



# *Community Health and Wellness*

*Mobile Integrated Healthcare Partnered  
with Supportive Housing*

*A Collaboration of the William K. Warren Foundation and  
The Mental Health Association Oklahoma*

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Mental Health Association Oklahoma

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Medicine

**buildinglives**  
preventing mental disorders promoting wellness

# Cedars Apartments



# Brighton Park Apartments





# Sheridan Point



# Baltimore Apartments





# Walker Hall Apartments



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# Altamont Apartments





# The Bradstone Apartments





# Indianapolis Apartments



# Terrace View Apartments





# Belle Arms Apartments



# Ranch Acres Manor





# Charan Apartments

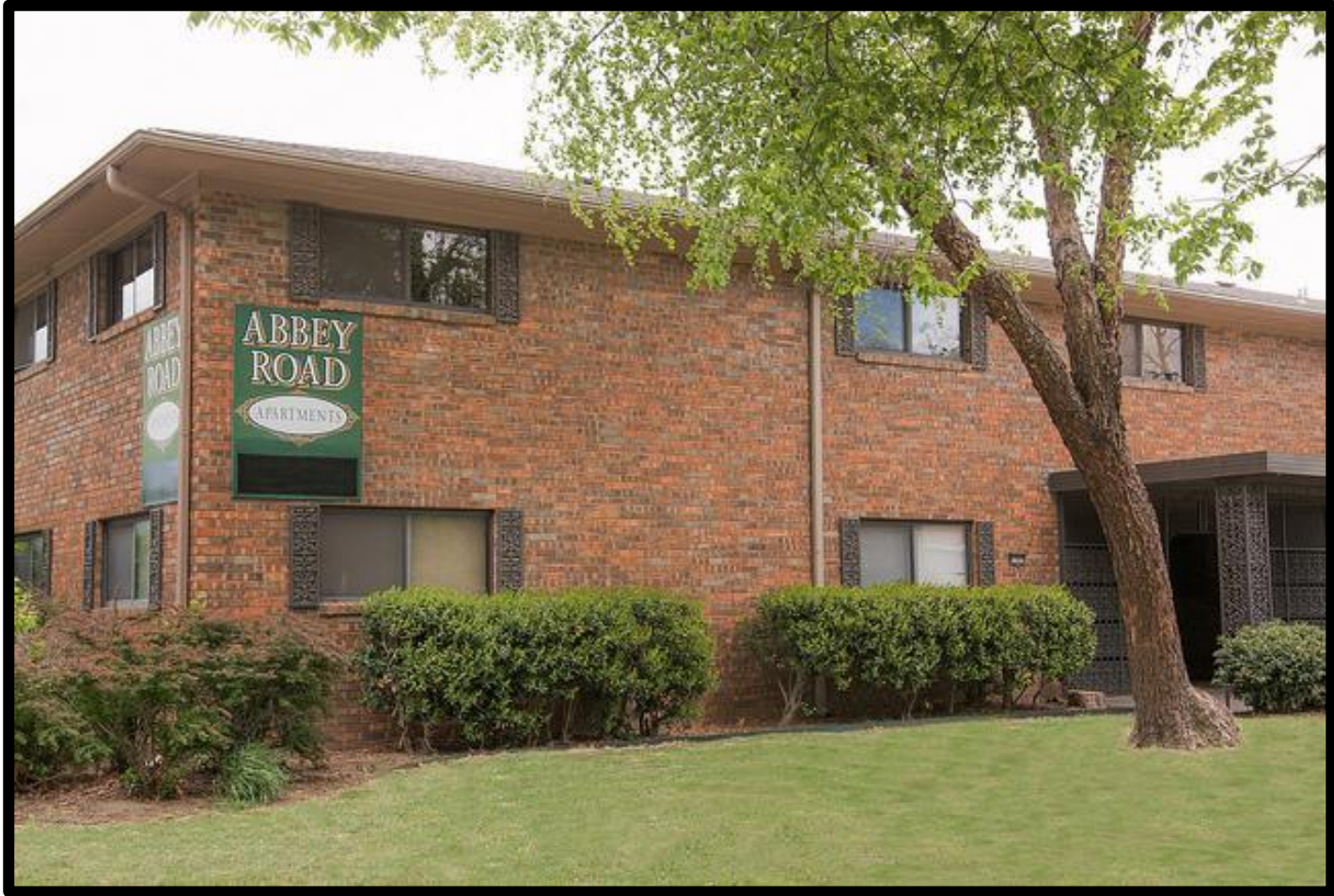


# Velda Rose Apartments





# Abbey Road Apartments



# Autumn Ridge Apartments





# Yale Apartments



# Pheasant Run Apartments





# Lewiston Apartments



# 31<sup>st</sup> Plaza





# Community Health & Wellness Program

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Mental Health Association Oklahoma



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# Programmatic Context

- ❑ Target population housed in permanent supported housing
- ❑ People who are formerly homeless
- ❑ People affected by serious, untreated mental illness, addiction and trauma
- ❑ Historic absence of mental health and physical health care, regardless of benefits



# Community Health and Wellness Team

- ❑ Physician Assistant:  
Whitney Phillips
- ❑ LPN: Jacki Sauter
- ❑ Service coordinators,  
consulting psychiatrist &  
family medicine provider



# What do we do?

- ❑ Assess Mental Health Association Oklahoma program participants for eligibility.
- ❑ Provide ongoing primary care for participants who qualify for our integrated care model
- ❑ Provide transitional primary care/referrals/community resource links
- ❑ Provide urgent care to Mental Health Association Oklahoma residents and homeless drop in center



# Program Eligibility

- ❑ Live in program housing
- ❑ Have service coordinator
- ❑ Documented serious mental illness
- ❑ Must meet one of physical health conditions:
  - ❑ type 2 diabetes OR
  - ❑ uncontrolled hypertension
  - ❑ statin eligible/elevated ASCVD risk

# Ongoing Primary Care

- ❑ insured AND uninsured
- ❑ meet with individuals twice monthly in their home
- ❑ provide access to lab-work/ medications/ medication management/referrals to specialty care
- ❑ 24/7 access to PA and nurse
- ❑ bimonthly team staffing of patients



# Transitional Care

Individuals who fall into the “gap”...



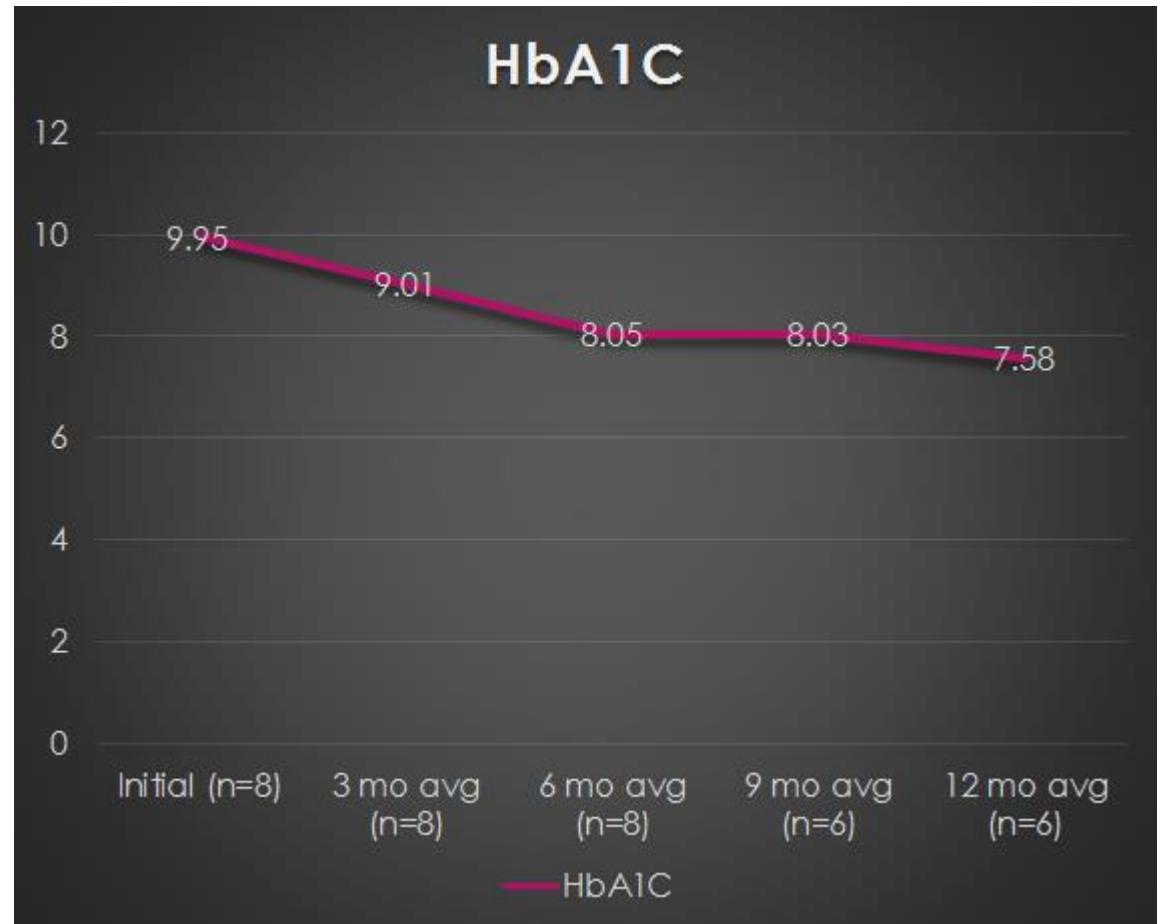
# Urgent Care

- ❑ Provide urgent care to program participants of Mental Health Association Oklahoma
  - ❑ market rate renters on property site
  - ❑ homeless individuals at drop-in center



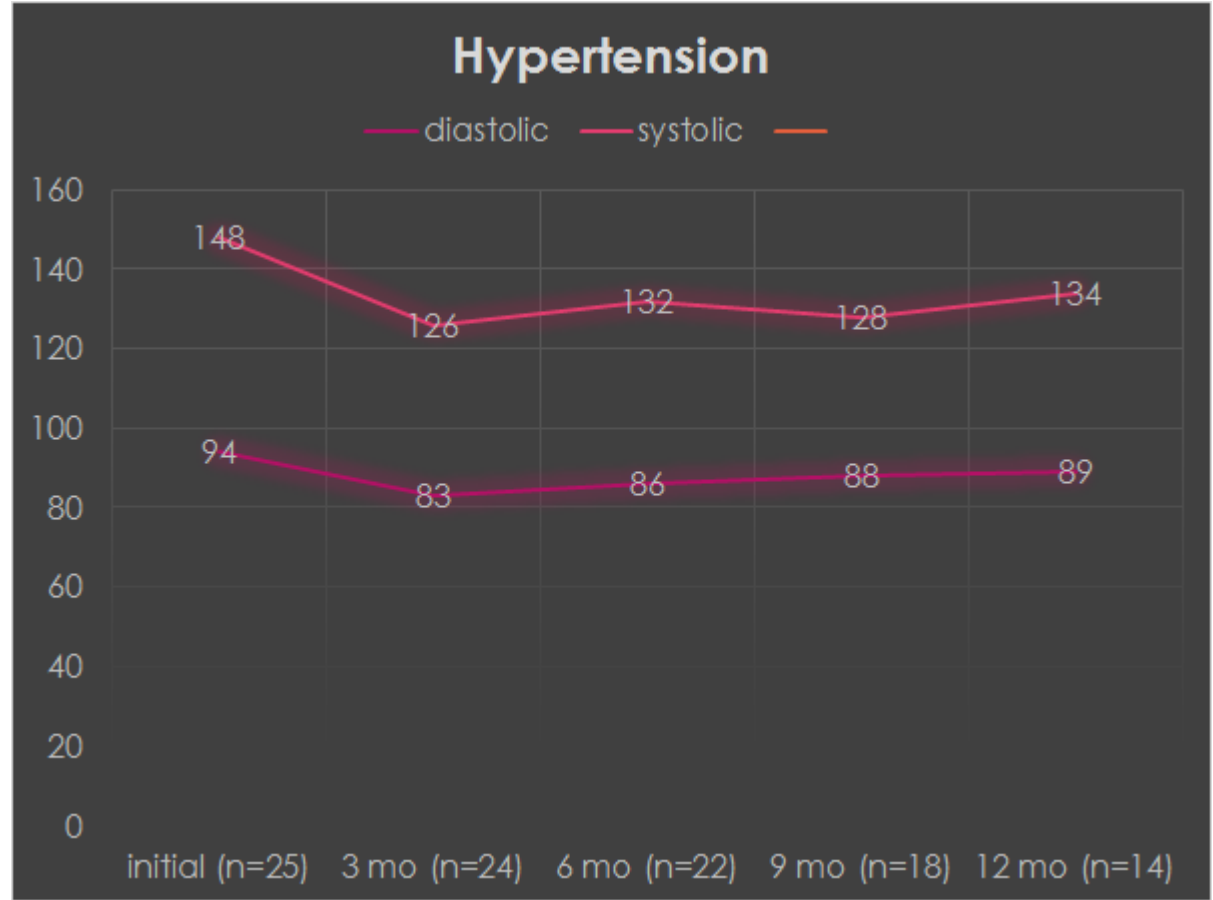
# HbA1C Outcomes

- ❑ 7 enrollees with Type 2 DM (A1C 6.5 or >)
- ❑ 6 enrollees with Pre-DM (A1C 5.7-6.4)
- ❑ Decreased avg A1C from 9.95 to 7.58
- ❑ Greatest Reduction with individual patient: HbA1C 13 to 6.1 with 12 mo. treatment



# Hypertension Outcomes

- ❑ 25 patients currently enrolled with diagnosis of hypertension
- ❑ Average BP upon enrollment: 148/94
- ❑ Average BP 3 mo: 126/83
- ❑ Average BP 6 mo: 132/86
- ❑ Average BP 9 mo: 128/88
- ❑ Average BP 12 mo: 134/89
- ❑ Goal: <140/90



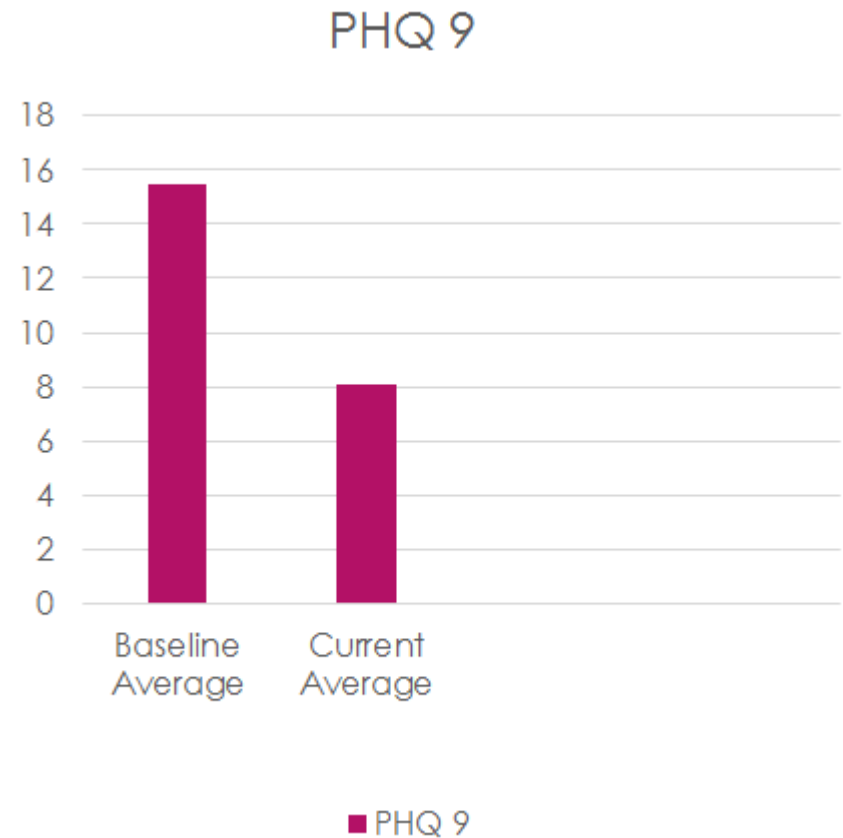
# ASCVD Risk Reduction

Statin Intervention			initial ASCVD risk		post statin therapy ASCVD risk			Risk reduction
pt 3			15.8		8			-49%
pt 4			12		8			-33%
pt 5			25		19			-24%
pt 6			32		24			-25%
pt 7			27.5		18			-35%
pt 11			16.7		11			-34%
pt 12			27.9		17			-39%
pt 18			8.2		6.1			-26%
pt 20			16.8		11			-35%
pt 21			19.3		14.5			-25%
pt 25			9.9		7			-29%
pt 27			15.3		7			-54%
pt 29			25.7		16			-38%
pt 30			31		23.6			-24%
pt 34			13.6		13.6 (no intervention)			0
pt 35			16.9		12.1			-28%
pt 37			14.4		10.8			-25%
pt 38			12		9			-25%
pt 39			15.33		10.1			-34%
pt 40			17.4		17.4 (no intervention)			0%
average			18.64		13.16			-28%



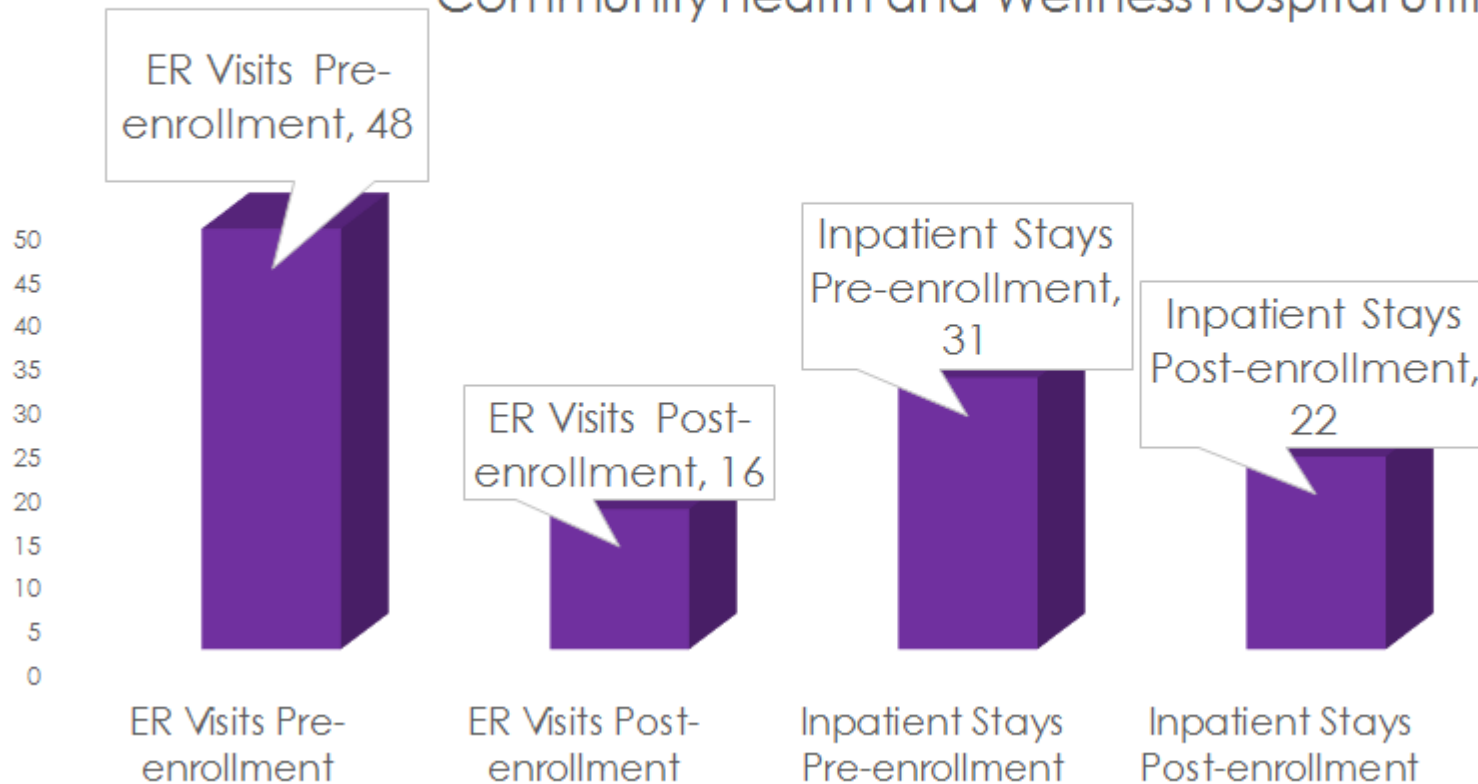
# PHQ 9 Baseline Avg and Current Avg

- ❑ 20 primary care patients currently treated for depression
- ❑ Baseline average (n=18) pre-treatment: 15.5
- ❑ Current Average(n=18) post-treatment: 8.05
- ❑ **% reduction in PHQ 9 scores: 48%**



# ER/Inpatient Utilization Pre and Post Enrollment

Community Health and Wellness Hospital Utilization



# Urgent Care Visits

> 200 urgent care visits since program inception





# Next Steps/Future Endeavors/Model Morph (yr 4)



# Next Steps/Model Morph (Year 4)

## Mobile Integrated Healthcare Team

- ❑ Triage,  
Assessment,  
and Referral
- ❑ Urgent Care
- ❑ Transitional  
Primary Care
- ❑ Dental Care
- ❑ Fully Mobile
- ❑ Total Integrated  
Model



# Toward an Integrated Healthcare Model







**Questions?**

