behavioral health clinicians in an interdisciplinary process towards providing consumers all that PBHCI has to offer.

2018-09

Through much surprise and appreciation, Lipid Panel screenings were able to be offered to all staff members at Allegan County CMH. Approximately 30 employees participated in having their blood drawn. These individuals were able to see the process that our consumers go through when they have their levels tested. Several staff members made comments about how quick, easy, and virtually painless the screening was. The staff were also quite impressed with how informative and detailed the results were presented. Result sheets were provided to explain individuals' cores and the ranges that these scores should fall between. For scores outside of the range, recommendations are provided on how to best change parts of one's lifestyle to help these scores fall back in place. Staff were pleased to see that the SAHMSA Grant has been able to provide excellent service and prevention to our consumers.

2018-08

ACCMHS recently obtained a CLIA waiver to preform on-site point-of-care testing, which has allowed us to provide real-time health stats for our consumers. This information can be a powerful motivator when used as a method of reinforcing lifestyle changes, assessing health status, and providing recommendations to support clients in their decision to make changes. The testing evaluates mechanical measures required of the grant; Plasma Glucose, HgbA1c, Total Cholesterol, HDL, LDL, and Triglycerides. These provide measurable health indicators of potential or real health problems, as well as, current and future health risks. With these results, we are able to mediate the client's health status and support healthy lifestyle choices. As this data is collected more frequently, we will have a better snapshot of the true population averages in the graphs above. We are also in the process of building client dashboards, which will trend and track progress over time.

2018-07

The PBHCI team is excited to announce that our Certified Peer Support Specialist has taken the necessary steps to become certified in Whole Health Action Management. This training program includes classes and support groups that encourage increased resiliency, wellness, and self-management of health and behavioral health among individuals with mental illnesses and substance use disorders. A WHAM class will be offered to PBHCI participants in the near future. This month, we would like to share how our program has not only benefited our participants but also the positive impact it's had on our staff. With the addition of point of care blood testing machines, our peer support specialist has been given the chance to reflect on their own health. Learning of their elevated levels, in

addition to WHAM training, they have reflected on the need for their own health journey. This life experience is something that they will be able to share with PBHCI participants to encourage a side-by-side journey of whole health wellness.

2018-06

Reduced Healthcare Utilization

Longstanding status update of an integrated heath consumer being followed for continuing medical care; A recent visit from this client unveiled reductions in self-reported symptoms and pain between prescribed and holistic remedies, and improved compliance. The client also reported improved healthcare access, treatment efficacy and overall satisfaction with chronic disease management. As a result, overall reduction of unplanned healthcare utilization was optimized and the client's outlook on planning for future management was realized.

2018-05

Reduced Healthcare Utilization

A call from a behavioral health clinician, while in session with an existing primary care consumer, requested an evaluation of the client due to their complaints of sharp chest pain. This client was screened previously both during enrollment and through behavioral health clinician's coordination to which they were referred to primary care that facilitated this evaluation. In the past, the client had been going to the emergency department for refills of a short acting inhaler and was without routine medical care or control of their asthma. Since the last encounter the client has seen a primary care provider arranged through care coordination, and has received a long-acting inhaler, but are currently in need of refills. Their vital signs were taken, and suggestions were offered to manage their breathing issues. It was explained to the client that while there are many possible causes for their current pain, it could be caused by poor asthma control. Suggestions included using long-acting inhalers, proper diet, exercise, electrolyte replacement, supple mentation, use of OTC medication, and healthcare utilization if his symptoms persists.

2018-04

Reduced Healthcare Utilization

A consumer who has joined the PBHCI program had come in to complete a NOMs assessment. During this time they expressed concerns about oral discomfort. The consumer was afraid the symptoms showed signs of a serious condition, and intended to seek immediate treatment from urgent care. Discussions with the Nurse Care Coordinator (NCC) helped to lessen the consumer's concerns, as the NCC was able to explain that what was being seen did not require urgent care. Suggestions were provided for managing symptoms, as well as instructions on when best to seek additional medical attention. The consumer left their appointment reassured, as well as equipped with tools that will encourage self-management.

2018-03

An existing integrated health consumer was referred to the Nurse Care Coordinator by their primary clinician for nutritional counseling to address a specific aspect of their physical and behavioral health needs that required special dietary considerations. This consultation provided the client with concise dietary information in an easily indexed table that they could use to plan meal choices. The client was provided with this information in addition to a simple explanation to help guide options and direct therapeutics to facilitate whole health wellness.

2018-02

A client, referred to the Nurse Care Coordinator from their primary behavioral health clinician, sought out dietary advice in managing a chronic health condition. This client was provided an initial phone consultation to plan for their first primary care appointment scheduled following their behavioral health provider appointment. The phone consultation seemed to alleviate the consumer's anxiety towards the upcoming first appointment. The consumer is now prepared on what to expect during the appointment, what might be discussed, and appropriate planning for this meeting.

We are also very excited to announce the newest addition to the PBHCI team, Eric Beauchamp! Erin is joining the grant program as a Nurse Practitioner, and will start providing primary care medical services to our consumers in the very near future.

2018-01

During the NOMs assessment, a discourse of smoking cessation options and motivational interviewing led a consumer to consult their primary care provider for medication-assisted options to help quit smoking. On periodic contacts with this consumer, the Primary Care Comprehensive Care Manager (PCCCM) found them to be smoke-free for several months. Upon six month reassessment, the consumer continues to be smoke free because of this intervention. In addition, this particular client's vital sign measurements revealed a combined systolic/diastolic drop in blood pressure of 30 mmHg; significantly reducing this person's risk of stroke or heart attack.

2017-12

A shared client presented to the ACCMHS: Allegan Access to Care program, primary health clinician through direct referral for multiple complaints of chronic pain, resulting from a serious trauma event. This client is receiving behavioral health clinician services and psychiatry for emotional pain and trauma and coping of physical effect. The client had experienced resistance from their outside primary care health providers for the treatment of physical pain, with complex co-occurring substance use; to which, they stated as supplementing the lack of treatment for their symptoms. The clients complex presentation and understanding of processes within the primary medical realm required direct staff to accompany them to appointments for mediation and setting the agenda for their visit, in addition coordinating referrals and collaborating directly with their outside health providers alongside of the client to accomplish the client-directed shared care plan. This client was provided with a new PCP for general medical needs as well as alternate specialist providers for the treatment of physical complaints including surgical consults. This client is currently working among the shared collaborative efforts of their BH clinician and the PC clinician to attend to the client's ongoing care, provide hope and to provide shared care planning for the clients physical and emotional needs.

2017-11

As part of the NOMs baseline assessment, a young adult's asthma was found to be uncontrolled. The consumer did not currently see a primary care physician and he sought medical care from the nearest emergency department when he ran out of his rescue inhaler. This consumer was also found to have symptomatic complaints, therefore, a primary care physician was found and an appointment was scheduled for them. In addition, a release was signed so that the Primary Care Comprehensive Care Manager (PCCCM) could follow their course of treatment and assist them in compliance and asthma management planning to gain control over this aspect of their health. In the course of completing the NOMs assessment with clients by the PCCCM, medical needs can be identified, which can also impact other conditions, such as their mental health. For example, if this client also had anxiety; asthma can contribute to this mental health condition, as this physical health concern may make it difficult to breath, and thus be a trigger for ones' anxiety.

2017-10

A young male client was referred to the PBHCI program by his primary behavioral clinician for nurse coordination. He was reported by his BH clinician to be having multiple physical complaints that were adversely affecting their progress toward optimal whole health and self-actualization due to problems resulting from an industrial accident that nearly took his life. He had extensive surgical intervention and partial organ removal that resulted in altered physiologic status affecting multiple aspects of daily living. Care coordination began with a historical context of his experience with care providers in regard to his injuries, current state of health and treatments.

Accompanying the client to appointments with his health providers, facilitated his understanding of available testing and treatments. This approach also aided in effectiveness of the appointments, by expediting recommendations and decisions of his care provider. While this client was still referred to medical facilities in another region for follow up care, our services provided him with available standard medical and alternative therapies that would help him cope with the aftermath of his injuries and permanent limitations. Goals of care coordination for this client focused on improvement of daily functioning through reliance on intervention therapeutics and creating hope, by empowering self-management and ownership over personal health.

2017-09

The PBHCI Team is offering its first Whole Health Action Management course beginning Wednesday, September 13, 2017. This 8-week course encourages the participant to develop whole health goals in the areas of nutrition, healthy living, weight loss, and smoking cessation. A peer supported approach encourages participants to support one another as they work toward, achieve, and maintain individual goals. The class will be led by Allison Goodman, our certified WHAM instructor.

The PBHCI Team is also hosting an open house to welcome current consumers and the public to learn more about our resources for physical and mental health. On September 13, 2017 from 9am to 3pm, we will be offering information on tobacco cessation, nutrition, wellness programs, healthy snacks, healthy recipes, and the opportunity to enroll in our program.

2017-08

An elderly client with depression, insomnia, and dysphoria was referred to the PBHCI Care Coordinator by his Primary Behavioral Health Clinician, with concerns regarding his whole health and deterioration of independence of personal and home maintenance activities. Cognitive decline and frequent falls in the home were affecting the client's competence in managing his chronic illness and overall safety. The PBHCI Care Coordinator visited this client in his home to assess these health and safety concerns. The first visit, completed in the afternoon, the client exhibited moderate cognitive impairment and unsteady gait. The client stated he had been "feeling ill" and "not

quite with it today". The visit was cut short at the client's request. The PBHCI Care Coordinator set up a follow-up visit to reassess the situation. The second visit, this time completed during the morning, the client presented with both improved cognitive abilities and gait. A medication list and account of physical and/or sensory limitations was attained. In addition, the client agreed to have nursing support at his next PCP visit. At the PCP visit, care coordination efforts focused on a reduction of the client's opiate pain medications, as his dosage was near the ceiling of an average adult. Consideration of the client's advanced age and metabolic limitations were considered. Physical therapy was requested to facilitate developing improve physical adaptation. There was improvement to cognitive and physical coordination abilities, but his perception of pain begged the PCP to reduce his opiate therapy.