Part I: Organizational Information	
Grant Number	D04RH23569
Grantee Organization	County of Nevada Health and Human Services Agency (HHSA)
Organization Type	County Behavioral Health Outpatient Services
Address	950 Maidu Avenue Nevada City, CA 95959-8600
Grantee organization website	http://www.mynevadacounty.com
Outreach grant project title	Healthy Outcomes Integration Team (HOIT)
Project Director	Name: Michael Heggarty, MFT
	Title: Interim Director HHSA
	Phone number: (530) 470-2562
	Fax number: (530) 265-9860
	Email address: Michael.Heggarty@co.nevada.ca.us
Project Period	2012 – 2015
Funding level for each budget period	May 2012 to April 2013: $150,000.00
	May 2013 to April 2014: $150,000.00
	May 2014 to April 2015: $150,000.00

Part II: Consortium Partners *Indicates consortium partners who signed a Memorandum of Understanding/Agreement		
Partner Organization	Location	Organizational Type
County of Nevada Health and Human Services Agency: Fiscal Department	Nevada City/Nevada County/California	County Government
Western Sierra Medical Clinic*	Grass Valley/Nevada County/California	FQHC
Sierra Family Medical Clinic*	Nevada City/Nevada County/California	FQHC – Look Alike
Community Recovery Resources*	Grass Valley/Nevada County/California	Substance Use Treatment Program
Common Goals, Inc. *	Grass Valley/Nevada County/California	Substance Use Treatment Program
Sierra Nevada Memorial Hospital*	Grass Valley/Nevada County/California	Hospital
Turning Point Community Programs	Grass Valley/Nevada County/California	Mental Health Outpatient Program

Part III: Community Characteristics

A. Area

The County of Nevada Health and Human Services Agency's program, Healthy Outcomes Integration Team (HOIT) provides services to a rural county in Northern California: Nevada County.

B. Community description

The needs of the community include improved access to health care services; coordinated services across health and behavioral health care (which includes mental health and substance use services); and integrated treatment planning to improve health outcomes. One of the most significant health factors in Nevada County is the high rate of suicide. Nevada County has a rate of 23.1 suicides per 100,000 population compared to 9.9 per 100,000 Californians statewide. There is also a large number of older adults, with over one-third of the population 55 years of age and older. This aging population presented opportunities for HOIT to promote health and well-being and ensure easy access to health and behavioral health services. Many of these older adults do not have a history of utilizing behavioral health services, but life experiences place them at a higher risk for depression, anxiety, and other mental health disorders, or substance use as a result of depression or prescription drug use for pain management.

C. Need

Persons with a Serious Mental Illness (SMI) often have multiple health conditions. These health conditions may impact their mental illness and prevent them from achieving wellness and recovery. These individuals also need and/or benefit from a person-centered health care system that addresses their health care, mental health, and substance use issues. HOIT was designed to develop the capacity to deliver bi-directional, integrated health care services by co-locating primary care services at the Nevada County Behavioral Health (NCBH) clinic, as well as co-locating behavioral health services, including psychiatric services, at the FQHCs to meet the needs of clients. In addition, HOIT was designed to link individuals and their families to needed services, including substance use services in the community.

Part IV: Program Services

A. Evidence-based and/or promising practice model(s)

HOIT implemented a modified version of the IMPACT model, an EBP, to assist in the coordination of a person-centered health care home and coordinated health and mental health services for persons with a SMI and had chronic health conditions. HOIT utilized a full-time Registered Nurse (RN) to coordinate services between the FQHC primary care providers and the mental health psychiatry and outpatient mental health services for persons enrolled in the program. The HOIT RN and NCBH Clinical Team Leader met weekly with the FQHC RN and FQHC Primary Care doctor to create a Health Care Home and coordinate services for clients receiving services. This team coordinated and reconciled medications for the clients, and coordinated care to ensure physical health and behavioral health and conditions were addressed and monitored.

Also consistent with the IMPACT model, the project also hired three (3) part-time Service Coordinators to help coordinate care, provide case management, and link clients to needed services including accessing substance use services and other resources in the community. The RN and Service Coordinators coordinated services, offered health and wellness activities, and assisted clients understand how to manage their chronic health conditions; reduce use of tobacco; and develop skills in nutrition, shopping, and healthy meal preparation. The HOIT staff ensured that the client (and their family members, as feasible) was an active participant in all aspects of their health care plan. These activities promoted integrated, person-centered care, helped individuals achieve healthy outcomes, and helped ensure that each client and their family members were actively involved in the treatment.

B. Description

The focus of this outreach program was to identify adults ages 18 and older with an SMI who also have chronic health conditions, or are at risk of chronic health conditions. Once identified, the individual was linked to primary health care services, and specialty health services, as needed. A thorough assessment for both health and mental health (including lab work) provided a comprehensive baseline for identifying the needs of the individual. Based on this assessment, HOIT staff worked with each client to 1) identify a person-centered health care home; 2) develop a written Wellness and Recovery Action Plan (WRAP) to support clients in achieving positive health outcomes; 3) ensure they were enrolled in the needed services including health, mental health, and substance use services.

An Individual Wellness Report (IWR) was also developed for each individual, which provided an easy-to-understand display of core health indicators that included carbon monoxide level (indicates impact of smoking); Body Mass Index; Blood Pressure; Blood Sugar (diabetes); and Heart health (Cholesterol). The IWR compares the individual's score on these health indicators with standard measures, and color codes their values (green – good; yellow – caution; red – at risk). Clients then identified which health indicators that they wanted to address and staff linked them to workshops, classes, and activities to support them in meeting their goals.

The HOIT RN and HOIT Clinician worked closely with the RN from each FQHC to coordinate care. The HOIT project greatly enhanced communication between organizations. Initially, staff from each organization felt that they didn't have time for a weekly meeting. Within about two weeks of meeting, staff began to understand the value of coordinating care, identify all of the medications a client was taking (or not taking), and who was prescribing each medication. By creating a health home and sharing information across organizations, clients received coordinated services and care. Within the first month of the grant, the FQHC nurses and physician were calling to coordinate services throughout the day, for shared clients. The FQHC Primary Care Physicians who worked with HOIT participated in the many of the calls and fully supported this health integration model.

Our initial goal was to co-locate primary care inside the building of the Nevada County Behavioral Health program. Upon further review of the extensive change of scope and necessary California licensing changes, the FQHC found that it was too time consuming to make this strategy cost effective. However, they were creative and met the goal by driving their mobile van (which is licensed to deliver primary care services anywhere in the community) to the parking lot of the NCBH clinic. Clients were able to receive services just outside the front door of the clinic, and felt welcomed by the Primary Care Physician.

The HOIT RN provided medication support and education to the clients; conducted the health assessment at admission, every six months, and at discharge; and offered educational workshops at the clinic and local wellness centers. She filled medication caddies for several of the clients to help them manage their medications and take them as prescribed. She closely monitored all lab results and follow-upped with abnormal levels. She was always available to answer questions, and celebrated success. She worked closely with the HOIT Service Coordinators, psychiatrists, and primary care staff to coordinate services and activities. She updated the psychiatrist and Primary Care Physician on changes in medications and side effects. She also coordinated prescriptions with the pharmacy and coordinated services with local Primary Care Physicians in the community.

The HOIT Clinician provided therapeutic oversight to the team, conducted assessments, and managed client care. The Service Coordinators provided support to clients, facilitated wellness activities, linked clients to needed services, provided training, and served as ambassadors for the client, to help them navigate the system. They accompanied clients to appointments, helped them get signed up for services, and provided transportation, when needed, to ensure that clients were able to access health services. The Service Coordinators served as the client's voice at appointments, their coach and mentor, their social support system, and cheerleader to celebrate every step of their successes.

C. Role of Consortium Partners

At the beginning of the project, there were five organizations in the consortium who were actively involved in planning and implementing HOIT, with NCBH as the lead agency. Western Sierra Medical Clinic, a Federally Qualified Health Center (FQHC), and Sierra Family Medical Clinic, an FQHC Look-Alike, participated in all of the planning meetings, developed the concept for the HOIT project, developed the grant, and implemented components of the goals. The two substance use treatment agencies, Community Recovery Resources (CoRR) and Common Goals, were also actively involved in all aspects of planning and implementing the project.

Upon grant funding, NCBH developed a Request for Proposals and hired Turning Point Community Programs as the contract organizational provider. Turning Point worked closely with NCBH to develop the job descriptions. NCBH and Turning Point collaborated to interview and hire the HOIT staff and begin implementing the goals of the grant. Turning Point/HOIT staff provided the core services for clients. The partnership between NCBH and Turning Point was seamless and clients were unaware of the difference in staff employed by Turning Point and those employed by NCBH.

The FQHC RN and Primary Care Physician helped clients navigate access to health care, linked them to the appropriate physician, helped the clients navigate the FCHC health care system, and participated in weekly (and more frequent) calls to reconcile medications and coordinate services across health, mental health, and substance use treatment.

The two substance use treatment providers, CoRR and Common Goals coordinated services across programs. This coordination helped clients receive services for their co-occurring disorders and support clients in their recovery from substances.

The local hospital, Sierra Nevada Memorial Hospital, located in Grass Valley, is an important partner in the system of care. SNMH operates the Emergency Department which treats individual in crisis and is the first point of contact for individuals who need to be hospitalized for a psychiatric emergency. SNMH and NCBH have developed a close working relationship. When clients are in crisis, the crisis is deescalated whenever possible. SNMH and NCBH have a new grant to develop a Crisis Stabilization Unit on the grounds of the hospital, which will provide an additional level of support for our clients.

SPIRIT Peer Empowerment Center also had a significant role with HOIT clients. SPIRIT is a peer-run center that had created a healthy community that is open at no charge to people facing challenges to their mental health. They have a number of trained peer counselors who offer a holistic approach, acceptance, support, education, and advocacy. They support people as they identify their path to recovery, and empower themselves to achieve their personal goals. Many of the wellness activities offered to

HOIT clients were held at SPIRIT. This relationship created a strong system in our community to support clients, and provide additional peer support to help clients achieve their health and wellness goals.

In the first year of implementation of the grant, these organizations worked together to develop a Memorandum of Understanding (MOU). This MOU outlined the roles and responsibilities of each organization, discussed confidentiality and shared services, and created the foundation for developing person-centered health care homes for shared clients. It also outlined data sharing, exchanging electronic health records, and sharing meaningful use data on primary care, mental health, and substance use treatment services. The partnership and collaboration was outlined to ensure that HOIT services met the needs of shared clients. As a component of this MOU, a Release of Information was developed to allow the organizations to share information on mutual clients.

Part V: Outcomes

A. Outcomes and Evaluation Findings

A number of health outcomes were measured on this project. These outcomes included the number of HOIT clients who had an identified person-centered health care home; the number who had a written Wellness and Recovery Action Plan (WRAP); the number who received health care, mental health care, and substance use treatment services; and the number who showed improvement on health indicators.

System outcomes included: co-locating of FQHC primary care services at the NCBH clinic and behavioral health services at the FQHCs; implementing an evidence-based practice (EBP) called IMPACT; developing the capacity to collect and share health information on key health indicators between members of the consortium; and developing shared data reports to track outcomes and improve services over time.

There were 84 clients enrolled in HOIT. All 84 clients now have a person-centered health care home, 100% developed a WRAP plan, and all received health and mental health services. In addition, approximately 20 % received substance treatment services. The majority participated in services at SPIRIT Wellness Center.

The HOIT project had a significant impact on crisis and inpatient services for clients enrolled in the program. Crisis Services: Nearly half (45%) of all HOIT clients (38 of the 84) received crisis services while enrolled in HOIT. Following discharge from the program, only 26% of the clients received crisis services (12 out of 46). Inpatient Services: Only 3.5% of all HOIT clients (3 out of 84 clients) were admitted to psychiatric inpatient hospitals while enrolled in HOIT. Following discharge, only 2% (1 out of 46) were hospitalized. This clearly illustrates the impact of HOIT on the lives of our clients while in the program, and after discharge.

The health outcomes achieved for clients enrolled in HOIT are also outstanding! For clients who had a baseline score of "At Risk" on a heath indicator when they enrolled in HOIT:

- 78% showed improvement on their Systolic Blood Pressure;
- 86% showed improvement on their Diastolic Blood Pressure;
- 33% reduced their Body Mass Index;
- 40% improved their Fasting Plasma Glucose;
- 50% improved their Hemoglobin A1C;
- 67% improved their Total Cholesterol; and
- 63% improved their Triglycerides.

Of the individuals who smoked at admission, 87% showed an improvement in their Breath Carbon Monoxide Measurement. These results truly demonstrate the impact of HOIT on improving the health outcomes of clients with a serious mental illness.

HOIT arranged for clients to have free gym memberships. The client was required to attend the gym at least 10 times a month (as evidenced by information from the gym). This requirement resulted in a huge incentive to keep their membership. Some clients use the gym every day to swim, use the workout equipment, and participate in classes. One of the important successes of these gym memberships is the reduction in stigma for our clients. HOIT clients are working out with members of the community, which

helps to reduce stigma and also helps the client feel comfortable as one of the citizens of the town. We have seen an increase in self-confidence, improved health outcomes, and participation in other community events.

Client Success Stories

"Elise" has dementia, severe symptoms of agoraphobia, and Seasonal Affective Disorder (SAD). She has been inside a lot this winter, declining most offers of outings, groups, or support, descending into depression and confusion. Her Service Coordinator arranged for Elise to have an In-Home Support Services worker start coming to her home, to help her with daily activities. Elise is also using the free LifeLine phone that HOIT obtained; this program helps Elise call family members who had been worried about her. Her Service Coordinator helped her to visit SPIRIT to obtain a box of groceries from their food pantry, as she frequently forgets to buy groceries or to eat regularly. While at SPIRIT, she reconnected with an old friend who remembered when Elise volunteered at SPIRIT as a Peer Counselor, where Elise even cut hair for the participants since she had been a beautician. Her Service Coordinator reports, "Elise picked up a free book to read and is wearing the biggest smile that I have seen in months."

One middle-aged male client had a problem with angry outbursts and threatening behavior. He was also having a hard time making friends. HOIT provided him with a gym membership and supportive weekly contacts with his Service Coordinator. The client has since been working out at the gym at least 3 days each week. His anger has been reduced; he has lost weight; and he feels fitter. He also reports making friends at the gym and feeling an increase in positive mood.

The motto at SPIRIT Peer Empowerment Center is "Together we change lives." We do this at HOIT too!

B. Recognition

There have been local newspaper articles highlighting our clients' successes. For example, there was an article about one of our clients stopping smoking. The HOIT project was nominated for an award by the California Behavioral Health Director's Association. Many counties in California are implementing Health Care Integration activities and are utilizing our Individual Wellness Reports and other components of our program. Staff from other counties frequently call to learn more about the HOIT activities, and obtain examples of our MOU and Release of Information. The HOIT RN obtained support from the NCBH Workforce Education and Training (WET) funds to partially pay for her nursing degree.

Part VI: Challenges & Innovative Solutions

The biggest challenges to implementing HOIT and how they were addressed are outlined below:

- Co-locating FQHC services at NCBH
- Sharing Electronic Health Record (EHR) information between consortium members
- Improving access to care for the most remote communities

Co-locating FQHC services at Nevada County Behavioral Health. FQHCs have federal regulations and certification for the type and location of services offered. FQHCs need to complete a Change of Scope request to deliver services outside of their initially-certified site location. In addition, California has certain requirements in their licensing for changing the location of services. These regulations results in months of effort to obtain a change of scope and licensing. After initially reviewing the application process, Western Sierra Medical Clinic (WSMC) determined that the optimal method for delivering primary care services to NCBH clinic was to utilize their mobile van. As a result, WSMC did not need to apply for the Change of Scope request. This decision saved time and money, and provided co-located health care services at our clinic.

The mobile van arrived at each clinic one morning per week. The HOIT RN and Service Coordinators scheduled HOIT clients in 30 minute intervals to be seen by the Primary Care Physician and nurse. The HOIT RN was also available to the van medical team to coordinate care and communicate information from a behavioral health perspective.

Sharing EHR information between consortium members. It was our goal to develop and/or modify existing electronic health records (EHR) to achieve interoperability and be able to exchange health information to meet Stage 1 Meaningful Use Specifications. It was also our goal to identify middleware to allow the integration of data from different systems. While there are several larger counties in California with Health Information Technology grants who have been working to develop this interoperability, it was too big of a project for this project. During the three years of funding, NCBH and WSMC both purchased

and implemented new EHR systems. Both systems are able to meet Stage 1 Meaningful Use Specifications, and are able to fax prescriptions across organizations. Unfortunately, these two EHR systems are not able to achieve interoperability at this time. It is still a goal across California to develop this capacity. We will work closely with the counties that are able to implement this standard, and learn from them as they achieve this goal. Fortunately, the NCBH software system, *Anasazi*, is working with one of these grant-funded counties. Their experience will benefit us in achieving this goal and resolving this barrier.

Improving access to care for the most remote communities. The geography of Nevada County creates significant barriers to services for the eastern part of the county. During the winter, snow frequently closes the highway and prevents travel. The HOIT staff have worked to assist persons in remote locations to access health and behavioral health services from the most convenient provider. We also utilize Telemedicine and Telepsychiatry to improve access to health care services, whenever possible. Currently, there is a small health care clinic and behavioral health services in Truckee. In instances where a HOIT client near this location needs additional primary care or behavioral health services, the HOIT team have been able to link the client to needed services to these sites.

Part VII: Sustainability

A. Structure

Our consortium will continue. We continue to meet periodically to support the enhanced collaboration and coordination between the agencies. It is now routine for the FQHC(s) and NCBH to coordinate services and reconcile medications for shared clients. Shared collaboration between NCBH and the two Substance Use Treatment programs (CoRR and Common Goals) also occurs on an ongoing basis. Turning Point will continue to have a contract with NCBH to employ an RN and Service Coordinators. The SPIRIT Peer Empowerment Center will continue to support wellness and recovery activities and coordinate services with NCBH. SPIRIT also has a contract with NCBH to provide Crisis Peer Counselors to support clients when they are in crisis and need additional support.

Sierra Nevada Memorial Hospital will continue to work closely with the consortium and develop additional services with NCBH. NCBH obtained additional funding to develop a Crisis Stabilization Unit at the hospital. This fully supports the goals of this grant and the consortium, and promotes coordination and collaboration across clients and organizations. This program will help reduce crisis and inpatient service utilization for clients.

B. On-going Projects and Activities/Services To Be Provided

__✓__ All elements of the program will be sustained

____ Some parts of the program will be sustained

____ None of the elements of the program will be sustained (i.e. the program will completely end after the grant period)

The HOIT health integration activities will continue to be sustained. The FQHC RN, HOIT RN, Service Coordinators, and NCBH Clinical Team Leader and Clinician will continue to work together to coordinate care and improve access to services. These positions will continue to be funded through Medicaid reimbursement of services. All agencies coordinate services for shared clients. Similarly, clients will continue to access wellness and recovery services at the SPIRIT Peer Empowerment Center.

As mentioned above, Sierra Nevada Memorial Hospital will continue to serve clients in their Emergency Department as well as through the development of a Crisis Stabilization Unit, which will operate to reduce the number of crisis services and inpatient service utilization for clients. NCBH obtained California funding through the California Health Facilities Financing Authority to construct this Crisis Stabilization Unit.

C. Sustained Impact

The vision and success of this Health Integration project will have lasting effects on this county and the way in which services are coordinated across agencies. As a result of this project, there has been a change in the range of services delivered by the NCBH program. The focus on the "whole person" is evident across the agency. Staff have learned how to understand and support clients to manage their chronic health conditions, link them to physical health care services, and offer wellness and recovery

services to improve health outcomes. These values and skills are used across the continuum of care and evidenced by all providers, including psychiatrists, nurses, clinicians, and Service Coordinators (Case Managers). Clients have been empowered by learning about their health conditions and are actively managing their chronic health conditions. These changes are also evidenced by the exciting improvement in health outcomes from the project.

The Rural Health Grant has been instrumental in creating a strong foundation to allow us to obtain additional funding to expand our Crisis Continuum of Care. In 2013, California legislation passed Senate Bill 82, which created two new funding opportunities to expand crisis mental health services across the state. Nevada County successfully obtained funding from both funding sources. The first funding opportunity supports Nevada County HHSA to expand our mental health crisis services to locate crisis workers in the Emergency Department of the local hospital 24/7. Prior to this funding, crisis workers were on-call, but needed to travel to the ED to conduct the crisis assessment. This co-location at the hospital allows immediate crisis response and supports the crisis worker to help resolve the crisis in a timely manner.

In addition, Crisis Peer Counselors have expanded hours when they are available to come to the ED and support clients and their families during the crisis situation. This strategy creates a more welcoming environment while the client is in the ED. This funding is also being used to develop a Peer Run Respite Center. The four-bed Respite Center is available for individuals to have a home-like, welcoming place to stay for up to 28 days. The Respite Center staff will help create a safe place where individuals can resolve a crisis, receive supportive services after discharge from the psychiatric inpatient hospital or ED, and/or prevent the need for crisis services.

The second funding opportunity for the HHSA has created a mental health Crisis Stabilization Unit (CSU) on the grounds of the local hospital, adjacent to the ED. The CSU also expands the Continuum of Crisis Services for our county, to help prevent an individual's admission to a psychiatric hospital. Nevada County does not have a psychiatric inpatient hospital in-county, so all clients who are hospitalized need to be transported to other counties. By having a CSU, many clients will be able to resolve their crisis locally and not need to be hospitalized. Individuals from the CSU can also be discharged to the Respite Center, to further support their recovery.

Part VIII: Implications for Other Communities

HOIT offers an excellent model for other small, rural counties to utilize in integrating health, mental health, and substance use services to improve health outcomes for adults with an SMI. The HOIT program has outstanding strategies for other counties to use, including the HOIT Memorandum of Understanding, Multi-Agency Release of Information, and Individual Wellness Reports. These documents provide methods and policies for referring clients; sharing electronic health care information; tracking health indicators across providers; protecting confidentiality; and celebrating healthy outcomes for clients and the health care system. All data collection forms, policies, and models for outcome reporting are available to other communities to utilize and modify to meet their needs.