SECTION A: Population of Focus and Statement of Need

Population of Focus Demographic Profile

Claratel Behavioral Health (Claratel BH) is an innovative, community-based behavioral health and developmental disabilities services organization in DeKalb County, Georgia. As a public, not-for-profit organization, the Claratel BH operates more than 20 locations in DeKalb County and employs a diverse workforce of more than 500 direct care and support staff. Claratel BH provides the highest-quality, evidence-based mental health, substance abuse, and developmental disabilities services. Claratel BH aims to expand integrated primary care services at the Winn Way mental health clinic. The county has a Health Professional Shortage Area designation for primary, cognitive, and dental care. The low-income population has a Medically Underserved Population status in the Stone Mountain/Clarkson area, and the South Decatur/Candler/Mcafee area has a Medically Underserved Area status (*Find Shortage Areas*, HRSA, 2024).

Claratel BH will not target any specific sub-population but will recruit clients primarily from the current client base and the county population. Claratel BH currently has an outpatient base of 3000 active clients, 100% of whom have Serious Mental Illness as defined by the State of Georgia. African Americans make up 77% of clients, followed by Whites (13.52%), and Other Races (7.13%). The majority (88%) fall between eighteen and sixty-five. Clients age seventeen and under make up 11.65%. Almost half (48.51%) of outpatient clients served are indigent or uninsured.

Disparities for Population of Focus and Sub-populations

In general, low-income and uninsured populations face significant barriers to care. Compared to those with higher incomes, low-income people experience disparities in access to and quality of health care. Individuals with lower incomes are less likely to have a specific primary care provider and source of ongoing care and are more likely to delay or go without needed care. Low-income individuals younger than age sixty-five are less likely to have health insurance. Furthermore, they receive lower-quality care than individuals with higher incomes. For example, children from low-income households are less likely to receive recommended immunizations, dental checks, vision screenings, and education about exercise and nutrition than their higher-income counterparts ("2009 National Healthcare Disparities Report," AHRQ, March 2010, http://www.ahrq.gov/qual/qrdr09.htm). Compared to those with insurance, the uninsured are much less likely to receive clinical preventive services that have the potential to reduce unnecessary morbidity and premature death. They are more likely to be diagnosed with an advanced stage of cancer. They are at greater risk of death from congestive heart failure, trauma, and other acute severe conditions such as heart attack and stroke ("America's Uninsured Crisis," Institute of Medicine, February 2009).

In DeKalb County, poverty is a more significant issue for minorities when compared to the overall population. Whereas African Americans make up just over half (54.3%) of the total population, they make up 63.1% with income below 100% FPG. The same disparity is true for Hispanics, who account for 9.8% of the total population and 17.0% with income below 100% FPG ("2010 Census," U.S. Census Bureau, 2011). Of the approximately 235,000 low-income

residents in the county, 91%, or 214,000 people, are unserved by a Section 330 grantee, indicating that most do not have access to affordable primary care (UDS Mapper, May 30, 2012). Lacking access to primary care, many rely on high-cost services such as those offered through local emergency rooms.

These types of barriers hold for the predominantly minority, low-income, uninsured Claratel BH client base. The obstacles these clients face have driven the organization to seek a means of providing primary care to improve overall health. For several years, Claratel BH staff observed that chronically mentally ill clients were going without primary health care service. Many suffered from chronic primary care illnesses, which were exacerbated by their mental health conditions. Lack of treatment of these primary care conditions ultimately leads to the death of many clients, though their primary care conditions would have been treatable if they had access to care. Even though Claratel BH staff referred them to Grady Memorial Hospital or a local Federally Qualified Health Center (FQHC), few clients attended their referral appointments despite repeated encouragement through follow-up. This lack of treatment made it difficult for Claratel BH providers to make significant improvements in the mental health conditions of clients who had co-morbid primary care conditions. Because of this, Claratel BH psychiatrists and therapists became the "de facto" home health care providers to this underserved population, providing not only mental care but limited primary care as well. Claratel BH estimates that at present, well over half of clients have no primary care relationship, and most have seen no healthcare provider in five years or more other than care received at Claratel BH.

Claratel BH providers were unable to provide anything that approached the primary care needed to treat the chronic primary care conditions of most clients, so the Claratel BH board and management decided to partner with a local FQHC to integrate primary care at the Claratel BH Winn Way mental health center.

All 3000 Claratel BH Winn Way site clients have SMI. A large majority of them have a chronic disease condition as well, which often causes premature death. Though Claratel BH does not track data on physical conditions, staff estimate that 60% of clients are overweight. Most suffer from hypertension or diabetes. Of all client deaths, approximately three out of four result from heart disease, hypertension, or diabetes-related conditions. Despite Claratel BH staff efforts to provide limited care or referrals to care, these problems persist due to the barriers described, such as lack of insurance, ability to pay, and transportation.

While Claratel BH staff observe increased morbidity from untreated physical conditions among SMI clients, numerous studies provide evidence of this link. A study published by the National Association of State Mental Health Program Directors (NASMHPD) found that clients with SMI have a life expectancy of approximately twenty-five years less than the average U.S. resident. Most of those deaths come from cardiovascular conditions and infectious diseases (Park, Joe, MD, et al., "Morbidity and Mortality in people with Serious Mental Illness," NASMHPD Medical Directors Council, 2006). A study conducted at the University of Freiburg in Germany showed that clients with SMI, especially depression, are twice as likely to die of coronary disease over two years as clients who are not diagnosed with depression (Barth, Jurgen, PhD, Martina Schumacher, MA, and Christoph Herrmann-Lingen, MD, "Depression as a Risk Factor

for Mortality in Clients with Coronary Heart Disease: A Meta-analysis," *Psychosomatic Medicine*, vol. 66, no. 6, November 1, 2004). Most factors that affect coronary heart disease are behavioral and can be controlled by the client (Allan, Robert, PhD and Stephen Scheidt, MD, "Heart and Mind, the Practice of Cardiac Psychology," American Psychological Association, Washington, D.C., 1996), meaning that the integrated services and coordinated care proposed in this program can have a positive impact on client health. Given this, and in line with the Million Hearts initiative program goals, Claratel BH will pay special attention to providing care to SMI clients with chronic conditions related to heart disease.

SECTION B: Proposed Evidence-Based Service/Practice

Purpose of the Project

This project aims to provide a health home for the population of focus by integrating primary care at Claratel BH's Winn Way Mental Health Center. The goal is to improve the health and quality of life of the population of focus.

The project has three main objectives:

Objective 1: Improve the health status and quality of life of clients with SMI by increasing access to integrated primary care to 265-300 clients by Year 1. Measurable improvements in health status will include the percent of clients with controlled hypertension and diabetes (blood pressure, HgbA1c, lipid profile, BMI, etc.).
Objective 2: Enhance the consumer's care experience (including quality, access, and reliability) as measured by client surveys and focus groups conducted throughout the project.
Objective 3: By the end of the project, reduce the per-client cost of care for the population of focus to include costs related to hospitalization and emergency department use.

Strategies for the project will work toward the achievement of those objectives:

Strategy 1: Embed a Medical Case Manager at the Winn Way facility to facilitate care management, care coordination, health promotion, referrals, and transitions.
Strategy 2: Implement a Peer Navigator model (HARP) to increase client activation, including compliance with medication, scheduled primary care visits, and care plans.
Strategy 3: Expand access to integrated primary care services at the Winn Way facility by increasing the availability of a primary care provider team to 4 days per week in Year 1.
Strategy 4: Provide a range of health-related activities such as yoga, exercise, art therapy, and education on healthy eating habits

Description of Evidence-Based Practice

For this project, Claratel BH will utilize the Primary Care, Access, Referral, and Evaluation (PCARE) practice developed by Dr. Benjamin G. Druss, M.D., M.P.H., and his associates at Emory University in Atlanta.

The PCARE Evidence-Based Practice (EBP) was developed to integrate primary care into a mental health setting. PCARE utilizes an enhanced care coordination system to effect positive

change in clients' mental and physical health. As part of a primary care provider team, PCARE includes a Care Navigator and a Peer Navigator.

Scientific studies, such as that conducted by researchers at the State University of New York (SUNY) at Buffalo, back up what Claratel BH providers had noticed among clients: untreated primary care conditions often lead to premature death for clients with SMI. Many clients still fail to access primary care services despite access to referral providers. The SUNY study aimed to determine the effect of either a Peer Navigator, Care Navigator, or both on client access to care. Clients with the Care Navigator had a 71% connection rate to care, while those with a Peer Navigator connected at 63%. Those clients who had both a Care and Peer navigator connected at a rate of 93% (Griswold, Kim, MD, MPH, et al., "Access to Primary Care: Are Mental Health Peers Effective in Helping Clients After a Psychiatric Emergency?" *Primary Psychiatry*, 2010).

These Peer Navigators and Medical Case Managers (Care Navigators) form the critical parts of this EBP and will drive success in the planned model of care. In developing this model, Dr. Druss and his team found that peer navigators are crucial in improving the quality of care and access to care for clients, especially vulnerable clients, such as those with mental health issues. The navigators accomplish this because they "facilitate improved primary care in the community through a combination of advocacy, education, and helping clients overcome logistical barriers to care" (Druss, Benjamin, M.D, M.P.H, et al., "A Randomized Trial of Medical Care Management for Community Mental Health Settings: The Primary Care, Access, Referral, and Evaluation (PCARE) Study," *American Journal of Psychiatry*, 2010).

PCARE proved successful in improving the primary and mental health of participating clients. Specifically, this EBP showed improvements in care for cardiometabolic conditions, primary care access for participants, and mental health quality of life. The following data provide evidence of the EBP's effectiveness:

- 58.7% of participants received recommended preventive services, compared to 21.8% of non-participants
- 34.8% of participants received evidence-based service for cardiometabolic conditions compared to 27.7% of non-participants
- 71.2% of participants had a primary care provider compared to 51.9% of non-participants
- 8% of participants showed significant improvement on the SF-36 mental component summary compared to a 1% decrease for non-participants

Participants also showed better scores (6.9%) on the Framingham Cardiovascular Risk Index than non-participants (9.8%) (Druss, Benjamin, M.D, M.P.H, et al., "A Randomized Trial of Medical Care Management for Community Mental Health Settings: The Primary Care, Access, Referral, and Evaluation (PCARE) Study," *American Journal of Psychiatry*, 2010). The results demonstrating improvement in cardiovascular health are of particular importance, given the documented link between SMI and increased risk of heart disease and related conditions. This EBP will help Claratel BH work toward the goals of the Million Hearts initiative, such as those for reducing cholesterol and hypertension. EBP navigators will work to promote adherence to

proven clinical preventions emphasized by Million Hearts, such as aspirin therapy and smoking cessation.

The nature of this EBP makes it suitable for clients of all demographic groups. Claratel BH will train the Medical Case Manager and Peer Navigator to ensure proper care coordination. The Medical Case Manager will provide case management and coordination of client care, including counseling clients regarding medication therapies, organizing support groups, arranging referrals to community services, tracking and evaluating client progress, identifying barriers to progress, and developing solutions. The Peer Navigator will follow SAHMSA's description and expectations of behavioral health peer navigation ("Recovery Support Services: Behavioral Health Peer Navigator," SAMHSA, 2011, http://www.samhsa.gov/grants/blockgrant/BH_Peer_Navigator_05-06-11.pdf). By this description, the Claratel BH Peer Navigator will facilitate communication between the client and providers, coach clients to help them communicate with providers, and attend client referral appointments as needed. The Peer Navigator will also identify available resources; provide emotional support, health education, and referral contacts; assist in completing applications; educate family members regarding available resources and client needs; and submit regular reports on client progress.

Because of the importance of peer navigation in this model, Claratel BH will utilize Health and Recovery Peer (HARP) program training and materials developed by Dr. Druss and the research team at Emory University, the developers of the selected PCARE model. The HARP materials were initially designed to build on the Stanford Chronic Disease Self-Management Program (Lorig, Kate, RN, Dr.PH, et al., *Living a Healthy Life with Chronic Conditions*, Bull Publishing Company, Boulder, CO, 2006), which utilizes peer navigators to aid self-management for clients with chronic disease. Clients meet once a week for six weeks in workshops aimed to help them self-manage chronic disease. Two trained leaders direct the groups, while peer counselors, who also have a chronic disease and have worked through the program, also attend to assist new members. Instructors teach clients how to deal with problems such as pain, fatigue, and frustration associated with their condition; how to maintain appropriate exercise; how to use medications, how to communicate with their support group of family, friends, and health professionals; how to maintain proper nutrition; and how to evaluate available new treatments. Using their new learning, clients in the groups set self-management goals, and group members help each other meet those goals ("Chronic Disease Self-Management Program," Stanford University School of Medicine," 2012, http://clienteducation.stanford.edu/programs/cdsmp.html).

Also, Claratel BH will train staff to ensure culturally competent care for all clients, and the mental health center will seek to hire staff that reflects the cultural and racial demographics of the client population.

SECTION C: Proposed Implementation Approach

Health Home Service Implementation and Provision

To provide a health home for clients involved in this project, Claratel BH will implement several services, including primary and mental care provision, care management and coordination, health promotion, and recovery. The primary care provider and clinical staff ensure the provision of needed clinical services and proper direction on treatment plans. At the same time, the Medical Case Manager and Peer Navigator play a unique role in coordinating all aspects of client care and ensuring access to all needed services. Together, this team ensures a comprehensive Health Home for each client. Aspects of this Health Home include:

- Comprehensive care management

The Medical Case Manager and Peer Navigator, the primary care provider, will conduct comprehensive care management services,

a. Identification of high-risk individuals and use of client information to determine the level of participation in care management services;
b. Assessment of preliminary service needs; treatment plan development, which will include client goals, preferences, and optimal clinical outcomes;
c. Assignment of health team roles and responsibilities;
d. Development of treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions;
e. Monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines and;
f. Develop and disseminate reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery, and costs.

- Care coordination

Care Coordination is the implementation of the individualized treatment plan--with active client involvement--through appropriate linkages, referrals, coordination, and follow-up to needed services and supports, including referrals and linkages to long-term services and supports. Specific activities include but are not limited to appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes, and communicating with other providers and clients/family members. The primary responsibility of the medical case manager is to ensure the implementation of the treatment plan to achieve clinical outcomes consistent with the needs and preferences of the client. The Medical Case Manager and Peer Navigator will communicate and coordinate between primary care, mental care, referral providers, clients and providers, and ancillary services. The Medical Case Manager will also encourage and coach clients on self-management and adherence to treatment regimens.

Claratel BH will adapt and use parts of the Medical Home Practice-Based Care Coordination model developed at the Center for Medical Home Improvement to serve as a framework for care coordination. This model provides valuable tools and worksheets that ensure coordination across all aspects of care, including treatment, referrals, emergency services, transitional care, and community resources. The model utilizes the Plan, Do, Study, Act (PDSA) methodology and

standardized tracking instruments to ensure positive care coordination outcomes for clients, families, staff, and the agency. As listed in the model and tracked by the worksheets, these include the following:

Client outcomes
- Decrease in ER visits, hospitalizations, & school absences
- Increase in access to needed resources
- Enhanced self-management skills

Family satisfaction outcomes
- decrease in worry and frustration
- increased sense of partnership with professionals
- improved satisfaction with team communication

Staff satisfaction outcomes
- improved communication and coordination of care
- improved efficiency of care
- elevated challenge and professional role

Systems outcomes
- decreased duplication
- decreased fragmentation
- improved communication and coordination

While developed for youth with special health care needs, the designers formed the structure to allow for ready adaptation to adult clients as well (McAllister, Jeanne W et al., "Medical Home Practice-Based Care Coordination," Center for Medical Home Improvement," 2007).

- Health Promotion

Health promotion services shall minimally consist of providing health education specific to an individual's chronic conditions, development of self-management plans with the individual, education regarding the importance of immunizations and screenings, providing support for improving social networks and providing health-promoting lifestyle interventions, including but not limited to substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, and increasing physical activity. Health promotion services also assist clients in participating in the implementation of the treatment plan and place a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions. The primary care provider and care navigators will each participate in Health Promotion activities. The success of health promotion activities is enhanced by the wellness coaching and family education delivered by the Peer Navigator.

- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

In conducting comprehensive transitional care, the Medical Case Manager will provide care coordination services designed to streamline care plans, reduce hospital admissions, ease the transition to long-term services and supports, and interrupt frequent hospital emergency department use patterns. The Medical Case Manager will collaborate with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue the implementation of the treatment plan with a specific focus on increasing clients' and family member's ability to manage care and live safely the community and shift the use of reactive care and treatment to proactive health promotion and self-management. The primary care provider, Medical Case Manager, and Peer Navigator will all provide comprehensive transitional care activities, including, whenever possible, participating in discharge planning.

- Individual and family support, which includes authorized representatives (e.g., persons with power of attorney)

Individual and family support services include but are not limited to advocating for individuals and families and assisting with obtaining and adhering to medications and other prescribed treatments. In addition, health team members are responsible for identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and the community, including facilitating transportation to medically necessary services. A primary focus will be increasing health literacy, increasing each client's ability to self-manage care, and encouraging participation in the ongoing revision of each client's care/treatment plan. The Medical Case Manager and Peer Navigator will provide this service. The Peer Navigator, in particular, will organize the family support groups and provide health education to family members regarding client care needs and barriers to treatment adherence.

For individuals with developmental disabilities (DD), the health team will refer to and coordinate with the approved DD case management entity for services more directly related to habilitation and for services more directly related to a particular healthcare condition.

- Referral to community and social support services, including appropriate follow-up

The project will include an extensive referral system to ensure clients access all needed care. This will consist of referrals for medical specialists and dentists. Referrals will also link clients with needed community and social support services, including long-term services and supports, assistance for clients to obtain and maintain eligibility for healthcare, disability benefits, housing, personal needs and legal services, and others as needed. The Medical Case Manager and Peer Navigator will coordinate referrals and follow-up.

Client Recruitment and Retention

Claratel BH clients receive a total behavioral health and substance abuse assessment, and some receive a psychiatric evaluation during their first visit. All clients accepted at Claratel BH have been diagnosed with SMI. Initial admission screenings include questions regarding access to primary care. Case managers also screen current clients for primary care access and refer those without a primary care provider to the pilot integrated program. Staff collect and sort the screening data using the EHR system.

Since all Claratel BH clients have SMI, and most lack access to primary care, Claratel BH will initially recruit clients from its current client base. With over 8,000 clients in outpatient service, the Winn Way project will have ample eligible clients to meet requirements.

To identify clients for enrollment in the integrated program, Claratel BH clinical staff—including psychiatrists, nurse specialists, licensed social workers, and case managers—will select clients who request primary care referrals, lack a primary care relationship, or exhibit signs and symptoms of targeted chronic diseases such as obesity, hypertension, and diabetes.

The client population includes numerous sub-groups, such as pregnant women, children, and HIV/AIDS clients. The selection will include these, but Claratel BH will not target any specific sub-groups.

Once clinical staff identify eligible and willing clients, they will refer them to the primary care integration staff. The FQHC integrated primary care team will evaluate each client for primary care needs and determine appropriate interventions. The project Medical Case Manager and Peer Navigator will then meet with each client to define and coordinate proper support services, including referrals to hospitals, specialty care, transitional care, social services, labs, pharmacy, and other services. The Medical Case Manager and Peer Navigator will continue coordinating care throughout a client's treatment plan. After completing treatment, each client will be re-assessed and discharged or returned to care.

Meaningful Outcomes for Clients
Claratel BH also aims to achieve the following specific outcomes for participating clients:

- Increased access to primary care and integrated primary care, in particular
- Reduced morbidity and mortality
- Improvement in clinical measures such as BMI, blood pressure, and glucose levels
- Improved experience of care, including quality, access, and reliability
- Reduced per capita cost of care and overall cost of care
- Reduced rates of emergency room use
- Reduced in-hospital admissions and re-admissions
- Improved consumer satisfaction

Focusing on these strategic initiatives and related goals will improve the health outcomes and healthcare experience for clients served by Claratel BH. Work in these areas, and subsequent data collected will support research conducted by SAMHSA and further improve systems and services for a broad network of healthcare providers.

SECTION E: Performance Assessment and Data

Data Collection, Analysis, and Reporting
Claratel BH staff are experienced in using the EHR system, which will be used to collect the following clinical data.

- Blood pressure—quarterly
- Body Mass Index—quarterly
- Waist circumference—quarterly
- Breath CO—quarterly
- Plasma Glucose (fasting) and/or HgbA1c—annually
- Lipid profile (HDL, LDL, triglycerides)—annually

Clients to be Served by the program: 265-300

A. Personnel

Medical Case Manager: The Medical Case Manager will provide case management and coordination of client care, including counseling clients regarding medication therapies, organizing support groups, arranging referrals to community services, tracking and evaluating client progress, identifying barriers to progress, and developing solutions.

Peer Navigator: The Peer Navigator will facilitate communication between the client and providers, coach clients to help them communicate with providers, facilitate group interventions (HARP), and attend client referral appointments as needed. The Peer Navigator will also identify available resources; provide emotional support, health education, and referral contacts; assist in completing applications; educate family members regarding available resources and client needs; and submit regular reports on client progress.

These two positions will have a 25% productivity requirement to provide allowable billable services to State Contract or Medicaid. This revenue will partially supplement the position salaries.

Appendix A: Budget Proposal

Integrated Health Program

FTE	Personnel Cost	Salary + Benefits	Productivity Requirements 25%	
1.00	*Medical Case Manager*	$ 72,726	$ 18,182	
1.00	*Peer Navigator*	$ 51,400	$ 12,850	
2.00	***Personnel Total***			$93,094.50
	Medical Services			
	FQHC Contracted Services	$ 125,000		
	Lab work	$ 20,479		
	Medical Services Total			$145,479.20
	Client Benefits			
	YMCA Health Fitness Memberships	$ 7,000		
	Transportation	$ 10,500		
	Client Benefits Total			$17,500.00
	Operations			
	Staff Training	$ 8,000		
	Educational Materials	$ 1,000		
	Contracted Staffing	$ 4,000		
	Equipment	$ 8,500		
	IT and Software	$ 1,500		
	Admin Overhead/Indirect	$ 27,907		
	Operations Total			$68,407.37
	Program Cost			**$306,981.07**