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Q1 Please provide your contact information below.

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Q2 Please describe your company or organizations overall goals and mission.

Founded in 1986, ICL (Institute for Community Living, Inc.) is an outcomes-oriented human services agency that provides clinical, rehabilitation, health, housing and other support services to people affected by mental illness, developmental disabilities, or situational crises such as homelessness. Our goal, encapsulated by our motto, “People Get Better with Us,” is to provide person-centered, recovery oriented, trauma-informed, integrated services to children, youth, adults, and families to improve their wellbeing, recovery and community participation. ICL serves nearly 10,000 residents of New York City – from all five boroughs - every year.

Q3 Please indicate which category your organization falls under.

Community Based Organization

Q4 Innovation Executive Summary. Please describe the innovation, and how it addresses the social determinants of health. Please identify how the innovation addresses the 6 innovation criteria (i.e. ROI, scaleability, feasibility, evidence based support for innovation, relevance to the Medicaid population and speed to market).

The Innovation:
ICL successfully implemented a multi-dimensional health strategy to reduce the incidence of high blood pressure for people with serious mental illness living in our supportive housing programs. ICL’s innovation focused on leveraging the existing relationship between housing case managers and residents to focus on health, specifically increasing health literacy and knowledge, connecting people to trusted health care providers, and ensuring access to healthy foods as critical adjuncts to the typical hypertension protocol (a doctor recommends changes in diet, exercise, and possibly medication during an all-too-brief medical appointment).

Call for Social Determinants of Health Innovations

Traditionally, OMH-funded housing programs focused primarily on housing and psychiatric stability. But maintaining a narrow focus on behavioral health may cause agencies to miss critical opportunities. ICL is committed to helping its workforce to practice beyond its traditional roles to collectively impact the health outcomes and quality of life for the people we serve.

Among its many program services, ICL offers several different models of supportive housing, including community residences, treatment apartment programs, and supported housing, with nearly 2,500 beds in more than 35 distinct programs. Residents in these programs have a diagnosis of Serious Mental Illness; the majority are Black/African American or Latino, and low income, with Medicaid as the most common form of health insurance. Case managers working in these programs meet with people frequently, typically in their own homes, to address behavioral health issues and provide rehabilitative support services. These meetings are longer, and far more frequent than appointments with primary care providers. As a result case managers know residents well, and have established trusting relationships.

As an important part of their job, case managers work with residents to address social determinants of health through providing stable housing and assistance with concrete needs (such as access to food, healthcare, personal/household supplies, and transportation.) Focus on these basic needs is essential not only to helping maintain community tenure; it also helps prevent the escalation of stress and symptoms that can in turn result in increased hospitalizations for either behavioral or physical health reasons.

While case managers' minimum activities are prescribed by State regulation, ICL recognized an opportunity to provide a program enhancement by asking supportive housing case managers to leverage their relationships with residents to monitor and address high blood pressure. ICL selected this health risk because of its prevalence in people with diagnoses of mental illness, as well as its impact on our health care system, and on individuals themselves. Supportive housing case managers are well-positioned to take on this work because they already meet frequently with residents, often in people's homes. This familiarity builds trust and engagement, which are essential elements of supporting long-term behavior change.

In this innovation, ICL used supportive housing case managers to identify and work with individuals with high blood pressure readings:

1. Supportive housing case managers were trained to conduct blood pressure screenings using portable blood pressure monitors. Case managers were also trained to provide residents with basic health information about high blood pressure using ICL-developed tools and other resources. A reading was recorded at baseline, as well as six months later. Any residents with initial at-risk blood pressure readings (defined as systolic>140 or diastolic >90) were targeted for additional support. A treat-to-target approach was used to reduce individual blood pressures to below "at risk" levels.

2. Nursing support was made available to both case managers and residents to answer questions and address concerns about blood pressure readings, care planning, and disease management.

3. Case managers facilitated connections with trusted primary care providers (PCPs) as needed, making referrals, encouraging follow-through with medical appointments, and coordinating with PCPs to obtain information about diagnoses, medications and treatment recommendations. Case managers fostered consumer activation by helping residents prepare for medical appointments, including making a list of questions for the doctor and role-playing ways to express concerns about medication side effects.

4. To increase wellness self-management, case managers used ICL-developed resources with residents to increase health literacy and knowledge:
   - ICL developed a High Blood Pressure Fact Sheet to increase understanding of normal and hypertensive blood pressure ranges, possible risks, and recommended actions to lower blood pressure (i.e. see primary care provider regularly, take medications as prescribed, eat healthier, and exercise). Increasing understanding of hypertension, risks and strategies to lower blood pressure allowed individuals to make informed decisions about their own health and healthcare. The tool was specifically created to provide accurate, accessible, and actionable information for residents and case managers alike.
   - ICL used its Healthy Living Workbook as a key resource in this effort. The Workbook is an action oriented tool kit that uses a person-centered motivational interviewing approach. The Workbook includes worksheets, mini self-assessments and action plans to elicit change talk and facilitate behavior change. Case managers focused specifically on the Taking Charge of Check-Ups, Taking Medication Choosing Healthy Foods and Being Physically Active modules in the Workbook. The Workbook features bright colors, plain language,

and photographs to make it easier for people who find reading challenging.

5. Because of the special importance of nutrition in the management of high blood pressure, case managers paid extra attention to helping individuals make healthier food choices. Recognizing that there are often underlying social, environmental and financial barriers to eating healthier, case managers helped people identify local places in the community to access healthy foods and talked with residents about meal preparation, staying attuned to cultural preferences. Case managers also worked with residents to help them obtain benefits/entitlements to reduce food insecurity, and identify local options for buying healthy foods.

   The multi-approach innovation was extremely successful, achieving the targeted reduction of high blood pressure readings for more than 40% of our at risk population in just six months. In addition, interviews with case managers and program directors have demonstrated that case managers themselves have continued their focus on reducing high blood pressure, both monitoring readings and providing ongoing support for those whose readings are at risk.

   Potential ROI:
   Implementation of this innovation was inexpensive: the only required purchase was portable blood pressure monitors, which are available for less than $20 a monitor (staffing relied on existing personnel.) In contrast, High Blood Pressure costs the U.S. approximately $46 billion per year in health care expenditures (Source: NYS DOH BRFSS Briefs, 2013). In addition, healthcare costs are 2-3 times higher for individuals with co-occurring chronic medical conditions and behavioral health conditions, mostly due to treatment of physical health conditions (Source: Economic Impact of Integrated Medial-Behavioral Healthcare: Implications for Psychiatry. Milliman Inc. April 2014). This innovation has the potential to significantly reduce health care costs related to high blood pressure including emergency, outpatient, and inpatient care, as well as prescription medication.
   Because reducing the incidence of high blood pressure decreases the use of emergency room and hospitalizations, there are additional benefits to individuals, such as reduced traumatic experiences, economic disruption, and family stress. Moreover, reducing high blood pressure also decreases risk for adverse outcomes including cardiovascular events and premature death.

   Scalability and Feasibility:
   This innovation uses a data-informed approach targeting a specific at-risk subpopulation by tapping into pre-existing relationships between case managers and residents. Broad replication is highly feasible given that the model uses case management staff already working in programs coupled with low-cost tools. Moreover, many supportive housing programs are currently working with residents to address social determinants of health, such as housing, economic stability, and access to nutritious food. Therefore, asking case managers to focus on blood pressure and related social determinants is not an expansion of services requiring significant additional resources. ICL has the expertise to help other agencies to easily replicate this innovation.

   Evidence based support for innovation:

- Heart disease is the leading cause of death for New Yorkers, and hypertension is among the top ten causes of death (NYS DOH BRFSS Briefs, 2013 & 2014). Furthermore, adults with mental illness have higher rates of heart disease, stroke, and hypertension than the general population (SAMHSA, NSDUH Report 2012) due to a range of issues including poverty, toxic stress, and even obesity caused by psychotropic medications. These same cardiovascular conditions also contribute to high health care costs.

- The increased use of human service professionals to support integrated health through Health Homes and other care coordination programs speaks to the potential of case managers and social workers to expand their roles by focusing on the management of chronic health conditions such as heart disease. The U.S. Department of Health & Human Service's Million Hearts Initiative co-led by CMS and CDC, recommends use of a home blood pressure device with added clinical support, including counseling and health education, to improve access to care and quality of care for individuals with high blood pressure (Source: https://millionhearts.hhs.gov/). Home blood pressure monitoring can identify individuals whose blood pressure appears controlled in a medical office setting but is uncontrolled at home. Additionally, home blood pressure monitoring serves as a reminder to engage in health behaviors related to lowering blood pressure, such as taking medication, healthy eating, and exercise (Source: Breaux-Shropshire, T. L., Judd, E., Vucovich, L. A., Shropshire, T. S., & Singh, S. 2015. Does home blood pressure monitoring improve patient outcomes? A systematic review comparing home and ambulatory blood pressure monitoring on blood pressure control and patient outcomes. Integrated Blood Pressure Control, 8, 43–49.)

- Challenges with health literacy remain an important risk factor for poor health outcomes. For example, limited health literacy is connected to less frequent use of preventive services and management of chronic conditions such as diabetes and high blood pressure. Researchers have also connected limited health literacy to an increase in preventable hospital visits and admissions.

  Several studies have underscored the importance of targeted approaches to health literacy that are responsive to the specific needs of a population (such as people with low literacy, poverty, or behavioral health challenges.) When these adaptations are further tailored to each participating individual, impacts are even greater. (Source: U.S. DHHS: National Action Plan to Improve Health Literacy, 2010.) ICL's innovation focused on both skill building to improve health literacy, as well as resources that were written specifically for our population.

- There is a base of evidence documenting the value of connection to a trusted primary health care provider. For example, national survey data shows that people who use primary care physicians rather than specialists for their usual care have a lower mortality rate. (Franks and Fiscella, 1998) ICL's innovation is based on a firm understanding of the value of this relationship. (Source: Franks and Fiscella. "Primary care physicians and specialists as personal physicians: health care expenditures and mortality experience." J Fam Practice 1998; 47 (2):105–9.)

  Relevance to the Medicaid population:
  Almost 30% of New York State's Medicaid population has high blood pressure (NYS DOH BRFSS Briefs, 2013 & 2014). And people with mental illness have even higher rates. This intersection of limited income and co-occurring behavioral health and chronic medical conditions contribute to high healthcare costs and poor long-term health outcomes for Medicaid enrollees.

  Speed to market:
  The strategy could be launched within 3 – 6 months.
  1. Plan - Develop project implementation plan, including definition of elevated risk
  2. Equip - Purchase portable blood pressure monitors and Healthy Living Workbook
  3. Staff – Ensure nursing staff is available to provide consultation regarding management of any high risk health concerns
  4. Train - Provide training for supportive housing case managers on:
  a. Protocol for responding to people with high risk blood pressure readings
  b. Use of portable blood pressure monitors
  c. How to incorporate lessons from Healthy Living Workbook into case management activities with people served

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Q5 Was your innovation implemented? If so, please explain when, the number of people impacted, and the results.

Yes (please specify when and the estimated number of people impacted):

In July 2017, case managers conducted blood pressure readings of 721 individuals living in ICL supportive housing programs. Of these, 180 individuals had high blood pressure readings and received the targeted intervention. At the 6 month follow-up screening, almost half (42%) of the target population were no longer at-risk. (This result is particularly significant due to the demographics of the target population - predominantly African-American/Black and Latino, diagnosed with mental illness with income below poverty level). With strong outcomes in hand, ICL conducted initial screenings for an additional 700 ICL residents in other programs.

Q6 Please identify the SDH Domain that your innovation addresses. (Select all that apply.)	**Health and Health Care** , **Neighborhood and Environment** , **Economic Stability**
Q7 I give the Department of Health the right to share the information submitted in this application publicly (for example: on the DOH website). I understand that there is no monetary reward/reimbursement for my submission or for attending the summit should my innovation be selected.	**I consent to have my innovation shared**