

Navos Overview



David Johnson
CEO

Navos is a \$62 million, 640 employee non-profit organization founded in the 1960s.

We are one of the largest community behavioral healthcare organizations in the state of Washington.

Agency Overview



We are licensed both as a community mental health center and as a chemical dependency treatment organization.

We also provide housing for over 300 people in our apartment buildings and family sized homes because it is often difficult for our population to secure safe, decent and affordable housing.

Agency Overview



We are proud to focus many of our services on people who have serious mental and emotional illnesses (and often substance use disorders) who often live in or near poverty because of the poor functioning resulting from those illnesses.

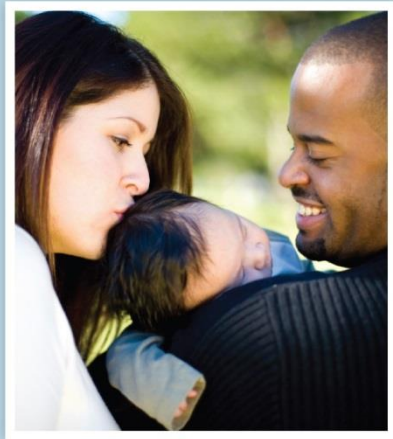
Agency Overview



We have a 70 bed free-standing psychiatric hospital in addition to the full continuum of services for children, adults and older adults.

Our intensive inpatient services serve involuntarily committed adults deemed to be at imminent risk of harm to themselves or others or who are so gravely disabled that they are at risk of death.

Service Overview



1 in 5 children
has a
diagnosable
mental, emotional or behavioral disturbance.

Our youngest client ever was five weeks old in our Infant and Early Childhood mental health program.

Our oldest client ever was over 100 years old in our nursing home consultation and treatment program.



The difference between life and living.
WWW.NAVOS.ORG

Child, Youth & Family Services

Outpatient Services



School-Age Services (age 5 – 21) in office, home, community and schools

- Currently providing school-based services in 50 schools in both the Highline and Seattle School Districts
- Includes both mental health and substance abuse services
- Individual, family and group therapy as well as case management services are available

Adult & Older Adult Outpatient Services



Adult Services

- Serving over 1350 clients
- Walk-in times open every day
- Outreach to engage hard to engage individuals
- Psycho-educational groups
- Staffed with Peer Support Specialists, Bachelor's and Master level clinicians and graduate level interns



Public Health
Seattle & King County



*Primary & Behavioral Healthcare
Integration:
Promising & Measurable Outcomes*

**A Partnership of Navos
and
Public Health—Seattle & King County**

Navos' Integration Services

- › Integrated services are provided both onsite at our Navos campuses and through Navos staff embedded in other organizations
- › Partners include
 - › Public Health of Seattle and King County
 - › NeighborCare Health
 - › Neighborhood House
 - › Highline Medical Center
 - › Northwest Kidney Center
 - › Genoa Pharmacy

SMI population's life expectancy is 13 to 25 years less than the general population and for the many that also have a SUD, it is even grimmer

Our goal is to develop a model that produces **positive outcomes** and is **financially sustainable**

Partnership model with *Public Health—Seattle & King County* as our primary care partner

Developing a **health home** for the SMI population served at Navos

- One stop shopping
- Patient-Centered Health Home
- Collaborative Care Model
- Wellness Program



Our One Stop Shop



Co-Location



Full Integration

- One stop shopping
- **Separate care teams**
- **Separate health records**
- **Separate treatment plans**
- Opportunity for **curb side consultation**
- Improved (but still limited) **communication** between primary care and behavioral health providers
- Improved **referral arrangements** between primary care and behavioral health providers

- One stop shopping
- **One care team**
- **One health record**
- **One treatment plan**
- Population focused **care coordination and management using a patient registry and 'Treat to Target'** to manage treatment
- Seamless referrals and transfer of clients between behavioral health and primary care



Mental Health and Wellness Center



Shared Reception



Exam Room



Staff Work Area



Collaborative Work Area



Our Model

- **Partnership with an FQHC** having a shared mission and experience with a similar population
- **Full scope primary care** services operating as part of a **collaborative care team** with behavioral health clinicians
- **On-site primary care** operating 4 days per week
- **Staffing**
 - › **Nurse Care Manager**
 - › **Family Practice Physician and Nurse Practitioner**
 - › **Medical Assistants**
 - › **Reception and referral staff**
- **On-site lab and pharmacy**
- **Wellness Program**
 - › **Smoking Cessation**
 - › **Exercise**
 - › **Nutrition**

Exercise



- Groups/classes
 - › **2 walking groups** led by our Peer Specialist and Nurse Care Manager
 - › **Yoga group** led by a Certified Yoga Instructor who is also a Licensed Therapist
 - › **Exercise group** provided on-site at the MHWC through a **partnership with the SeaTac YMCA**, designed for clients looking to increase physical activity, lose weight and improve overall physical fitness and emotional wellness. Class consists of a low-impact cardiovascular workout, body strengthening and stretching tailored to the needs and fitness level of the group.
 - › **Referrals** from case management, psychiatry and primary care

Nutrition



- Adequate nutrition is a significant problem in this population and one that significantly impacts an individual's physical and emotional well-being.
- **Cooking class** provided on-site at the MHWC through a **partnership with the Solid Ground Cooking Matters Project** (and funded through the federal SNAP-ED Program), this class provides nutrition education, meal preparation, recipes, weekly bag of groceries and a hands on experience of shopping for nutritious food on a budget
- **Referrals** case management, psychiatry and primary care

First Collaborative Care Pilot

- **Target population**—individuals living with depression along with diabetes, hypertension and/or obesity
- **Treat to Target**—measurable outcomes
 - › PHQ-9
 - › HbA1c
 - › LDL
 - › Blood pressure
 - › BMI
 - › Housing stability
 - › Tobacco



- **Team Care Structure and Process**—Care Manager, Primary Care, Psychiatry, Nursing and Case Management
- **Patient Registry**

Navos/Public Health organizational structure better supports integration

Went through several iterations, then launched Team WIN

Navos/PH Joint Leadership team – responsible for oversight and direction-setting

- Senior leader, medical director and manager from each organization

Integrated Service Delivery team (ISD) - Responsible for on-the-ground integration activities

- Supervisors, med staff, program managers
- Use Lean tools
 - Fishbone (patient focus group)
 - PDCA cycles

Reducing ED use – Phase 1

Why focus improvement efforts there?

- Better care for patients, traction with MCOs, possible overall decrease in health care costs
- Patient survey
 - Few knew about PH's after hours call line
 - Lack of knowledge of urgent care option
 - Few received follow-up call from either primary care or behavioral health after ED visit

After Hours Emergency Number

For clients of NAVOS Mental Health Solutions

Your emergency after-hours number for Behavioral Health is

Adult: 206-248-8227

Always call 911 in a life threatening emergency



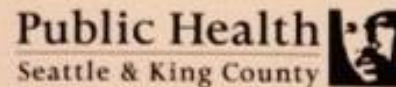
After Hours Emergency Number

For clients of the PUBLIC HEALTH CLINIC at Navos

Your emergency after-hours number for Medical Concerns is

206-257-6870

Always call 911 in a life threatening emergency



ED use reduction – Phase 2

We knew we needed to do more

Literature review supports case management as an effective strategy to reduce ED utilization

Team WIN – “Wellness Integration at Navos”

Nurse Care Manager position (NCM) grant-funded by Pacific Hospital Preservation and Development Authority (PHPDA)

Multi-disciplinary team convened by NCM

Why this structure?

- Literature supports multi-disciplinary team with involvement of PCP, supportive services
- BH Case Managers not equipped at this time to do holistic care management. We are training up to move from Case to Care Managers

Team WIN

NCM activities

- Coordinated development of a whole team common care plan
- Office visits
- Telephone follow-up
- Connection with BH providers

Surprise! Not everyone who goes to the ED has an emergent medical issue

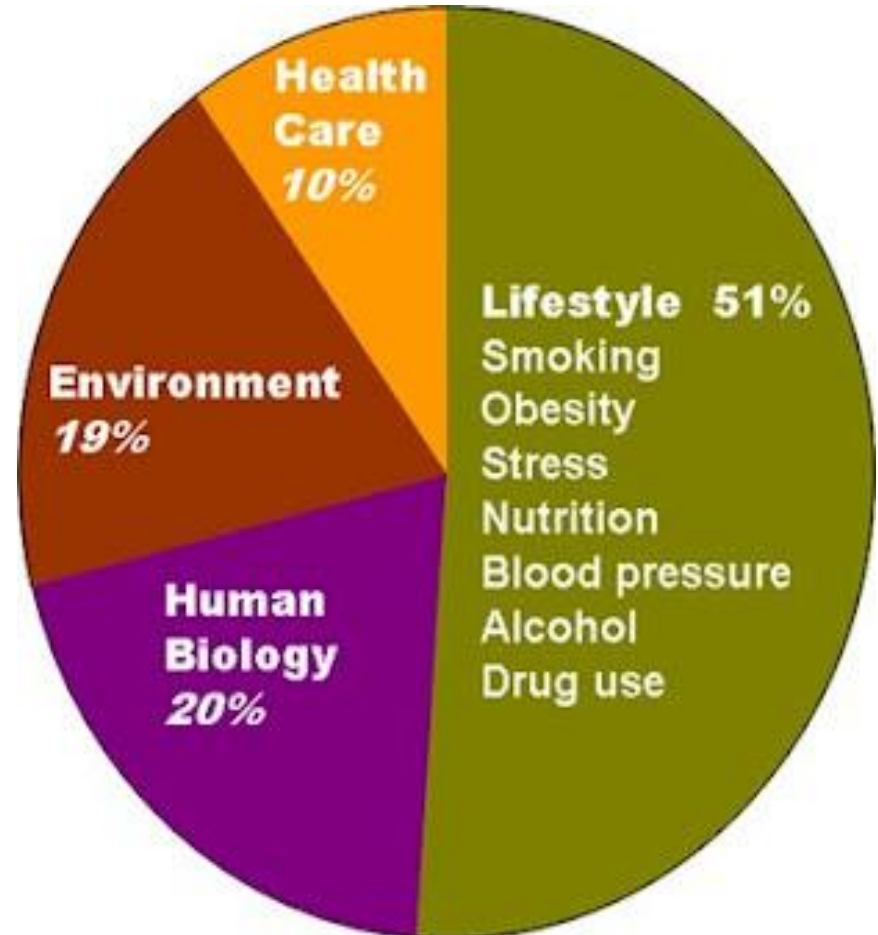
So we added an outreach worker from Evergreen Treatment Services' REACH program (funded by Healthcare for the Homeless Network)

Housing affects ED utilization

We are using Edie to track and analyze use of the Emergency Department

Determinants of Health

- Lifestyle 5 times more important than access to medical care



Wellness Program

Nutrition and meal preparation

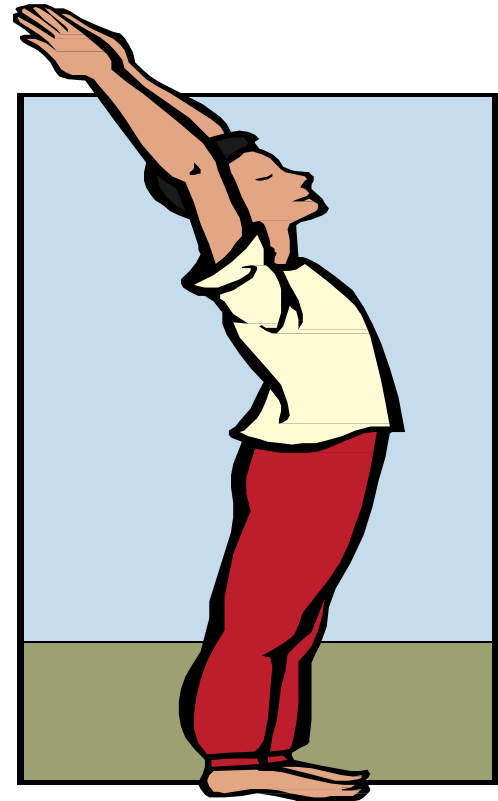
- Cooking Matters

Stress Management

- Yoga
- Meditation

Chronic Disease Self-Management

- Diabetes
- Chronic pain



Phase 2 Plan

- **Develop robust Wellness Program that is data driven and supports clients in adopting healthy behaviors and managing their chronic illnesses (quit smoking, exercise and nutrition)**
- **Develop and implement a Collaborative Care Model and culture that produces positive outcomes**
- **Further develop our model of care in this (reverse integration) setting that is consistent with the elements of a Patient-Centered Health Home**
 - Patient Panels
 - Continuous Team-based Healing Relationships
 - Patient Centered Interactions
 - Engaged Leadership
 - Quality Improvement Strategies
 - Enhanced Access
 - Care Coordination
 - Organized Evidence-Based Care

Physical Health Profile at Baseline

- **Fasting Plasma Glucose**

- › < 100 61%
- › > 100 39%

- **LDL**

- › < 130 74%
- › \geq 130 26%

- **Blood Pressure**

- › Normal 29%
- › Pre-hypertensive 49%
- › Hypertensive 22%

- **Tobacco users 61%**

- **BMI**

- › < 25 20%
- › 25-29.99 28%
- › \geq 30 52%

- **Stable housing 59%**

Physical Health Outcomes

Change from Baseline to 6 Month Interview

March, 2014

	Outcome Improved	No Longer At-risk
Blood Pressure	13.2%	14.1%
BMI	44.5%	1.8%
HgbA1c	insufficient data	
LDL	insufficient data	

Social/Emotional Health Outcomes

January, 2014

	Positive at Baseline	Positive at 2nd Interview	Percent Change
Functioning: <i>Were healthy overall</i>	36.2%	42.7%	17.9%
Functioning: <i>Were functioning in everyday life</i>	39.2%	43.8%	11.8%
Functioning: <i>No serious psychological distress</i>	55.0%	66.5%	21.0%
Functioning: <i>Were not using tobacco products</i>	41.8%	42.3%	1.2%
Functioning: <i>Were not binge drinking</i>	96.6%	96.0%	-0.6%
Retention: <i>Retained in the Community</i>	84.7%	86.2%	1.9%
Stability in Housing: <i>Had a stable place to live in the community</i>	62.1%	63.7%	2.5%
Education/Employment: <i>Were attending school regularly and/or currently employed/retired</i>	13.0%	17.2%	32.0%
Crime and Criminal Justice: <i>Had no involvement with the criminal justice system</i>	99.4%	99.4%	0.0%
Perception of Care: <i>Client perception of care</i>	NA	84.4%	NA
Social Connectedness: <i>Were socially connected</i>	50.8%	56.1%	10.5%

Outcomes

What the research tells us about outcomes:

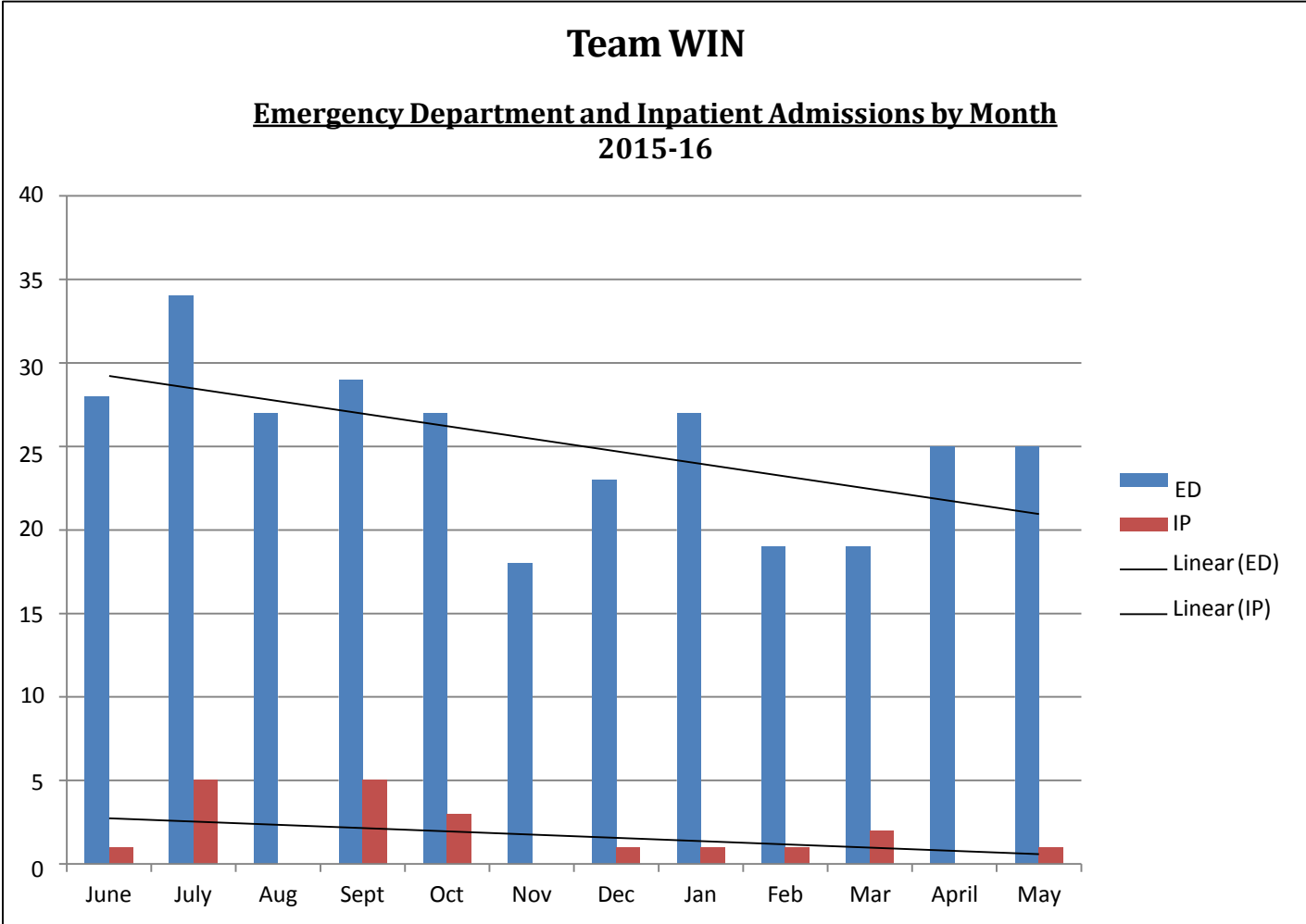
- Case management and home services reduced ED use in diverse populations
- May not see gains in a short period of time
 - Engagement and behavior change takes time, especially in patients with BH or SUD issues

Next Interventions

From June 2015 to May 2016 we implemented the following strategies in Team WIN clients to impact outcomes:

- Added 1:1 time with a peer each week
- Added a group to support the work toward the client's goals
- Increased meetings between primary care and outpatient case management staff
- Increased visits with the primary care team
- Increased check-ins with the Nurse Care Manager

Outcomes



What we have learned

What made the “successful” clients successful?

- Housing first
- Engagement with care providers - connectedness
- Progress is often slower with our population
- Flexibility to go serve and educate people in their home

What we will be testing next

Work with MCOs

- Using claims data to target high utilizing members
- Exploring Health Home designation with multiple MCOs – BH CMs would be Care Managers

Course correction with Team WIN

- More involvement with individual CMs
- Considering including non-PH clients in Team WIN

Stories from the Field

What are behavioral health staff saying about the primary care treatment team?

- ❖ **‘People who had never been able to see a doctor for a variety of reasons, now were able to get good medical care’**
- ❖ **‘We are able to have a tighter circle of support for clients by having primary care as part of our team and services’**
- ❖ **‘This partnership allows us to better manage our clients who have unique and complex needs without further hospitalization’**
- ❖ **‘They are wonderful...the best thing ever!’**
- ❖ **‘Clients love them and the fact that they can get everything in the same place...’**
- ❖ **‘I can walk over and talk with them whenever I need to. There is real collaboration.’**
- ❖ **‘They even deal with our difficult clients. I just don’t think that there can be a better thing than having Primary Care with us.’**