

NATIONAL COUNCIL

The National Council for Behavioral Health

MAGAZINE

2014 | ISSUE 1

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The Many Faces of

Integration

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FOR BEHAVIORAL HEALTH**
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ELECTRONIC HEALTH RECORDS VENDOR STABILITY MATTERS

2014

Echo enters its 34th year, still with its original owners

2011

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2001

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1998

Echo releases **FIRST** Windows-based EHR software for BH

1980

The Echo Group is founded with the goal of simplifying the billing process for Behavioral Health Organizations

CLOUD BASED EHR

2012



SIX ECHO CUSTOMERS AWARDED SAMHSA

PRIMARY CARE INTEGRATION GRANTS

6

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2011

100%

FIRST VISUALLY ORIENTED CHARTING SYSTEM

2009



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2003



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2000



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FIRST EHR WITH AUTOMATED ELIGIBILITY CHECKS

1991



FIRST WATERFALL BILLING SOFTWARE FOR BH

1983



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THE GAME OF ACO

BACK INSERT

ABOUT

The National Council for Behavioral Health (National Council) is the unifying voice of America's community mental health and substance use treatment organizations. Together with our 2,200 + member organizations employing 750,000 staff, we serve our nation's most vulnerable citizens — more than 8 million adults and children living with mental illnesses and addiction disorders. We are committed to ensuring all Americans have access to comprehensive, high-quality care that affords every opportunity for recovery and full participation in community life.

The National Council pioneered Mental Health First Aid in the U.S. and has trained approximately 250,000 individuals to connect youth and adults in need to mental health and addictions care in their communities. We operate the SAMHSA-HRSA Center for Integrated Health Solutions to provide nationwide technical assistance on integrating primary and behavioral healthcare.

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NATIONAL COUNCIL MAGAZINE

2014 | ISSUE 1

THE FACES OF INTEGRATION



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P.115

Increasingly, healthcare preferences are being shaped by consumers' shopping, entertainment, and lifestyle experiences.

embed behavioral health in primary care settings. After all, even those with transportation, moderate incomes, and the support of family and friends don't have the time for multiple visits, follow up on referrals to different specialists, or the ability to take time off work for doctor's appointments that can take up to half a day with all the driving and waiting.

In fact, Mike Hogan, former New York State Mental Health Commissioner, predicts that in 45 years, distinct public mental health systems with state-operated and state-funded specialty services will no longer exist in anything like their current form. "We should not maintain state systems if the alternative is being part of the mainstream," he said.

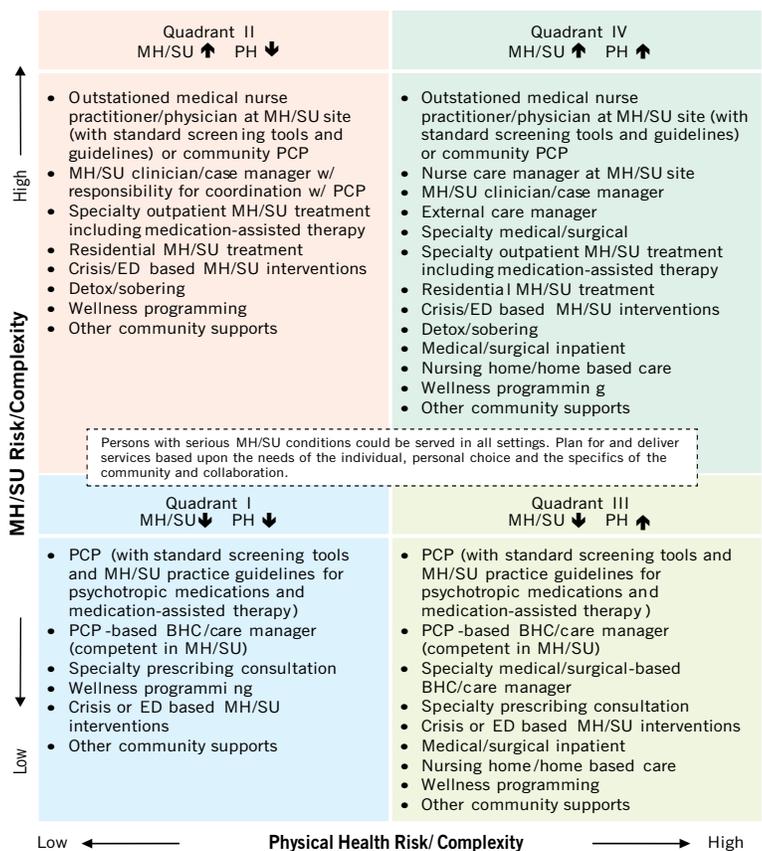
And being part of the mainstream means offering all healthcare — for mind and body — anywhere and anytime the customer needs it. At urgent care clinics, at the library where they go for Internet access, or even at home with a smartphone and monitoring devices. How often have you wished you could just text or email your doctor for a quick consultation? Imagine the savings, and the convenience for all. The one-stop shopping approach in healthcare is highlighted in several case studies in this issue of National Council Magazine — Integration Road Trip (page 62) Montefiore (page 52), SSTAR and Gosnold on Cape Cod (page 58), Family Services Inc. (page 68), Cherokee (page 78), and many others.

Community behavioral health organizations have long been the best suited to offer integrated care for the vulnerable, indigent populations they typically serve. The National Council for Behavioral Health has led the way by helping to shape policy, institute best practices through consulting, and provide platforms for networking and sharing of successes and challenges. The SAMHSA-HRSA Center for Integrated Health Solutions — a federal technical assistance center that the National Council runs, has provided tremendous momentum to an integrated care effort around the nation. Our members have pursued all avenues for integrated care delivery — thoughtful engineering of staff roles, intensive community outreach, exploration of public and private and funding options, and creative collaborations and partnerships.

Today, as integrated care evolves to a broader population health management concept, community behavioral health continues to have the advantage, with its unique approach, experience, and skill sets.

What is population health management? First, we must note that from a population health perspective, health has been defined not simply as a state free from disease but as the "capacity of people to adapt to, respond to, or control life's challenges and changes." Population health management is the coordination of care delivery across a population to improve outcomes through disease management, care management, and demand management. The approach focuses on reducing health disparities that occur on account of the social determinants of health — social, environmental, cultural, and physical factors that have a measurable impact on health. The World Health Organization estimates that in the U.S., social determinants account for 70 percent of avoidable mortality.

While population health management is becoming the norm today — as evidenced in the increasing number of Accountable Care Organizations, health homes, and care management organizations — community behavioral health has long practiced the tenets of this approach. In fact, the popular Four Quadrant Model developed by the National Council a decade ago is in essence a population-based planning framework for the clinical integration of primary and behavioral health services.



As Mike Hogan, goes onto say, “Almost all the new service models unleashed by the Affordable Care Act — from Medicaid health homes to ACOs to patient-centered medical homes — cannot succeed without integrating behavioral and general medical care. The theme of “integration” is popping up everywhere. Yet the mainstream is not prepared. They need our help. On almost every crucial test — for example people discharged from an emergency room after self harm, or people who commit suicide after seeing a primary care provider — the mainstream still gets it right only about half the time.”

If we consider where “the mainstream needs our help,” behavioral health offers three distinct advantages.

“National Council members are ‘community problem solvers.’ That’s exactly the kind of leadership we need.”

First, we know more about **person-centered care and patient engagement** than the mainstream. A primary care appointment lasts 10 minutes or less, leaving little time for engagement. In contrast, behavioral health providers spend considerably more time with each patient, building relationships, nurturing trust, and helping them navigate life in the community. Customized, long-term treatment plans are developed for patients based on their preferences and with the involvement of family and caregivers. We’ve modeled care that extends beyond clinic walls, into the community and into people’s lives. That’s really what Assertive Community Treatment is all about. Dom Scotto, who directed an ACT program in New Jersey describes ACT as “community mental health at its raw, basic level.” He explains, “Staff have conducted psychiatric intakes at Burger King and on the boardwalk. They don’t think twice about teaching someone to fry an egg or clean a dirty house.”

Second, we know that partnerships and collaborations are crucial to the success of a population health approach. As Abby Cofsky, program officer at the Robert Wood Johnson Foundation says (page 28), building healthy communities requires “leadership that focuses on authentic and meaningful engagement with the people that live in the community. National Council members are ‘community problem solvers.’ That’s exactly the kind of leadership we need.” Behavioral

health has always collaborated with a range of community institutions and systems — criminal justice, hospitals, schools, faith communities, homeless shelters, supported housing and employment, veterans services, child welfare, and many more. We’ve always factored in the social determinants of health.

Third, the roles and responsibilities of community behavioral health staff have primed them for population health management. As Joan King notes in her article on new roles for case managers (page 118) “It’s important to bring access, understanding, and knowledge of the community and the resources to support management of chronic illness. Case managers in behavioral health have the skills to provide this level of service.” She points out that while care managers are in demand in the world of population health, they’re really just taking on existing case management skills and integrating them with healthcare. They’re becoming experts in health behavior change and building relationships, because positive change happens only in the context of good relationships.

MacArthur Genius and primary care physician Jeffrey Brenner sums it up well when he says “Actually, our behavioral health colleagues are about 30 years ahead of us. I hope primary care can learn from behavioral health. When psychiatric care was deinstitutionalized, behavioral health did heroic work to figure out how to deliver better care at lower cost and evolved some creative models. The different tiered interventions provided in behavioral health and ways to engage patients are really remarkable.”

However, we are not lacking in areas for improvement. If behavioral health organizations want to be effective in population health management, we must focus on building strengths that have traditionally not been high on our priority list. Let’s talk about three areas where we can do better.

First, we need to focus on public education and on prevention/early intervention. It’s been heartening to see how behavioral health organizations have embraced Mental Health First Aid. We’ve trained more than 150,000 people but so much remains to be done. We need literacy and early intervention programs like Mental Health First Aid to touch every community, every home, every school, and every corporation in America. Behavioral health organizations can help make this happen.

And we need the spread of initiatives like the Felton Institute’s Prevention and Recovery in Early Psychosis program, where early intervention and targeted treatment for schizophrenia are achieving dramatic results — 75 percent of people in are employed or in school by the sixth month of treatment. Within five years of entering treatment, most cases of psychosis are in remission. PREP provides early intervention and diagnosis for psychosis and translates evidence-based practices from academic to community settings.



“some of most innovative changes that have been made in healthcare over the years are the result of thinking from the outside in, rather than the inside out.”

Second, we must measure outcomes. Henry Chung, Vice President and Chief Medical Officer at Montefiore (page 52) notes, “There’s too much treatment inertia in all of healthcare. We keep doing the same thing over and over again. When we don’t measure, how can we tell if we’re really helping the patient or not? Population health is about looking for outcomes. We must have goals, and when we don’t meet them, we must look at what else we can do for our population.”

Third, we must capitalize on the power of technology to extend the reach of staff. Consider for instance, the Health Buddy — a simple clock radio-sized device designed to help individuals manage their physical and mental health needs on a daily basis in the comfort of their homes. Vinfen in Massachusetts is using Health Buddy (page 86) to transmit patients health status daily to an internet site for review by the nurse practitioner and action to ensure proper disease management and overall improved health.

Of course, we know that electronic health record systems can decrease the fragmentation of care by improving care coordination. Only EHRs can integrate and organize patient health information and facilitate instant distribution among all who are involved in a patient’s care. As Steve Ronik, CEO of Henderson Behavioral Health in Florida says (page 82), “We don’t have a choice — nobody does — you can go kicking and screaming, but you have to have an EHR.”

Chris Murphy, in an article in Information Week, argues that providers should benchmark their online engagement against other

industries. He points out that some of most innovative changes that have been made in healthcare over the years are the result of thinking from the outside in, rather than the inside out. He quipped, “How come a retailer such as Amazon or Apple can remember I bought an Ace of Base recording the last time I visited, but the people who help keep me alive or healthy have to ask about my allergies every time I show up at the doctor’s office? Why can I book a flight, hotel and car from three different companies on one website but not schedule doctor appointments online and see all of my upcoming medical visits in one place?”

Behavioral health can lead the way in population health management if we think from the outside in. If we commit to building the Amazon Prime experience for the millions of people who depend on us for better health and better lives.

LINDA ROSENBERG, MSW
PRESIDENT & CEO

National Council for Behavioral Health



[@LindaRosenberg](#)

Talk with Linda on the hottest topics at Linda’s Corner Office blog at www.TheNationalCouncil.org/lindas-corner-office

Integrated Care: Moving Toward Total Population Health

We are approaching 10 years since NASMHPD's study finding that people with severe mental illnesses die, on average, 25 years earlier than the general population.

In the past decade and a half, integrated care providers have moved from individual centers trying out new models to organizations leading the way in demonstrating the future of healthcare. Integrated care is becoming the norm for primary and behavioral health providers alike; those not yet on board are now the laggards.

In the near future, every person seen in a community mental health or addictions provider will be addressed as a whole person, and supported in reaching their self-directed goals including access to medical care, health prevention resources, and community integration. Behavioral health providers are doing amazing work to integrate care, to break silos within organizations and across the health care sector, and to enhance community partnerships to sustain improvements, outcomes, and the opportunity for all Americans touched by mental illness and addictions an equal opportunity to achieve health and wellness.

Centers are involved enough in integrated care to know that there are no "turf wars" here. There are many individuals who need mental health and addiction services, and different parts of the healthcare system can all play a part in addressing these needs. Integration is really about prevention, and people need to be served in a variety of places – just as is depicted in the four quadrant model of care, healthcare providers – whether primary or specialty behavioral healthcare – must find the best approaches to addressing the whole health and wellness of individual populations and their communities.

Advancing integrated health requires a population health approach. Trailblazing behavioral health providers are incorporating population health approaches and demonstrating that we can improve the quality of care, reduce the overall cost of care, improve health outcomes, and support individuals to live a self-directed life.

It is important to distinguish between population approaches to behavioral health and the work of behavioral health providers

to address the health disparities of individuals with serious mental illness and addictions. To improve the health of our country and to survive as an essential specialty part of our healthcare system, we have to look at interventions that can cross large groups. But we also cannot forget the experience we bring to healthcare – which is the ability to connect one-on-one with an individual and ensure their personal recovery goals are addressed alongside their health and wellness goals. As a behavioral health field, we have to be part of both.

Population Health in Behavioral Health

A new report recently reaffirmed the critical need to address the early death of individuals with mental illness. It has been my pleasure of the past four years to work with behavioral health providers who received SAMHSA Primary and Behavioral Health Care Integration grants to integrate primary care into their agencies. Their goal is to improve the physical health status of people with severe mental illness by supporting communities to coordinate and integrate primary care services into publicly funded community-based behavioral health settings. These grantees and other behavioral health providers are achieving the triple aim - improving the patient's quality of care, reducing the cost of care, and improving health outcomes. Currently, 62% of the SAMHSA PBHCI grantees are partnering with a Federally Qualified Health Center (FQHC), and more than 12% are partnering with their community hospital systems (integrating behavioral health into the hospital setting and providing medical personnel for primary care clinics embedded within the behavioral health setting). Several have established themselves as Medicaid health homes.

Population health management uses data to select a group of individuals to receive specific evidence-based interventions and treatments to see if the intervention improves health. I am proud of the work that SAMHSA PBHCI grantees have done to collect health data and to focus on achieving health outcomes for specific groups of individuals. The outcomes overview on page 62 of this magazine gives several examples of the changes we have seen to date.

“ Advancing integrated health requires a population health approach.”



In addition to informing grantees (and their clients) about their success in helping their clients toward wellness, health data is being used to demonstrate organizational excellence, new partnerships, and success of the behavioral health field against national standards for addressing individuals with multiple chronic conditions.

Resistance to data collection is extremely high; primarily because it's more work. The real difference comes when providers create individual client dashboards. They could be about the individual, and were a clear display of how small changes can make big differences in important health indicators like blood pressure, cholesterol, and overall health.

How are integrated healthcare providers moving toward population health?

They are:

- ① Developing clinical records that track individual health problems, vitals, care needs, wellness goals.
- ① Discovering how new approaches to patient information can help proactively identify at-risk individuals and intervene earlier for better outcomes.
- ① Sharing individualized health reports that show progress over time with individuals and supporting them to identify what is working and not working as they gain a sense of control of their health.
- ① Identifying where there are groups of clients who are not taking advantage of the available primary care and wellness services and learning what might be preventing them from doing so.
- ① Implementing a continuous quality improvement process to constantly explore what can be done differently to improve outcomes, make the most efficient use of staff time and resources, and improve client experience.
- ① Spreading the word – sharing clinical outcomes with all your clients, internal staff, newspapers, and local and state leaders.
- ① Looking at the social determinates of health, and addressing the risk factors involved with poverty, mental illness, and substance use.
- ① Training the workforce to understand and be supported in moving to whole health orientation.
- ① Establishing common goals with community partners to support ongoing constructive relationships between health sectors and community stakeholders.
- ① Maximizing opportunities for collaboration among Federal-, state-, and local-level partners related to social determinants of health.



Our Charge

We cannot settle for inaction. The individuals, communities, and agencies profiled in this issue of National Council Magazine offer a host of possibilities and opportunities for providers to take charge and make change. Their approaches show us that simply taking the first step toward action is a helpful part of the process of creating change. Population health approaches, based on data we can trust, show us the gaps we need to address and offer paths for trying new approaches.

If we are to tackle the biggest health problems in our country like obesity, we have to bring our expertise at supporting behavioral change to the primary care table. We have to share the elements we all need in terms of mental health and substance use prevention, early identification, and support. As healthcare delivery system changes like Patient-Centered Medical Homes become more common, integration of behavioral health is a key to ensuring that person-centeredness is more fully realized and that clients are engaged in their health.

And just as primary and behavioral healthcare providers cannot provide the highest quality whole person care without each other, these healthcare providers cannot silo themselves from their broader community. We must forge partnerships with community agencies and share population data with each other. Get involved in local efforts to address social disparities, employment/working conditions, housing, physical environments, and culture for the individuals you serve and to bring your expertise to the community. It is only with sharing information between each other that we can see if we are benefitting from the cost savings of an integrated care approach (ie, reducing hospital use).

POP QUIZ: Do you know the prevalence of diabetes and mental illness in your community? How about the number of Hispanic men in your clinic? We must have ready information like this about our communities so we can make informed decisions about priority areas to address. We don't have to create whole new systems to find this data, seek out what information is already available in your community, and grow your knowledge from there.



LAURA GALBREATH
Director, SAMHSA-HRSA Center for
Integrated Health Solutions

How Do You Measure

100 ORGANIZATIONS

participate in Substance Abuse and Mental Health Services Administration Primary and Behavioral Health Care Integration (PBHCI) program. Four-year grants support these publicly-funded community behavioral health organizations in coordinating and integrating primary care services.

AS OF JUNE 2014, PBHCI PROGRAMS SERVED

50,710 PEOPLE

These are adults with serious mental illnesses who have or are at risk for co-occurring health conditions and chronic diseases. Many of them live below the federal poverty line, and **more than 45% live in someone else's home/apartment, a transitional living facility, a hospital or nursing home, a group home, or are homeless.**



vs.



More than
45%
without
own home

THEIR HEALTH IS
MEASURED THROUGH

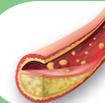
10 KEY HEALTH INDICATORS



Blood Pressure
(systolic and diastolic)



Plasma Glucose



Cholesterol
(HDL and LDL)



Body-Mass Index (BMI)



Glycated Hemoglobin (A1c)



Triglycerides



Waist Circumference

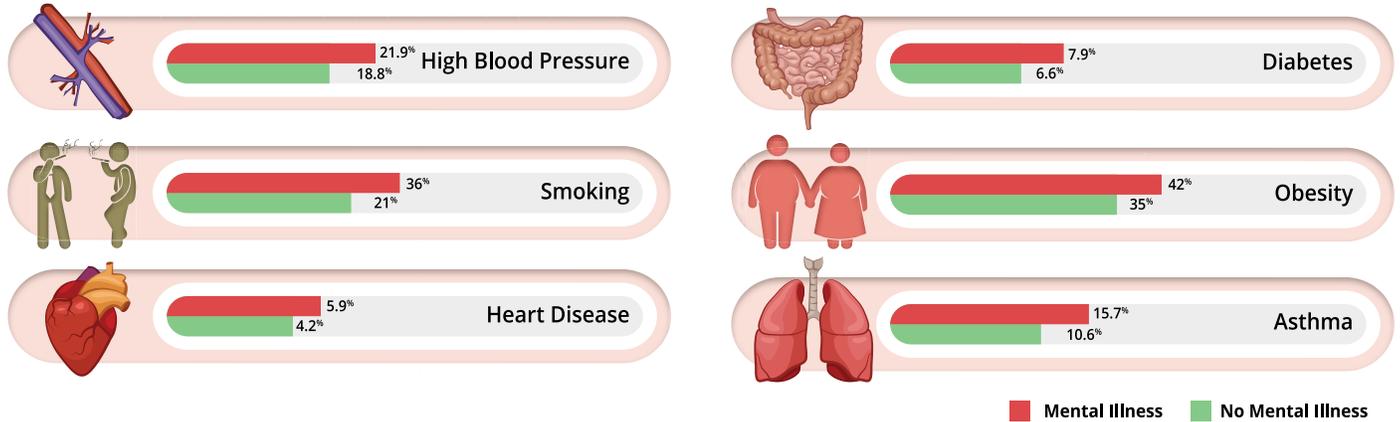


Breath Carbon Monoxide

These indicators alert healthcare professionals that their patients may be "at-risk" for certain physical health conditions, including obesity, hypertension, and diabetes.

the Success of Integrated Care?

Individuals with mental illnesses are more likely than others to have co-occurring chronic conditions.



Changing health behavior takes time. Yet, between their initial screen and most recent screens, **individuals at-risk show improved outcomes**

* FMRS Health Systems, Inc.
 ** Shawnee Mental Health Center
 *** Regional Mental Health Center



4.4% are no longer at risk for high BMI*



31.2% are no longer at-risk for hypertension**



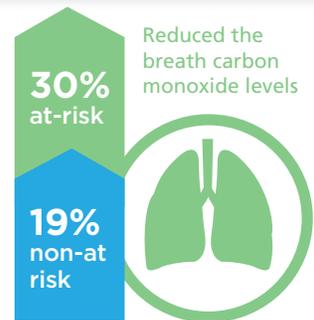
9% are no longer at-risk for diabetes*



55% reduced their HDL and LDL, or "bad" cholesterol***

PBHCI programs also address co-occurring substance use, including tobacco and alcohol use.

Southeast Inc. in Ohio focused on reducing tobacco use among their 1,200+ enrollees, and targeted people with at-risk breath carbon monoxide levels with a smoking cessation intervention. The intervention reduced the breath carbon monoxide levels of at-risk individuals by 30%, compared with a 19% reduction in non-at risk individuals.



San Mateo County began a medication-assisted treatment pilot program (as an outgrowth of their PBHCI program) for individuals with severe alcohol abuse that resulted in

More than 5 fewer drinking days per month per person (a 93% reduction)



Reduction from an average of 6 to 0.2 ER visits per patient in six months



How Do You Measure the Success of Integrated Care? *continued*



Grantees host wellness and nutrition groups, offer Whole Health Action Management (WHAM) groups, build partnerships with local YMCAs, and provide access to wellness and health management programs

More than
300 PEOPLE
are trained to
facilitate WHAM
groups.



Asian Counseling and Referral Services in Washington state has **more than 56%** of patients participating in wellness groups.

Shawnee Mental Health Center saw an average loss of **16 pounds** per participant in a nutrition group.



Individuals participating in a walking group at the Institute for Family Health saw an average loss of 13 pounds, and **56% lost more than 25 pounds** each.

Individuals are not only getting healthier, they also feel better.

31%

reported improved functioning in everyday life

22%

reported overall improvement in health



BODY
+ MIND

ONE

There's No Longer A Missing Piece In Treating The Whole Person

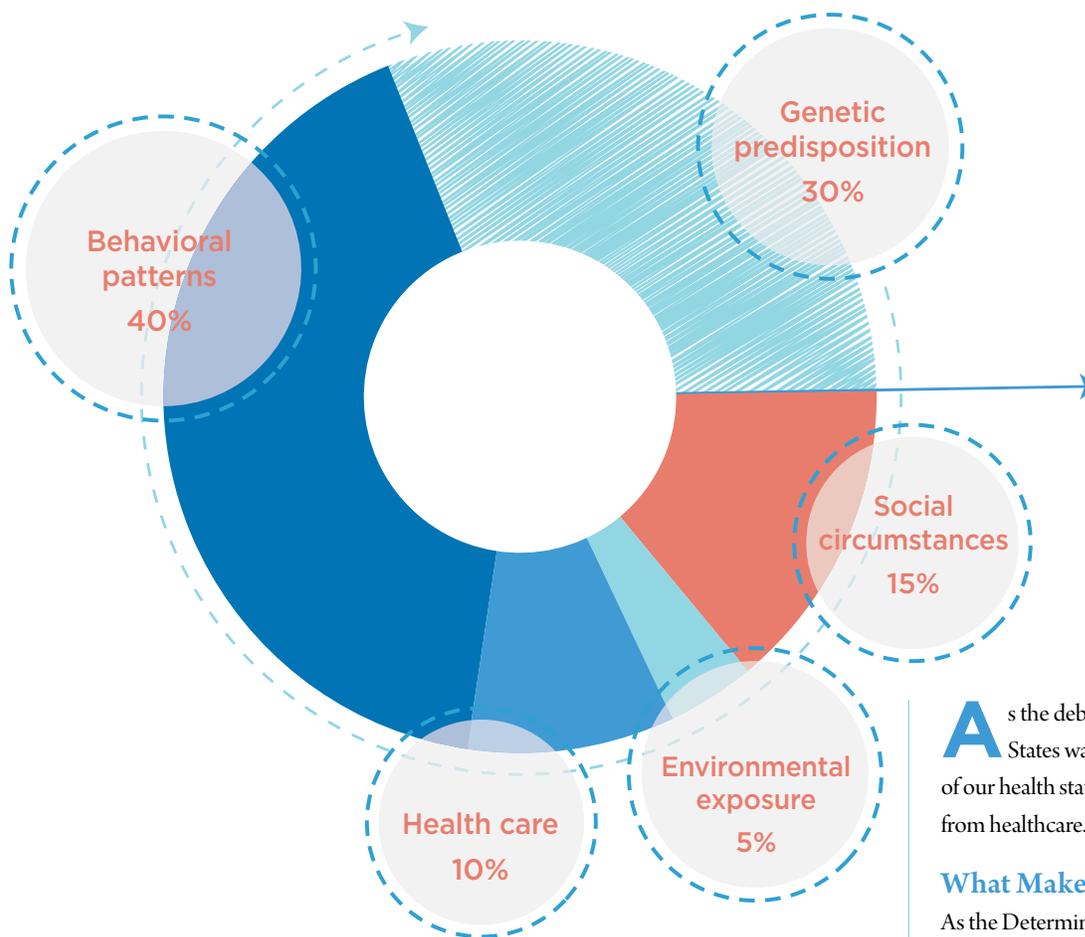
Our mission is the same – improving lives. In the past, healthcare's view of the world limited our ability to treat the whole person by separating the mind and the body...those days are behind us. For behavioral health providers looking to integrate or offer primary care services, innovative tools are now available to help make that vision a reality.

Leading providers across the country have supplemented their behavioral health EHRs with **Netsmart's Primary Care Module**, an application that facilitates and captures a primary care encounter...and then seamlessly makes it part of a single EHR. **Just as the mind and body are again one, so is the technology that supports care.**



Hear more from fellow providers achieving their mission, visit www.NTST.com/WholePerson

Transforming Healthcare to Improve Our Health



“Population health extends to the 90 percent of factors that make us sick.”

As the debate about improving health in the United States wages on, it turns out that only 10 percent of our health status and longevity, experts declare, derives from healthcare.

What Makes Us Sick?

As the Determinants of Health pie chart reveals, it is our behaviors, our habits (like excessive and poor eating, more than moderate drinking, smoking, physical inactivity, high salt, and processed food intake), that drive the lion's share (40 percent!) of our ill health and early demise. It is also mental health conditions that often disable people and keep them from effectively managing their illnesses. While 30 percent of our health may be attributable to our genes, we now recognize through the science of epigenetics that genes are turned on or off by their exposure to our environment and what we do and don't do — which helps to explain the rapidly growing rates of certain illnesses in this country.

Understanding the determinants of health is more than academic because of what it means to the quality of our lives and because the U.S. spends \$2.7 trillion annually on healthcare services (18 percent of the GNP). Yet, this vast sum of money appears to influence only 10 percent of the health outcomes we achieve. Citizens of the U.S. may live longer than we did two decades ago, but we suffer from higher rates of morbidity (where functioning is limited by disease) and death when compared with 34 other developed nations. While we greatly outspend other countries for healthcare we have far too little health to show for it.

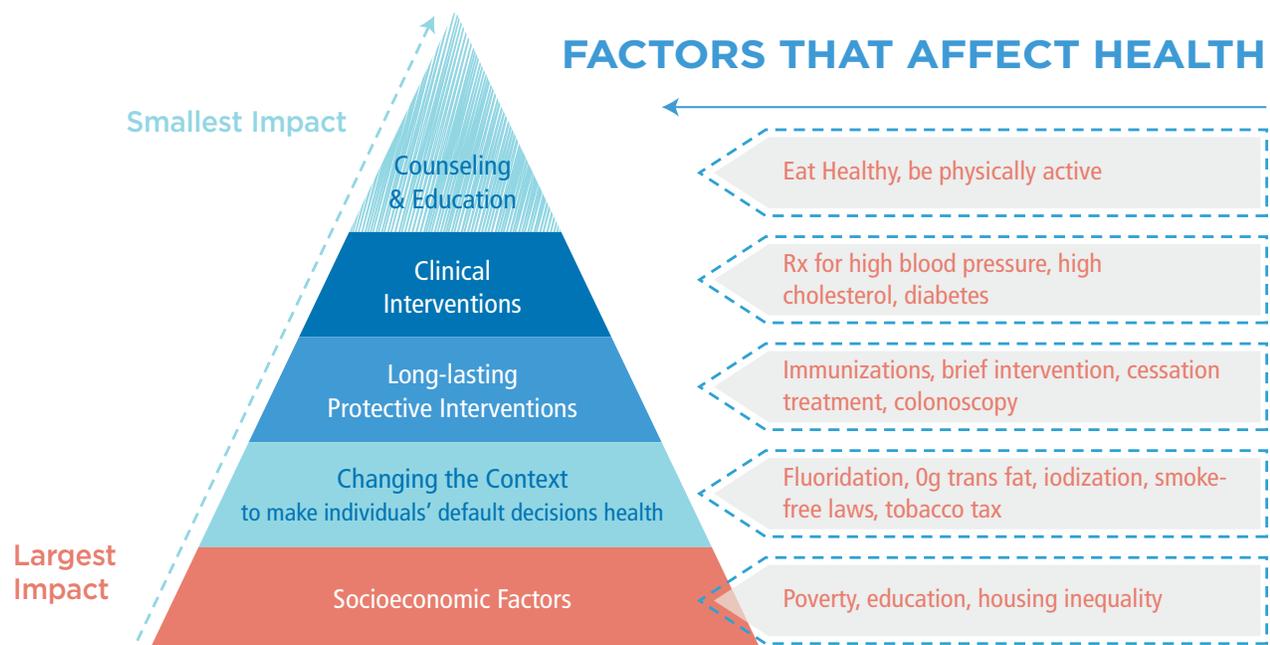
Of course, we want a top notch emergency room to go to if we have chest pain. We want skilled surgeons to operate on our vital organs and joints to sustain life, relieve pain and enhance mobility. We want (and need) scientifically proven disease management programs to slow the progression of the chronic diseases (like diabetes, heart disease, asthma, depression) that afflict our lives.

But it is population health, a growing movement in health policy and practices, that considers the wellbeing of a group of people and offers an approach that extends beyond the 10 percent of determinants managed by medical care delivered at hospitals, emergency rooms and even doctors' offices. Population health extends to the 90 percent of factors that make us sick.

What Can be Done?

Going beyond the pie chart of determinants of health leads us to the pyramid of factors that can improve our health.

This graphic, courtesy of the CDC and work by Dr. Thomas Frieden, depicts a graded approach of the actions a society can take to impact its health. But no level of the pyramid is meant to be primary or exclusive. The more levels affected the better we will mitigate disability and death.



“ We are far more apt to do something if it is shown to be in our self-interest or the interest of those we care about.”

Achieving success on any level of intervention in the pyramid depends upon partnerships among public health proponents, medical centers, business entities, communities, and citizens.

Stable and safe housing, even without healthcare, can stabilize chronic disease and reduce unnecessary emergency room and hospital care. Smoke-free environments can reduce respiratory illnesses and cancer. Early detection of cancer, colon and breast cancers for example, allows for earlier intervention and reduces death. Early detection in primary care or community settings of hypertension, diabetes, high cholesterol, and depression improves lives and saves money. Self-care with diet, exercise, and stress management are at the heart of healthy communities and nations.

Is Population Health Possible?

What makes us think that population health can be achieved? The natural act of self-interest may answer that question. We are far more apt to do something if it is shown to be in our self-interest or the interest of those we care about — and when it is built into the routines of medical care and our lives.

We now have inescapable evidence that illness is bad for business. We know that illness produces absenteeism, presenteeism (showing up but being unproductive), and greater rates of disability. We also know that wellness (“... a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.” – The World Health Organization) increases worker (from the factory floor to the corner office) productivity and is associated with higher corporate earnings (so says IBM).

We know that 1 percent of patients in a large group of people account for about 20 percent of medical costs; that 5 percent of patients account for 50 percent of costs; and that 10 percent of patients account for 75 percent of costs. But if only 10 percent of their health is determined by the provision of healthcare we are talking about a tiny fraction of what can reduce costs.

“ If Netflix and Amazon can know so much about you and influence what you buy and do, **so can health IT.** ”

Enter population health: Unless we change behaviors and the environments people live and work in there will be limited impact on the economic burden a society and a community face. In other words, we can't afford to still primarily focus on medical care.

We also have a sea change underway in the financing of healthcare. Buyers of healthcare (federal and state governments and large employers in the private sector — the vast predominance of the purchasers of medical services) are now putting in place payments that will reduce reimbursing medical providers for doing more and instead incentivize them to economically contain the health costs of their subscribers.

When health plans and medical practices are put at financial risk for not managing to a fixed budget or, even better, create arrangements where savings are shared by purchasers and providers together, the marketplace can add its muscle to achieving health. Penalties like not paying for inpatient readmissions within 30 days also drive better health. They force hospitals to be partners with communities and with patients (and families) since what happens after a hospital stay usually has little to do with what happened in the hospital and everything to do with follow-up care and the attention patients give to their health.

Privacy concerns notwithstanding, we also are seeing an explosion in information technology — the nervous system of healthcare. We are positioned to place a cortex, an IT cortex, to inform and help improve the health of patients and populations. Information need not stop at the grounds of a hospital. Patients, primary care clinicians, and medical practices can (and are doing so in demonstrations underway) be linked to information about what consumers buy in the supermarket, the fitness they pursue with pedometers and in clubs, and their smoking and drinking habits. If Netflix and Amazon can know so much about you and influence what you buy and do, so can health IT. What's more, insurance premiums paid by subscribers may come to reward, or not, those whose habits are less costly to society. Using information to shape public behaviors may be called the “nanny state” but it is also a way by which individuals can take control of their health while businesses as well as state and municipal governments save money and lives.

Who Is Leading the Way?

I recently attended a meeting, a Population Health Summit, in New York City, hosted by the New York State Department of Health with the support of the NYS Health Foundation, the New York City Department of Health and Mental Hygiene, hospital associations, NYS county governments, community healthcare providers, researchers, global and local companies, universities, and the New York Academy of Medicine. We met at the headquarters of the NY Academy of Sciences.

Attendees were there to advance the cause of population health: to assert the evidence for it and to provide examples of what can and is being done. The message throughout the day was that it is possible to reduce illness and death, improve quality of lives and “bend” the curve of (if not diminish) budget-breaking healthcare costs by attending to more than the 10 percent that has dominated our healthcare heretofore.

To do so, however, requires unprecedented collaboration among the varied groups assembled — who need proof that they can achieve results consistent with their respective interests. Hospitals have had to fill beds and do complex procedures to remain financially viable. Governments have had to regulate to try to control costs and quality. Businesses, large and small, have struggled with the growing burden of health insurance costs and have done what they need to do to limit them. Researchers have had little opportunity — or support — to move from controlled, university settings into the barrio, the supermarket aisle, domestic dysfunction, and damaging human habit disorders.

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Among the prominent public health experts at the Summit were Drs. Tom Frieden (head of the CDC), Nirav Shah (NYS Health Commissioner) and Tom Farley (NYC Health Commissioner). Their message to the diverse interests in attendance was that population health can be financially sustainable and can get NYS (and this country) out of the global cellar of rates of morbidity and mortality.

But experts, government officials, and corporate buyers cannot succeed without individuals and families coming to believe that their interests will be served, their lives improved, and their personal budgets spared by taking their health seriously. Changing habits is among the most daunting of endeavors for any of us. But we now have behavioral interventions like Motivational Interviewing and Screening and Brief Intervention and Referral for Treatment — SBIRT. We have smart phone apps (and other technologies) for monitoring and managing just about everything human from the food we ingest to the moods we have. Peer influences are helping to reduce smoking and excessive sugary drinks. Insurance incentives to live healthy can add leverage for prevention and self-care. No single intervention works here either but when bundled together, people do change.

Population Health

Population health will not be achieved by a few missionaries. But it can be led by a confederation of public health advocates, organized medicine, government, independent businesses, and patients and families. What seems out of reach is possible when so many players are on the same team.

As individuals, we can benefit from new medicines and more frequent MRIs, surgery, or other procedures. In fact, we have an amazing healthcare system in this country that does just that for those who have good medical insurance. We don't want to lose that capability; we want to add to healthcare the needed attention to the 90 percent of determinants that impact our health, our longevity, and our pocketbooks.

To paraphrase President John F. Kennedy, changing the public's health will not be easy — it will be hard. Those gathered at this Summit on Population Health were there for the sake of our generation and the generations to come. Let's wish them well and lend our collective support for they surely will need it.

LLOYD SEDERER

Medical Director, New York State Office of Mental Health and Author of *The Family Guide to Mental Health Care*

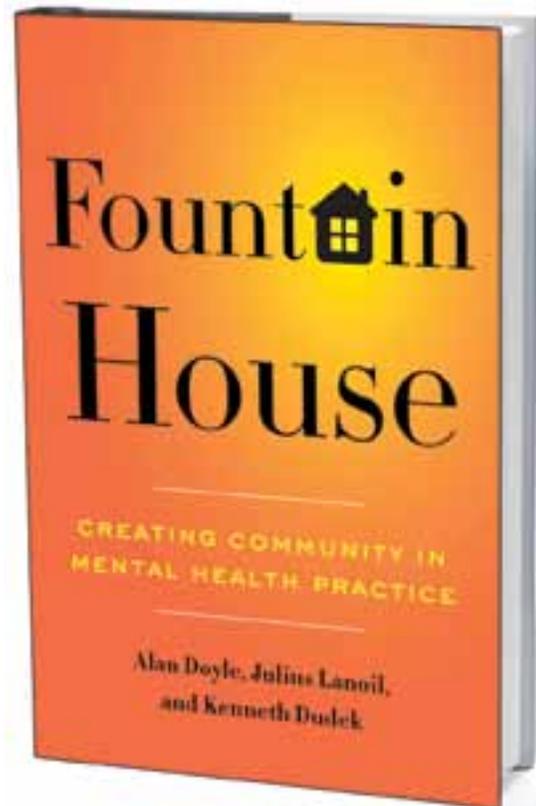
Article first appeared in in *Huffington Post Healthy Living*, Feb 14, 2014

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Creating Community in Mental Health Practice

ALAN DOYLE, JULIUS LANOIL,
AND KENNETH DUDEK



“This book, rooted in a historical perspective, illuminates the principles and practices that have guided Fountain House since its beginnings. It is a document, above all, of hope.”

—Oliver Sacks

“This is a book that should be read by all mental health practitioners and is essential for anyone who wants to understand community as a therapeutic methodology.”

—Thomas Jamieson-Craig,
president, World Association for
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Driving Smart with Population Health Dashboards



There has been much talk about population health management since Don Berwick's Triple Aim — improve the experience of care, improve the health of populations, and reduce costs — was linked to the Affordable Care Act. Healthcare administrators and clinicians have always sought ways to improve the health of patient populations as a whole. Over the past decade, vast amounts of data have been collected with the rapid adoption of electronic health records. Kindig and Stoddard assert “The importance of a population health perspective is that it forces review of health outcomes in a population across determinants.”

The ability to look at group data allows healthcare professionals and their teams to begin to tease out the drivers of health outcomes. However, two critical factors are required if this ability is to be realized.

1. Data must be presented in a format that healthcare professionals and patients can understand and use.
2. There must be a process or model for acting on findings.

Data in an understandable format can be hard to find. Spreadsheet reports or tables showing a series of numbers are not easily digested by most people, so the solution is to put the data in picture format with simple language explaining the various elements. Often described as dashboards (due to the similarity with a car's dashboard), data are provided in as simple to read and understandable format as possible. Dashboards can take on a variety of formats and provide a means for monitoring, analyzing, and managing data. The most effective dashboards are simple, provide real-time data that are colorful, and convey information in numbers and shapes. Dashboards can describe data for a group or population of patients (e.g., patients diagnosed with diabetes and schizophrenia), allowing a clinician or team to begin to hypothesize about the determinants of the findings. It is this process of hypothesizing, a fancy word for making an educated guess, that leads to the second necessary condition for

conducting population health management, namely the Plan-Do-Study-Act model for acting on dashboard findings.

You're probably familiar with the PDSA model as a quality improvement process that happens after a committee or team develops a detailed plan for how to improve a process. Management often reviews the plan and receives regular reports. While this is one approach, especially for large strategic initiatives, any staff member, patient, or team can conduct a PDSA with very little effort beyond making an educated guess about what is happening and agreeing to change a process or behavior to see if dashboard findings change in a few months.

For example, a healthcare team meets weekly to review several dashboard reports that tell the story of their care provision. One week in September, the team sees that more than 70 percent of their patients over age 65 have not received an influenza vaccine. The team agrees that either the data are wrong, or that they need to reach out to this population to assist them in getting their vaccinations. Each clinician agrees to ask the elderly patients on their caseload about their vaccination status to confirm if they have or have not received the seasonal influenza vaccine. The team nurse agrees to send all clinicians the Centers for Disease Control's influenza recommendations and locations where patients can get free vaccinations so all clinicians are prepared to talk with their patients. With the Plan component of the PDSA model completed, the staff set out to Do the work of contacting their patients. They agree to review the dashboard weekly to Study if it is trending in the right direction. If the numbers do not improve in two weeks, then the team agrees to set aside a meeting time to Act by reviewing what more can be done to improve the dashboard findings. You can probably relate to a team finding an issue that needs attention, such as a patient who needs to be located because of a few missed appointments or a patient who lost housing and needs access to the shelter, but it is probably not typical that a team will be able to look across a population of people to see what is or isn't driving a health outcome. Dashboards and rapid PDSA cycles bring population health management capabilities to any clinician, administrator, or team.

JEFF CAPOBIANCO

Director of Practice Improvement, National Council for Behavioral Health

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WHAT IS POPULATION HEALTH?



Most healthcare is delivered as a direct response to an individual's needs when they seek care.



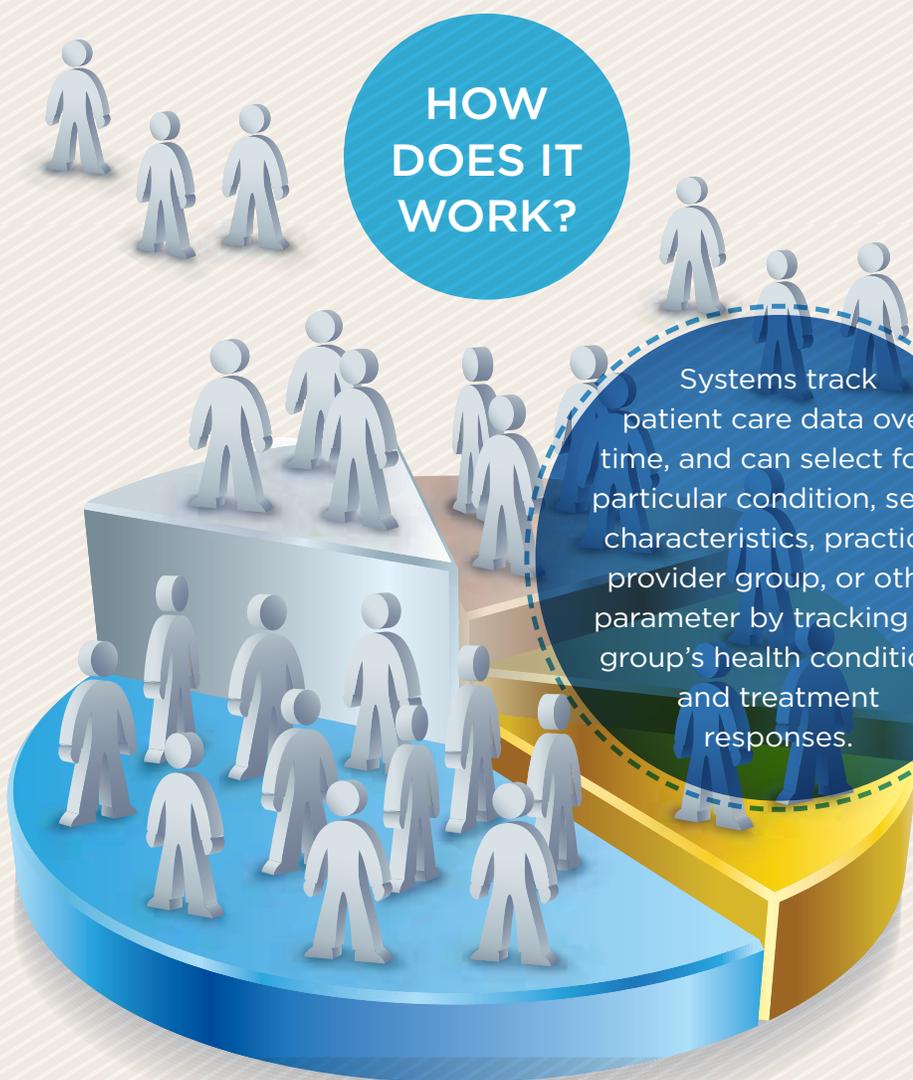
Population health assesses, tracks, and manages the health of an entire group, and not just when they seek care.

HOW DOES IT WORK?

Population health uses data to choose which patients receive evidence-based interventions and treatments.

Systems track patient care data over time, and can select for a particular condition, set of characteristics, practice/provider group, or other parameter by tracking the group's health conditions and treatment responses.

Examples of population health approaches include health homes, patient-centered medical homes, comprehensive care management, care coordination, and the chronic care model.



REMEMBER: Focus on pursuit of a specific care gap across all your patients. Do not use population management tools to address care for every patient.

10 STEPS to implement population health management in your organization

1

Map out all the places (databases, records, etc) your organization stores information on diagnosis, clinical values (lab results, blood pressure, etc.), and treatment.



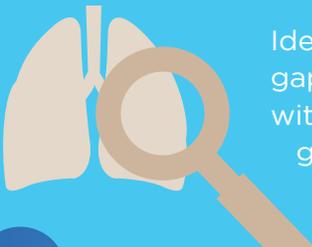
2

Aggregate all the data you collect into a single database.



3

Identify which care gaps you can act on without having to gather additional data.



4

Talk with your staff about the difference between population health-based care delivery and patient complaint-based care delivery.



5

Focus on quick and easy interventions (such as treatment of hypertension) before long-term interventions (such as weight loss).



6

Select a care gap which is easily and rapidly treated (such as hypertension), and have a care manager generate a list of all patients with this.



7

Identify a set of responses to the indicator (e.g., referral to a primary care provider, patient inquiry/ follow-up, medication adherence check), and work with the treatment team to confirm the response and assign a team member to take action.



8

Educate staff and patients on the current care gap being pursued.



9

Benchmark your progress as an organization and by teams.



10

Identify additional data that can be easily collected to address other actionable care gaps.



The Politics of Inclusion

INTERVIEW WITH
OCTAVIO MARTINEZ, JR.

Executive Director
Hogg Foundation for Mental Health



“The major barrier is a poor understanding of systems.”

NATIONAL COUNCIL: Why has the Hogg Foundation focused on physical and behavioral health integration, and what progress have you seen in this space over the years?

MARTINEZ: The Hogg Foundation is nearing our 75th anniversary. Since our inception, we’ve worked to improve mental health in Texas. Back in the early 2000s, we recognized that collaborative care was gaining ground — bringing physical, mental, and substance use services back together under one roof. This seamless approach made sense — the current healthcare delivery model was woefully inadequate because it was siloed.

And we were learning more about how physical ailments correlated with mental health symptoms and vice versa. For example, an individual who’s had a heart attack is at greater risk for depression and that an individual with depression is at increased risk for heart attack.

We looked at the collaborative care model developed by Jürgen Unutzer at the University of Washington. That model fit in quite well with understanding how mental health was part of the bigger healthcare picture. So we funded a program grant that looked at the collaborative care model in the community and grew from there. We’ve continued to develop grant programs and initiatives and partner with other organizations around integrated care, which really is the 21st century healthcare delivery model.

NATIONAL COUNCIL: How do recent changes in healthcare delivery and payment systems, like the Affordable Care Act, impact your efforts?

MARTINEZ: The ACA has certainly boosted our efforts — by continuing the integrated care dialogue, by putting person-centered care and the Triple Aim front and center, by expanding access to mental health and substance use care, by emphasizing the need for cost control, and by highlighting health disparities we must address within behavioral health.

NATIONAL COUNCIL: Do we continue to see barriers to the integration of primary care and behavioral health?

MARTINEZ: Yes. The major barrier is a poor understanding of systems. Even though we all work within systems, we’ve done a terrible job in healthcare of bringing systems to work together, of breaking down the silos that we’ve created through varied funding streams. It’s still hard to put a psychiatrist in a primary care arena, or do other things that would enhance the delivery of care because of issues of how to code and who to bill. We’re so entrenched in our own cultures that it’s hard to work together.

Another barrier is what I call the politics of exclusion. Our policies and the politics that drive our policies are mired in the past and remain exclusionary. We exclude health when we look at people. For example, if we had a culture of inclusion, then

“ Our policies and the politics that drive our policies are mired in the past and remain exclusionary.”

we'd talk about healthcare when we shape immigration policies and vice versa. But we don't, and this impacts how we view and interact with each other as individuals. Ultimately, this impacts health outcomes.

Integrated healthcare can't be effective unless we are really human-centered and address the needs of all populations that make up the U.S.

NATIONAL COUNCIL: How then can we adopt the politics of inclusion to build healthy communities?

MARTINEZ: We need to take a population approach to viewing our communities. We must think about who will be part of our communities tomorrow. By 2050, Caucasians will no longer be the majority in the U.S. and by 2030 among children under 18. So we must no longer marginalize certain individuals because they are different. A healthy community is one that is inclusive, not exclusive. It's one in which we've been able to learn and address all the social determinants and health disparities that have impacted that community. And it's one in which health outcomes will result in an improved quality of life for all individuals.

NATIONAL COUNCIL: How can a healthcare organization practice the politics of inclusion?

MARTINEZ: A real integrated healthcare organization must understand that it is part of the community and engage with everyone in the community — patients, and families, stakeholders — to understand the social and economic determinants of health. The organization must think about every aspect of the quality of life of the people it serves — health literacy levels, acculturation, transportation barriers, housing situations, safety concerns, and food options. It must think not

only about care delivery but also about capacity to follow through on recommended interventions and lifestyle changes.

The organization would have a multidisciplinary care team cross-trained in physical, mental, and substance use care. The team would be able to develop an overall intervention plan for each patient from a single health and behavioral health history. And this would be done in partnership with the patient and family.

A truly integrated care organization is also vested in health promotion and prevention across the lifespan. For too long, we've ignored what's happening in public health. We know about the statistics but we're not really doing anything with the data and implementing programs that are truly changing our health outcomes. Integrated care may be the game changer.

NATIONAL COUNCIL: Do behavioral health providers have an advantage in practicing the approaches you just described?

MARTINEZ: Mental health and substance use professionals have more insights into the social and emotional factors that impact an individual's health — this is a definite advantage. Behavioral health providers are also adept at bringing teams together to create effective interventions for patients and families.

But we have a serious workforce shortage in behavioral health. Many communities already confront a shortage of psychiatrists — and many private psychiatrists don't accept Medicaid and Medicare. This really comes in the way of access and integrated healthcare delivery. We can't be part of the solution unless we have enough staff to engage with everyone in need.

RESOURCES FROM THE HOGG FOUNDATION

Enhancing the Delivery of Health Care: Eliminating Health Disparities through a Culturally & Linguistically Centered Integrated Health Care Approach

This report is based on research conducted by the Hogg Foundation and from proceedings of a 2011 national consensus meeting. The report shares best practices, insights, and strategies to create a framework for integrated healthcare, placing focus on racial and ethnic minorities, and people with limited English proficiency. An accompanying literature review compiles the available evidence from practice and from peer and non-peer reviewed publications and summarizes the knowledge base on cultural and linguistic competence in health care delivery.

A Window of Opportunity: Philanthropy's Role in Eliminating Health Disparities through Integrated Health Care

Released by Grantmakers in Health and the Hogg Foundation, this report is based on a roundtable discussion with a diverse group of national, regional, and local foundations that Hogg brought together to explore how integrated healthcare can help eliminate health disparities among racial and ethnic minorities and people with limited English proficiency. The report captures key discussion points and presents recommendations for foundations to improve the health status of some of the nation's most vulnerable populations through integrated healthcare.

Breakfast Club: A Healthy

INTERVIEW WITH
JEFFREY BRENNER

MacArthur Fellow and
Executive Director,
Camden Coalition of
Healthcare Providers



“Our whole idea for how we deliver services came from behavioral health.”

The Camden Coalition of Healthcare Providers is a nonprofit formed to improve the quality, capacity, and accessibility of the healthcare system for vulnerable populations in the city of Camden, New Jersey. Founder Jeffrey Brenner found that in Camden, 80 percent of the costs were spent on 13 percent of the patients, and 90 percent of the costs were spent on 20 percent of the patients. He wanted to address this disparity through a collaborative community approach. He started the Coalition and built relationships across the Camden healthcare provider community — from community-based private practices to front line hospital staff to social workers across the city. Using those relationships and guided by the Camden Health Database to inform and evaluate, the Coalition operates several health initiatives to demonstrate a collaborative approach to improving care delivery and patient outcomes. The program models can be replicated and implemented in other cities across New Jersey and the country to result in improved patient care and reduced costs. The Coalition has also built relationships with the executive leadership of local hospitals, social service/public health agencies, state government agencies, Medicaid health plans, and policymakers to advocate for legislation to sustain this modern day approach to healthcare delivery.

NATIONAL COUNCIL: What does care coordination really mean?

BRENNER: The words care coordination and care management have been really rendered meaningless, and they’ve been loosely applied to different models. For us care coordination and care management mean data-driven interventions that focus on patients with significant needs or in crisis. And it involves intensive relationship building, face-to-face interaction, home visits, accompanying patients to appointments, significant training in harm reduction, trauma-informed models, and motivational interviewing.

NATIONAL COUNCIL: Who needs to come together to make all of this happen?

BRENNER: Complex patients touch so many different parts of the healthcare system that it doesn’t work to just have one stakeholder. A complicated patient moves from hospital to hospital, emergency room to emergency room, and sometimes primary care office to primary care office. They can even move through different insurance companies. They have interaction with long-term care, sub-acute care, durable medical equipment, visiting nurses, hospice ... It becomes enormously challenging to figure out how each entity by itself is going to make the relationships work. It calls for an umbrella approach at the community level that pulls stakeholders together and aligns them around the workflows and service delivery models.

NATIONAL COUNCIL: For the Camden Coalition, it was you — as the primary care practice — that took the initiative to reach out to other stakeholders, right?

BRENNER: Yes. I was a practice primary care doctor by myself in a three-exam room office, incredibly frustrated every day by how disorganized and fragmented the healthcare system was for my patients. And I spent a lot of

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Start to Community Coalitions

hours on the phone and a lot of time to try and make the system work for people, but you can only stand in the gap by yourself for so long and it's not a stable way to fix the system. So I began to pull people together for what we called the Health Provider Breakfast Group. It was literally a group of solo practice providers getting together having breakfast quarterly and eventually we formed the non-profit Camden Coalition. We brought the hospitals and the rest of the alphabet soup to the board of the organization as a way of collaborating.

NATIONAL COUNCIL: So anyone can take the initiative to bring the community together?

BRENNER: It takes humility, it takes patience, it takes fortitude. It takes playing for the long term and not getting discouraged in the short term. It takes data sharing, and I think data is a way of pulling people together.

It takes lots of little wins. So think about what's the smallest little win you can have tomorrow and don't play just for the big wins. Community organizing is a skill that very few people in the health profession have any knowledge of. That's really the technique we've used in organizing the community of healthcare providers and institutions.

And it also takes a lot of taking one-on-one relationship building to generate real collaboration. For example, a hospital is like a small city — made up of 5,000 employees who can become engaged and excited supporters. But just because you meet with the CEO doesn't mean you're collaborating with the organization. Just because the mayor's excited about what you're doing doesn't mean the city council and the department heads and the chiefs and the vice presidents are excited as well.

NATIONAL COUNCIL: At Camden Coalition, you say your mission is to help reduce costs and still deliver quality service. How do you do that?

BRENNER: The vision is for Camden, NJ, to be the first city in the country to bend the cost curve and improve quality. And that's really a breakthrough concept — if you can do both of those things then it's a game changer in healthcare. And if you can do it for one person you can do it for five, you can do it for ten, you can do it for fifty, a hundred, and in the end do it for thousands, which can generate millions of dollars in savings. This is our hypothesis.

We think the biggest preventable costs are unnecessary hospital admissions. So we're focused like a laser beam on reaching every hospitalized patient to keep them from coming back. Because we think that if you've been to the hospital, twice in six months, you're the exact subgroup that is in crisis. If you focus on every hospitalized patient with a defined workflow for when they leave the hospital, it's an incredible opportunity to save money. Each hospitalization is \$10,000. Every hospitalization should be considered a failure of the healthcare system until proven otherwise.

“ We've been heavily influenced. Rarely do people invent totally new ideas, innovation is just grabbing good ideas and twisting them into new combinations.”

NATIONAL COUNCIL: Are there other ways you look at cost reduction? An NPR story on the Camden Coalition described how you work like the airlines — overbook to avoid no-shows, etc.

BRENNER: Yes, there's a lot of task shifting that can be done. There are many things that doctors do that they don't need to do. We try to get doctors to delegate work to nurses, nurses to delegate to Licensed Practice Nurses, and LPNs to delegate to health coaches. Much work can be shifted to lower cost employees. This requires protocolization, standardization, and training, and you can't do those things unless you create a highly structured system to support it.

NATIONAL COUNCIL: How do you pay for these improvements?

BRENNER: Most of our services are grant funded, which is not a stable structure in the long term. We do have one contract now with United Healthcare. They've been great partners, very innovative, and now have an upfront payment for services we provide with a back end savings payment. But there needs to be a lot more work on payment reform.

I don't know that we need more money, we need to just spend the money we have better. Let me give you an example. In New Jersey, care management services are being delivered telephonically — nurses in cubicles are trying to call homeless people with no phones! New Jersey spends about \$38 million a year with 700 FTEs in cubicles. A small amount of that money moved into a community-based model could achieve a lot more.

NATIONAL COUNCIL: You are focused on high emergency room users, but can your learnings be applied to other populations using healthcare as well?

BRENNER: Of course. Our whole idea for how we deliver services came from behavioral health, it came from a visit that I had with an Assertive Community Treatment team — they knocked my socks off. I was so impressed with the model and thought, why isn't the medical side doing something like this? I've also been really impressed with PACE, Program for All-Inclusive Care of the Elderly, which is a similar model with wraparound services for dual eligible, high-risk geriatric patients that should be institutionalized but are being kept in the community.

We've been heavily influenced. Rarely do people invent totally new ideas, innovation is just grabbing good ideas and twisting them into new combinations.

Mental Health First Aid: Philadelphia's Population Health Approach

INTERVIEW WITH

SAMANTHA MATLIN

Special Adviser to the
Commissioner

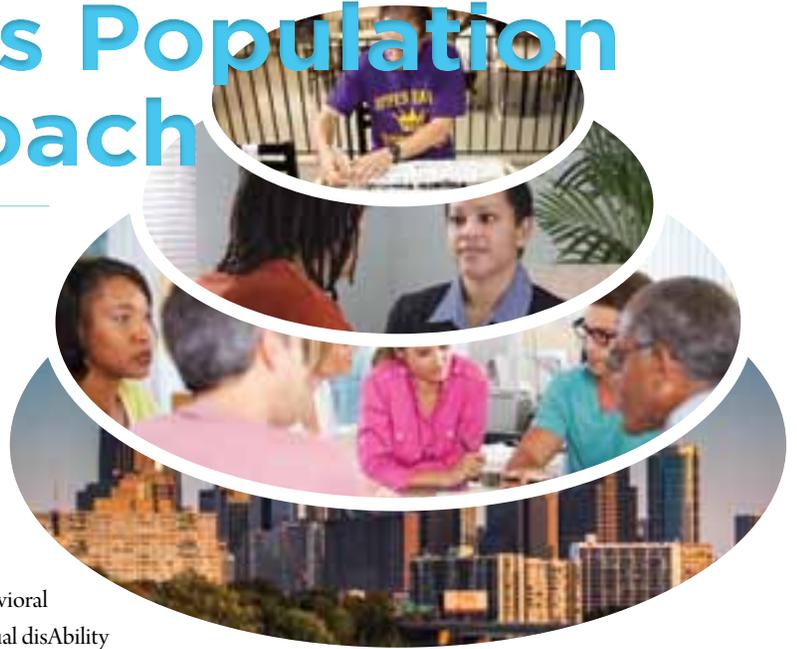
JENNIFER SEARS

Director of Mental Health
First Aid



MENTAL
HEALTH
FIRST AID™

“It’s really about aligning your resources with your values.”



In January 2012, the Philadelphia

Department of Behavioral Health and Intellectual disAbility

Services, under the leadership of Arthur Evans,

PhD, kicked off a population-based approach to improving the health and wellness of Philadelphians.

NATIONAL COUNCIL: Why do you take a population health approach to improving the behavioral health of Philadelphians?

We’re responsible for everyone in the city who has any kind of public assistance or who’s uninsured or underinsured, and that in itself is about a third of our population. As a city agency, we’re also responsible for the behavioral health of the 1.5 million people in Philadelphia.

We know many people are never going to access the formal treatment system. Even when people do come to treatment, they live in the community with their family and friends, and we want to support them to live healthy lives. We asked ourselves, “If we believe that everyone should wear helmets, that we should put fluoride in everyone’s drinking water... what can we do to address behavioral health?”

NATIONAL COUNCIL: How do you make a community healthier?

Philadelphia has been going through a 10-year transformation of services, working toward a city that embraces recovery, resilience, self-determination, and community inclusion and mobilization. We’re looking at ways to engage the community and to provide resources to people who haven’t accessed services, or don’t know about services.

We want to get people talking and thinking about behavioral health screenings in the same way as blood pressure screenings. We’ve trained a dozen of our provider agencies to do behavioral health screenings.

Mental Health First Aid is a big approach to reduce stigma and increase mental health literacy. We’ve conducted 157 trainings to date, reaching about 2,700 individuals. Every month, we have 15 to 25 free Mental Health First Aid trainings. We target those who have a higher probability of interacting with people with behavioral health needs — school staff, first responders, etc. We also have private sector partners, like Comcast, the National Constitution Center, and our transportation partner, SEPTA. They have folks who interact with individuals with behavioral health issues every day and could really use some skills.

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We train all new police recruits in crisis intervention. Community response teams go out after a traumatic event, like a shooting, to educate parents and caregivers on trauma response. In most of our emergency departments, a program called Healing Hurt People intervenes with young adults who come in after a violence-related injury, and are at high risk for violence retaliation.

We give grants to community coalitions to develop programming to fit their needs. They focus on specific populations and places, and we require them to partner with a community based organization, a physical health organization, a behavioral health organization, and the police.

We have a participatory public art project called Mural Arts focusing on wellness, and we're having community dialogues and art making around what does it mean to be well and how we understand wellness — physical, psychological, financial, educational, and spiritual.

NATIONAL COUNCIL: How do you measure change or success in prevention and early intervention initiatives?

It's tough, because if we're successful, we will not know it. Right now, we are mainly measuring our penetration — are we training diverse people across the city, how many people are we screening, how many people are we referring to services, etc.

We partnered with Drexel University's Department of Public Health to evaluate Mental Health First Aid. Preliminary findings show that people are using their training, in their jobs and at home. A mother told us her daughter was having some suicidal thoughts, and she felt like she was better able to listen to what the daughter was feeling, and encourage her to seek appropriate professional supports.

NATIONAL COUNCIL: What impact have you seen so far with Mental Health First Aid?

In 2012, we hit the ground running. We were good at getting the word out, and we trained many instructors as a result. From there, we recognized that we needed to match the capacity and the infrastructure to deliver on what we wanted to do and also where people's interest was.

We have a dedicated Mental Health First Aid staff of eight, and we have a strategic plan. We've ramped up our budget and we have measurable outcomes — training 10,000 people the next two years. Our populations of focus have broadened, and with that, our partnerships.

We're able to attract a broader base of people that are interested in what we're doing, and that's really exciting. Nine to ten years ago, our recovery walk had a few hundred people participate and we were tucked away in a park. Today, we have 20,000 people from across the country attend. It's very public, very open, celebrating recovery, and it speaks to the success of the transformation here in Philadelphia. People in recovery and their family members have taken ownership of this and are coming out and mobilizing.

Through Mental Health First Aid, we're able to partner with corporations and agencies that in the past we have not had the opportunity to work with. We are beginning to forge partnerships with companies like PICO, Comcast and SEPTA. With the Red Cross, we're able to deliver Mental Health First Aid alongside CPR. When these partnerships prove to be successful, they can be a national model.

Our department is seen more as a resource now. The University of Pennsylvania had a number of student suicides recently, and they've reached out to talk about what we can do to support them. That wouldn't have happened a few years ago.

NATIONAL COUNCIL: What are your goals for the next five years?

We want to train 100,000 people, or 10 percent of the population, in Mental Health First Aid. Right now we have a 3-year plan, and then we hope to evolve that. In our budget, less than 3 percent is being allocated to prevention or community intervention. We hope that there will be continued funding available through the state and federally, because right now we're supporting this through our reinvestment dollars, which may not be there after three years.

NATIONAL COUNCIL: What can other behavioral health agencies learn from what you do?

Everyone needs to tailor what they do to their population and their resources. We were not just going to add new programs. As you transform the system, programs follow.

It's really about aligning your resources with your values. We always want to have more money and resources for behavioral health, but we can't let that be the reason we're not doing better. We were able to save a tremendous amount of money by bringing youth from out of state placement, keeping them closer to home in Philadelphia, and reinvesting the savings into these programs.

Our commissioner, Dr. Arthur Evans, shares our approach and strategic plan with other states and systems. If you put Mental Health First Aid out there, people will want it. You must ensure you have the capacity and the infrastructure in place to respond to the demand. Part of that is figuring out how to engage and retain instructors. We implemented opportunities for instructors to come together and provide feedback on what they need and what's going on in the community. This gives them an opportunity to get to know each other, understand each other's learning styles, and look at strengths and areas for improvement.

As we branched out to the larger community, beyond traditional behavioral health networks, we realized that there are people out there that have the capacity to reach many more Philadelphians than we do. We realized early that we had to create partnership agreements with all of these entities, and support their marketing and outreach, to ensure that they fill their Mental Health First Aid classes. We also have an advisory board with representatives from the different stakeholders and partners.

A Tale of Six Cities

EXCERPTS FROM PROFILES AT www.countyhealthrankings.org/roadmaps/prize

The Robert Wood Johnson Foundation's Roadmaps to Health prize honors outstanding community partnerships that are helping people live healthier lives. The prize was launched to further the work of the County Healthy Rankings and Roadmaps program, which aims to educate the public and policymakers on the multiple factors that influence community health — education, economic conditions, and the physical environment — and to provide solutions that improve community health.

RWJF encourages National Council for Behavioral Health members — community behavioral health organizations that often take on the role of “community problem solvers” — to think about how they can replicate the success of Roadmaps to Health prize winners. Organizations already engaged in population health management initiatives in their communities are encouraged to watch for the call for applications for the 2015 prizes. Winning communities each receive a \$25,000 cash prize and have their success stories celebrated and shared broadly with the goal of raising awareness and inspiring locally driven change across the country.

Meet the winners of the inaugural RWJF Roadmaps to Health Prize in 2013 and discover how they are creating healthier communities.

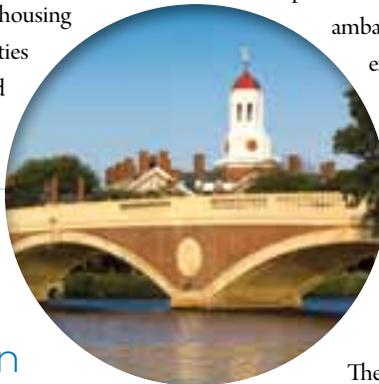
1 NOT ALONE

CAMBRIDGE, MASSACHUSETTS

What most people don't know about Cambridge, Massachusetts — home to Harvard and MIT — is that parts of the city struggle with immense poverty and public health challenges. More than half of the children in the city's schools live in subsidized housing. There is a large population of immigrants in this community. The goal for a healthier Cambridge is that a child born in one of the city's housing developments has access to the same opportunities to lead a healthy and successful life as a child born in one of the city's more affluent homes.

“ Cambridge has learned that there is no one entity that can solve any particular problem ”

Effectively serving the public health needs of such a diverse community requires a “culture of collaboration” where government agencies, businesses and non-profit organizations come together to identify and address needs. The health department has been a major force in forging these alliances. The health department is a part of Cambridge Health Alliance, a healthcare system with three hospital campuses and an extensive primary care network, giving it the unique ability to fully



integrate the provision of public health with related community health efforts.

With a community so focused on the health and well being of children, many of whom are from immigrant families, literacy is especially important. The Let's Talk literacy campaign brings knowledgeable ambassadors right to a family's home to bring books, and to explain to parents the best way to talk and read to their children. Public schools offer innovative physical education classes (such as ballroom dancing) and healthy meals that celebrate cultural diversity. Cambridge overhauled school lunch programs to offer locally grown foods, with an emphasis on fruits and vegetables. In addition, school-based health services treat the “whole child.”

The city has also seen great success with its Men's Health League, a program that reaches out to men in the community who, while they're making sure their families are taken care of, might not seek out health care for themselves. The initiative is especially focused on men of color and those that have been impacted by the burden of chronic disease.

Cambridge has learned that there is no one entity that can solve any particular problem. But when you take the expertise of the health department and join it with the expertise of community agencies and the human services department and the police department, there is a much greater opportunity to have impact.

IT TAKES A VILLAGE

INTERVIEW WITH ABBEY COFSKY

Senior Program Officer, Public Health Team, Robert Wood Johnson Foundation

NATIONAL COUNCIL: How would you define a healthy community?

COFSKY: Healthy communities are committed to addressing the barriers to health and having conversations about the root causes of poor health. They create environments that allow people to be healthy — whether through accessible healthcare, healthy food, or safe places for kids to play and exercise. It's going beyond education to create a culture and an infrastructure that fosters health.

A healthy community is one in which leaders across different sectors are making health a priority. It's not just about one organization that is trying to address a specific disease or population. It's about leadership coming from across the community — government, private sector, and community members who recognize that health and wellness are important to the quality of life.

NATIONAL COUNCIL: How does that leadership happen? Who takes the initiative and says, "Let's get people together and get this going?"

COFSKY: The leadership and convening power comes from different places in different communities.

The RWJF Roadmaps to Health project started with the county healthy rankings. It was therefore assumed that public health leaders and governmental public health agencies were the ones that were thinking and leading the effort to build healthy communities. And in many communities that is the case. But we're also seeing leadership from others in local government, from the county commissioners and the mayor's offices. They recognize that health is connected to the productivity of their communities.

We're seeing leadership from organizations like the United Way, which has foci across health, education, and income and is well positioned to bring diverse partners together. In some cases we're seeing leadership come from the schools that are thinking about how to foster an environment that enables students to succeed academically — and that gets back to healthy behaviors, and a healthy environment. We're also seeing local spenders play an important role in convening the players in a community. We're seeing leadership from local advocacy groups as community members call on leaders in the community to make health a priority and give them

the opportunity to live healthy lives. And we're seeing leadership from community health centers or hospitals or healthcare providers frustrated with patients coming in the door with chronic conditions fostered by unhealthy conditions in the community.

NATIONAL COUNCIL: When a single entity in a community wants to initiate the process of building a healthy community, where would they start?

COFSKY: One of the first steps would be to look around the community and take stock of who else is already working on these issues, of what else is already happening. That often gets missed and then organizations are working in silos, which takes away from potential collective impact.

There's been a lot of buzz recently around community health needs assessments. Nonprofit hospitals and health departments are required to do them. That assessment, if done well, should be an opportunity for stakeholders across the community to weigh in on the most pressing problems and barriers to health in the community and to come together to evolve a strategic plan for action. Different organizations bring different assets to implementing that plan.

NATIONAL COUNCIL: The RWJF Roadmaps to Health prize program recognizes communities that have already achieved a measure of success, how do you advance, and share, their work?

COFSKY: The prize is intended to spotlight those who are building healthy communities — it's not just about what we are going to fund one community or the other to do but about recognition that this is happening across the country.

With our first cohort of six winners, it really exploded. There was a real hunger to learn how this work could be replicated in other communities. Winners were invited to participate in conferences around the country. People want to focus on solutions and take what is applicable to their communities. They want the inspiration that these community leaders bring. They also want the opportunity to tap into the roadmaps that these communities have used.

Continued on page 31

2 STARTING YOUNG

FALL RIVER, MASSACHUSETTS

Fall River, Massachusetts was a mill town for about 150 years. When one of the biggest mills closed down, it plunged about a quarter of residents into poverty, driving the unemployment rate up to 9 percent. The health of the community reflected the economy. However, the town has come together to get and stay healthy. Leaders were able to bring together a coalition that looks at a plethora of problems —

poverty, lack of education, lack of community support, housing, jobs, etc. A former mill building was renovated into a state-of-the-art multi-vendor health center for low-income people. In a community where lack of transportation is a major issue, the facility concentrates a wide variety of resources, offering one place where families can see several providers all in a single visit.

Realizing that its public health efforts must focus on long-term changes, the town has worked hard to reach out to youth and foster youth-driven health improvement. Partners worked alongside youth who advocated for a successful citywide ban on tobacco sales in pharmacies. This initiative has empowered the youth to tackle new issues such as prescription drug abuse, bullying, and violence. The city has developed programs to reduce youth violence and help high school dropouts develop job skills. Graduation rates are now the best



“It’s gratifying when youth go on to college and choose to come back to Fall River to make a difference.”

they’ve been in decades. It’s gratifying when youth go on to college and choose to come back to Fall River to make a difference.

As with many public health efforts, the Greater Fall River Fitness Challenge started small and grew into something much bigger. Partners came together to challenge adults to get fit, stay healthy, prevent Type 2 Diabetes, and pledge to collectively lose more than a ton of weight. Participants gain access to programs and fitness centers throughout the city for little or no cost. Over a thousand people showed up in the first month! For some people it’s about getting connected with the concept of exercise. For others it’s about losing weight. And for many it’s about working together to spur on each other’s motivation.

3 FULLY INTEGRATED

MANISTIQUE, MICHIGAN

The legions of tourists who visit Manistique, Michigan each year head to the Seney Wildlife Refuge, lighthouses, a shoreline boardwalk, and the Hiawatha National Forest. But it takes a visit to the three miles of new sidewalks, the weekly school-based Zumba classes and walking groups, and the newly created farmers’ markets to see the most exciting things happening to the city and its almost 4,000 residents.

“Focus on increasing access to physical activity and healthier foods”

In just the last four years, Manistique has made great progress toward improving the health of the entire community, with a focus on

increasing access to physical activity and healthier foods. This effort was powered initially by a Centers for Disease Control and Prevention grant to the Sault tribe, which has members living on a reservation in the area, as well as in the larger community. Tribe members know that anything that benefits them benefits the larger community and vice versa.

After extensive research, the community started a Farmer’s Market, which serves many low-income families and also benefits local farmers. The market creates access to fresh, locally grown fruits and vegetables at affordable prices and allows low-income participants to use coupons.

Hiring a health educator with a focus on community promotion helped. And the passion and zeal that helped find a new buyer to keep one of the area’s largest employers — the local paper mill — from closing also fueled the success of several health projects. Manistique knows that a strong economy goes hand in hand with a strong population.

Manistique has a non-motorized transportation plan to get everyone in the community to walk and bike safely. In 2009, the city brought in an expert to conduct a “walking audit” to help identify and eliminate barriers to walking through the town. Manistique also implemented a safe routes to school project. Sidewalks, parks with walking trails, and “Walk Manistique” signs throughout the city also promote a healthy lifestyle.

Through a Coordinated School Health Plan, Manistique schools provide kids with healthy breakfasts and quality physical education. The Exemplary Physical Education Curriculum is geared toward teaching kids skills that are exciting to them, such as archery and snowshoeing. Efforts also include a farm-to-school program where local farmers bring fresh produce into schools. Kids are excited and take that home — they share that excitement with their families and sustain the enthusiasm as they get older.



Continued from page 29

“ When you start talking about health outside of the doctor’s office, there is not always a natural reimbursement process or funding source for that. ”

We’re seeing interest in understanding both the big picture and the tactics employed by the winning communities. How did the partnerships work? How do you address the issue of childhood obesity in your community? How are you thinking about violence? How are you engaging youth?

For many communities, it’s a significant shift to move from individual health to population health; from thinking about programs and services to thinking about policy and environmental change. Our prize winners point the way.

NATIONAL COUNCIL: What keys to success have you identified from the winners?

COFSKY: Sustainability of approaches is a key success factor. Our winners haven’t accomplished what they have as the result of grant funding from just one organization. They’ve really been creative in how they use resources and maximize existing assets in their communities.

People are measuring and sharing results. While there is room for growth, there has been a real commitment to tracking progress, being transparent, and using results to engage people in how the community moves forward.

Leadership is crucial. Leadership that focuses on authentic and meaningful engagement with the people that live in the community. Leadership that brings people to the table — and not just as an

afterthought. You mentioned that National Council members often think of themselves as “community problem solvers.” That’s exactly the kind of leadership we’re looking for in our Roadmaps to Health program.

Access to a network of like-minded peers and community leaders is also valuable. People do shamelessly steal, borrow, and adapt ideas that other communities have tried. We see RWJF and the prize as platform to allow communities to do that type of sharing.

NATIONAL COUNCIL: What barriers have the successful communities had to encounter along the way?

COFSKY: We hear communities talk about how much time it can take to feel the impact of this work. Changing the culture of a community takes more than two months. And it’s not easy to keep people at the table. Keeping partners engaged is one of the biggest challenges.

Of course, funding is not always easy to come by. That’s part of a broader conversation about how we think about the investments in our health and healthcare systems. When you start talking about health outside of the doctor’s office, there is not always a natural reimbursement process or funding source for that. Resources are an issue for all communities and we call upon people to be creative in how they secure support to move the work forward.

4 MINDING THE GAP

MINNEAPOLIS, MINNESOTA

“Change the environment in which people live so that making the healthy choice is the easiest choice”

Despite what you might expect with the climate, any annual list of “most bikeable” cities is going to have Minneapolis, Minnesota near the top. The community is designed with bike and walking paths. The city is healthy but also has one of the country’s largest gaps between ‘haves’ and ‘have nots’.

The focus is on closing those gaps. That means extending opportunities for a healthy lifestyle to areas such as North Minneapolis, which has a largely lower-income and African-American population. The land of 10,000 lakes is also the land of 10,000 nonprofits and organizations that can reach directly into the many cultural communities of the city. Partnerships between the city’s health department and nonprofits have put programs and policies in place to address problems that disproportionately affect people with limited incomes and education.

The Northside Achievement Zone project takes a “cradle to college to career” approach to help low-income families in North Minneapolis make sure every youth is ready for college. A critical part of helping



families realize that they have the ability to succeed is to close the “belief gap” — to prove that children born in a certain zip code of poverty, violence, and single parentage can actually excel in school. After a NAZ 12-week parenting education program, parents believe their kids are worthy of going to college. NAZ recently received a grant from the U.S. Department of Education to grow its program to support 1,200 families and 3,000 children.

The City of Minneapolis and more than 40 community organizations are implementing a comprehensive obesity and tobacco prevention initiative. Highlights include smoke-free multi-unit housing, banning smoking in bars and restaurants, corner stores that sell healthy produce, and a nationally known infrastructure and culture of biking and walking. The plan in Minneapolis is to change the environment in which people live so that making the healthy choice is the easiest choice.

Recognizing the impact of economic opportunity and academic achievement on health, Venture North Bike Walk & Coffee provides youth employment opportunities and bike sales/repair services in North Minneapolis. The bike repair and rental center is also working to bring the city’s culture of bicycling to the area. The nonprofit is able to sell affordable bikes to the members of the community by fixing up old bikes.

The health enjoyed by the residents in higher-income areas of Minneapolis is slowly spreading to those in lower-income areas.

5 CHOICES, CHOICES

NEW ORLEANS, LOUISIANA

From “20 feet under water” New Orleans, Louisiana has been rebuilt in more ways than one. In the wake of Hurricane Katrina, a partnership of the city’s health department, schools, businesses, and nonprofit organizations has made public health and prevention a major component of the recovery effort. Before Katrina, the city’s approach to health was focused more on clinical care than on prevention and public health. Using the Public Health Accreditation Board’s accreditation blueprint helped the department go quickly from “broken and outmoded” to a modern public health agency.

As New Orleans rebuilds roads, buildings, parks, and playgrounds, the city is also thinking about physical as well as mental health and

addressing chronic disease needs in the community. Successes in the Katrina-ravaged New Orleans East community include a full-service hospital, a 24-hour urgent-care facility, new athletic fields, and an indoor pool.

Since Katrina, New Orleans has developed a system of 103, community-based healthcare access points for uninsured, underinsured, and low-income patients, with 68 being primary care clinics. It has also adopted electronic medical records across the healthcare system and implemented the Greater New Orleans Health Information Exchange to share clinical data for the improvement of population health.

Part of prevention is making sure people have access to healthy food and

“ New Orleans believes that one of the core determinants of health is that if the right choices are in front of us, it makes the right choice easier.”

opportunities for physical activity. Fit NOLA is a Health Department-led, multi-faceted partnership with the goal of making New Orleans one of the ten fittest U.S. cities by the city's 300th anniversary in 2018. The Fresh Food Retailer Initiative is a public-private partnership bringing grocery stores that have a specified amount of fresh fruits and vegetables on their shelves to communities that are typically food deserts.

A renewed focus on schools promoting academic achievement and good health includes new gardens, cooking classes, state-of-the-art kitchens, and new physical activity programs. The goal is to bring farming back into the urban environment to get people comfortable

with fresh food and to expand their horizons. New Orleans believes that one of the core determinants of health is that if the right choices are in front of us, it makes the right choice easier.

Hurricane Katrina didn't create all the problems but it certainly exposed problems already existing in the community. And it served as a rallying cry for people to come together and find a way to solve those problems as a community.



6 DATA DRIVEN

SANTA CRUZ COUNTY, CALIFORNIA

In the southern end of California's Santa Cruz County — one of the wealthiest in the United States — are the fields that produce much of the food eaten at dinner tables and restaurants around the country. It's ironic that the healthy fruits and vegetables have such a hard time finding their way to the tables of the men and women who work those fields.

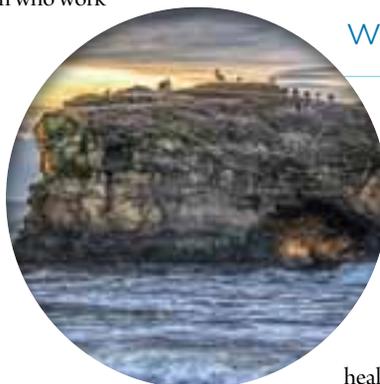
When people earn lower wages, they spend more of their income on housing, leaving less for other necessities in life. They do without healthy food. They do without opportunities to exercise. They do without visiting doctors when they need care.

In Santa Cruz County, diverse partners are facing these and other public health challenges as one.

Every step partners take is data driven. The annual Community Assessment Project details the goals the community wants to achieve while benchmarking where it stands on indicators such as air quality, unemployment, high school graduation, and crime rates. Today the Project's 18 years of information on community health, safety, economics, and environmental factors is critical for ongoing evaluation.

Santa Cruz County emphasizes getting the community's youth involved. Jóvenes SANOS is part of the "Go for Health!" collaborative to address childhood obesity. The youth advocacy project works to improve access to healthy food choices and physical activity through environmental policy and system change. Youth noticed that there were almost no healthy food options around the high school, so they

“ The annual Community Assessment Project details the goals the community wants to achieve.”



went to the city council and argued for health policies that encouraged new healthy restaurants and rewarded existing restaurants for adding healthy food choices to their menus. Youth have been working to bring healthy vending machine options to the county's metro stations. And these young people influence their families to adopt a healthy diet and lifestyle.

The Healthy Kids of Santa Cruz County program ensures children have access to comprehensive health, dental, vision, and psychological care. Diverse organizations came together to contribute resources and expertise. Today, more than 23,000 have been insured.

The Custody Alternatives Program is part of a partnership between law enforcement and the community that lets some people who have committed minor offenses be rehabilitated in their own communities in a way that is both cost-effective and successful. This alternative to incarceration program provides education, employment, treatment, and social services to get people's lives back on track.

Public Health Institutes Support Population Health

A photograph showing three people in a clinical setting. A male doctor in a white lab coat with a stethoscope around his neck is pointing at a tablet held by a female nurse in light blue scrubs. A young woman with long dark hair, wearing a light-colored button-down shirt, is looking at the tablet. They are standing at a counter with a glass top. The background is a brightly lit hallway with white walls and doors.

“The IOM report emphasized the need for neutral, third party organizations to facilitate long-term, sustainable collaboration between public health and healthcare organizations.”

Implementing the Affordable Care Act has stimulated transformations within the health system and also served as an impetus for further exploring the concept of population health. According to the Institute of Medicine's report "Primary Care and Public Health: Exploring Integration to Improve Population Health," primary care and public health have historically operated independently of one another, although both share the goal of promoting the health and well-being of all people. The IOM report emphasized the need for neutral, third party organizations to facilitate long-term, sustainable collaboration between public health and healthcare organizations. This intermediary role, and advancing population-based approaches to health improvement, are characteristics of public health institutes.

Public health institutes are nonprofit organizations that improve the public's health by fostering innovation, leveraging resources, and building partnerships across sectors, including government agencies, communities, the healthcare delivery system, media, and academia. PHIs are known for their entrepreneurial leadership and strong organizational and programmatic capacity. The National Network of Public Health Institutes serves as the national membership network committed to helping public health institutes promote and sustain improved health and wellness for all. As of February 2014, 38 PHIs comprise the network. NNPHI and its member institutes work together to implement initiatives throughout all 50 states.

NNPHI member institutes apply a range of competencies and approaches to population health improvement strategies. This includes

- Planning and hosting health information exchanges.
- Identifying high utilizers of healthcare services and engaging in outreach that pairs individuals with community health workers.
- Conducting community health worker training.
- Exploring the role of safety net providers.
- Convening stakeholders to develop state healthcare innovation plans.
- Strategizing health insurance exchange development and implementation.
- Supporting patient-centered medical home demonstration projects.

Public health institutes recognize the range of opportunities at the intersection of primary care and public health. As independent non-profits, public health institutes are uniquely situated to provide non-biased analysis and engage multiple stakeholders in discussion and action around the connections between primary care and public health. Numerous public health institutes also have recognized the importance of behavioral health integration to improve quality of care

for individuals and enhance overall population health. Examples below provide a snapshot of the behavioral health work of several NNPHI member institutes.

Since 1997, the **Louisiana Public Health Institute** has been active in primary care with a focus on improving access, quality, and sustainability of health services. In the wake of Hurricane Katrina in 2005, the communities LPHI served experienced an acute shortage of behavioral health services. LPHI served as an intermediary to enhance behavioral health integration, hosting collaboratives to improve the integration of primary care, behavioral health, and social services. Additionally LPHI's work includes providing technical assistance in clinical workflow analyses; quality improvement program development; implementation and optimization of electronic medical records; data standardization and measure selection; and conducting assessments of behavioral health service delivery systems.

For over 50 years, **Health Resources in Action** has played a vital role in realizing the nation's most significant public health successes. HRIA, based in Massachusetts, recently conducted a comprehensive behavioral health needs assessment including a care integration model analysis on behalf of Beth Israel Deaconess Hospital in Plymouth. This assessment provided a foundation for developing and implementing a new integrated primary care and behavioral health model within the hospital and a framework for engaging the broader community to ensure sustainable progress in the area's collective behavioral health. The hospital is currently in the process of launching this model and is developing a strategy to disseminate key findings from the assessment with the aim of convening the community to develop a behavioral health improvement plan.

Since 1995, the **Georgia Health Policy Center**, has provided evidence-based research, program development, and policy guidance for complex issues facing health and healthcare today. GHPC developed the Georgia Center of Excellence in Child and Adolescent Behavioral Health in partnership with the Georgia Department of Behavioral Health and Developmental Disabilities. The Center of Excellence aims to provide fidelity monitoring, evaluation, research, training, and technical assistance for the child and adolescent behavioral health System of Care in Georgia. The center is adding referral and linkage from a primary care physician to the performance measures they collect from the behavioral health coordination providers. The GHPC provides feedback to providers and agency officials on their progress and advises on how to improve data collection, measurement, and reporting.

Since 2002, the **Colorado Health Institute** has been a trusted and leading source of credible health information, data, and analysis for Colorado healthcare leaders. The state of Colorado contracted with CHI to assist in managing the development of a State Health Innovation Plan including lead components of the stakeholder process,

“ Public health institutes are uniquely situated to provide non-biased analysis and engage multiple stakeholders in discussion and action around the connections between primary care and public health.”



which highlights a vision and process for providing eighty percent of Coloradans access to integrated primary and behavioral health care by 2019. CHI also convened leaders in primary care and behavioral health to assess workforce and training needs essential to meeting this care integration goal.

The **South Carolina Institute of Medicine and Public Health** is an independent entity serving as a neutral convener around important health issues in South Carolina. IMPH also serves as a resource for evidence-based information to inform health policy decisions. The institute is convening a taskforce of behavioral and mental health professionals and stakeholders from across South Carolina to address priority areas for improving care and outcomes to better serve residents with behavioral health challenges.

For more than 40 years, the **Public Health Management Corporation** has served as a leading nonprofit provider of public health resources. PHMC serves close to 200,000 clients annually, with more than 250 programs in 70 locations. PHMC's network of five nurse-managed, Federally Qualified Health Centers offers affordable, high-quality, patient centered health services to communities throughout the Philadelphia area. This includes public housing populations and individuals experiencing homelessness. PHMC provides integrated behavioral health services across the network, including behavioral health consultants who offer onsite counseling for individuals with mental health and/or substance abuse issues.

NNPHI members are serving a wide range of roles advancing population health improvement and behavioral health integration. Visit the NNPHI website (www.nnphi.org) to learn more about the work of public health institutes.

ALIYAH A. ALI

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The Role of Engagement and Activation in Recovery-oriented Services

When Letitia (an example of an Optum member) first started seeing a provider for her behavioral health issues, there was no guarantee she would show up for her appointment. The team worked with Letitia in a very person-centered way, listened carefully and set up systems to help her with transportation and other barriers to making her appointments. Letitia never misses an appointment now, but she's not getting any better. As the team discussed and considered Letitia's unique needs, the question arose: "we know Letitia is engaged – she's not missing a visit – but is she activated?"

Building recovery and resiliency-based systems of care for those with behavioral health conditions requires a person-centered focus that is responsive and respectful to the needs of individuals and their families. Optum is committed to this approach and recognizes that there are many pathways to recovery and care must support an individual's preferences and personal choices. Resiliency is achieved when individuals are able to engage in care that promotes recovery and they become activated to improve their health status.

Engagement is the process through which a person is able to establish a connection with a health care provider or system and receive ongoing services. Optum recognizes that this process is different for each individual and there may be significant barriers that impede or restrict their engagement. Some of these challenges include social and psychological impediments, problems with access to care, health literacy, and the stigma that is associated with these conditions. Optum has developed a range of care coordination resources, including peer support services that help overcome the barriers to engagement in care.

Engagement is an important first step in the promotion of health, well-being, and the management of chronic physical illnesses and behavioral health conditions. Yet this does not guarantee that they will be motivated to adopt new healthy behaviors or improve illness self-management. Recovery begins when a person becomes engaged in care, gains hope that there is an opportunity for improved health and well-being, and is activated to pursue new healthy behaviors.

Activation is the key to the long-term improvement of a person's health, well-being, and resiliency, and is fostered by care that provides support for recovery and is respectful of the individual's personal preferences, knowledge, skills and their beliefs. This is

achieved when a person is involved in their treatment planning and decision-making, establishes a collaborative relationship with their providers, and achieves the necessary motivation to change and maintain new healthy behaviors.

Activation is a complex and challenging process that begins with an individual starting to take an active role in their own health. As they build knowledge and gain confidence, they are better able to understand and manage their personal health and well-being. As a person begins to take action to improve their healthy behaviors, ongoing support and encouragement are necessary and important to maintain these new healthy behaviors. In the example above, the key to Letitia's activation turned out to be an education session with other consumers where she felt safe discussing her fears about taking her medication; access to written materials that helped her better understand her illness and reinforce the message that her illness would just not go away by itself; and a Wellness' Recovery Action Planning® group that helped her set up and start using WRAP® to engage in healthy behaviors every day.

Optum has developed a range of face-to-face and online tools and resources and new care coordination tools to support activation. This includes offering person-centered treatment planning coaching programs for providers, offering technology-based health management tools for consumers, and care coordination services that are strengths-based and recovery-oriented. Additionally, access to free community resources that support provider treatment, as well as consumer-centered evidence-based tools and resources to support engagement and foster activation, is available.

For more information please contact Sue Bergeson at susan.bergeson@optum.com.



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Integration Bellwether Ohio Doyens Share Their Top Ten

BASED ON INTERVIEWS WITH

TRISHA DELONG, **Primary Clinical Consultant, Butler Behavioral Health Services**

JOHN SHEEHAN, **CEO, Harbor**

GWEN JONES, **VP, Quality Improvement, Harbor**

CARA DOUGLAS, **Team Leader, Harbor**

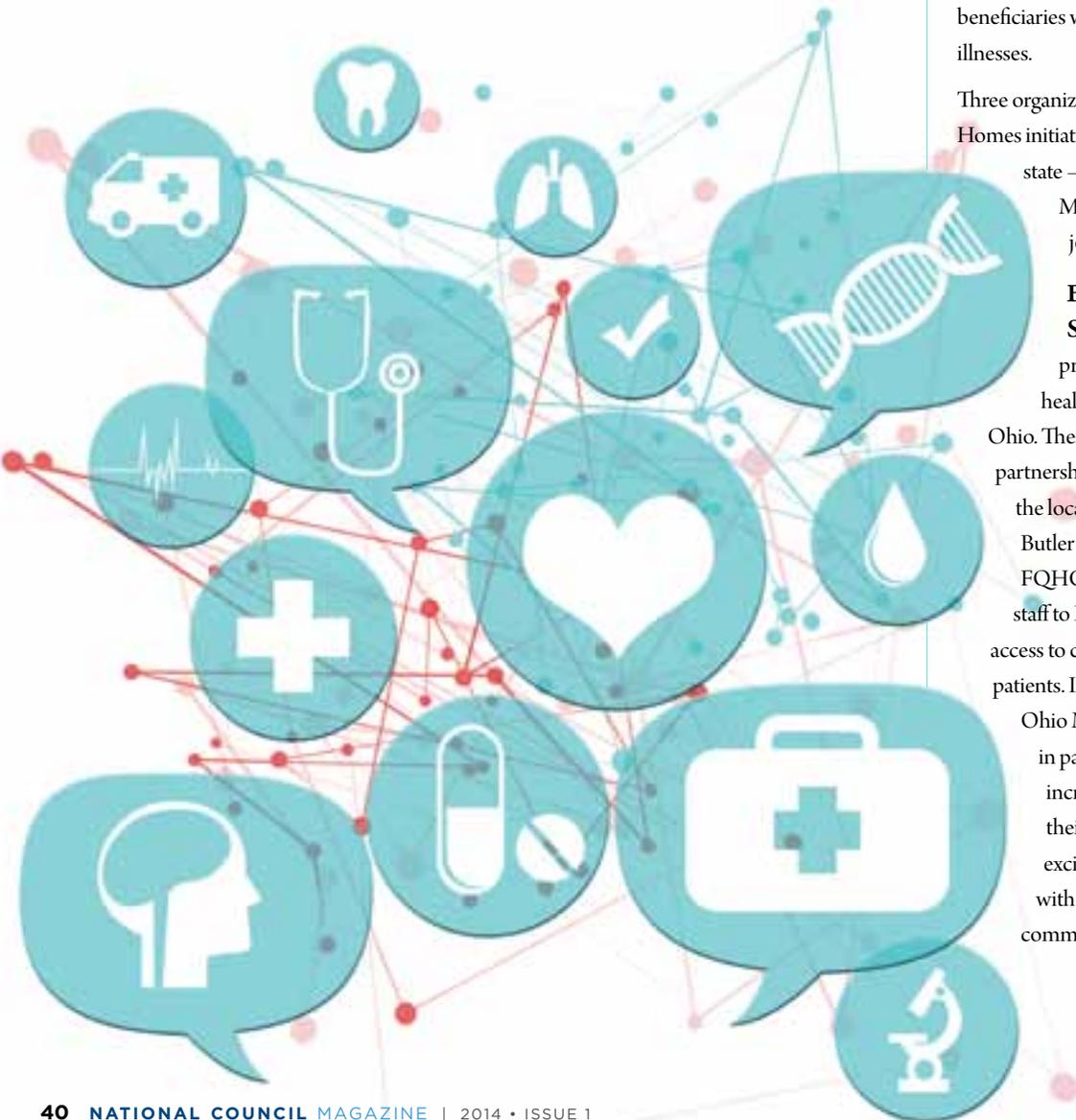
JEAN DREES, **Director of Marketing, Harbor**

SANDRA STEPHENSON, **Director, Integrated Healthcare, Southeast**

The National Council for Behavioral Health runs the Ohio Health Home/Health Integration Training and Technical Assistance Center for the Ohio Department of Mental Health and Addiction Services. The center supports learning and implementation needs for behavioral health organizations working toward Ohio Medicaid Health Home status, or integrating physical and behavioral health through other models. Participants are committed to transforming healthcare delivery for Medicaid beneficiaries with serious and persistent mental illnesses.

Three organizations in the Ohio Medicaid Health Homes initiative — integration pioneers in their state — talked with National Council Magazine about their integration journey.

Butler Behavioral Health Services is one of the oldest private providers of outpatient mental health and substance use services in Ohio. Their integration journey began with a partnership with Primary Health Solutions, the local Federally Qualified Health Center. Butler placed behavioral health staff at the FQHC, which in turn sent primary care staff to Butler. This staff exchange improved access to care and helped to better engage patients. In October 2012, Butler joined the Ohio Medicaid Health Homes Initiative, in partnership with the FQHC, to increase resources and momentum for their integration efforts. Now, they're excited they can send staff out to engage with patients wherever they are in the community.



Harbor launched its integration initiative in 2008, well before Medicaid Health Homes came into play. In addition to offering integrated physical and behavioral health services at its own site, Harbor has long-standing affiliations with large primary care practices like ProMedica Health System and Toledo Hospital and collaborates with these entities on its robust pediatrics program. Harbor provides certified developmental pediatricians at ProMedica's primary care sites and also offers wraparound behavioral healthcare in the community. Joining the Health Homes initiative has helped Harbor forge new relationships with more local primary care providers and strengthened their patient-centered model of care.

Southeast was incorporated in 1978 as a community mental health center and became an FQHC in 2011. Starting with colocated primary care and behavioral health services, Southeast gradually advanced on the integration journey. Having worked through the intense culture changes that integration of services demanded, as well as new ways of doing business with the addition of primary care, Southeast was well equipped to join the Medicaid Health Homes initiative.

The leadership and integrated care team members at Harbor, Butler, and Southeast share 10 lessons that all behavioral health organizations looking to integrate with primary care should note.

1. Accept that we're part of healthcare and get on board

Integration demands greater efficiency, less fragmentation, and better outcomes. All of which can happen only if leaders of community behavioral health organizations recognize that behavioral health is part of the healthcare system — the Affordable Care Act and parity have underscored that. Behavioral health can't stand apart any more — organizations must get on board with the rest of healthcare.

2. Get staff buy-in

Integration of primary and behavioral health care involves massive culture and process change. From billing and documentation to patient interactions and outcomes measurement, staff must be flexible and learn new ways of doing business as they work with "the other side." They need training in new skills. The transition is never easy. Leaders must communicate with staff about the changes, educate them on the potential for improved outcomes, and be open to discussion and questions. Be prepared for the learning curve, it can be steep! And invest in your staff — if you make your organization a great place to work, you'll attract great talent.

“
IF YOU CAN'T
MEASURE IT,
YOU CAN'T
IMPROVE IT!
”

3. Nurture a holistic approach

No staff must be allowed to think "That's not what I deal with." Everyone manages the total wellness of those they serve. Behavioral health staff must learn to take vitals and support management of chronic physical conditions like diabetes, obesity, heart disease, and more. And primary care staff must learn to screen for depression and anxiety. Case managers must turn into care managers.

4. Collaborate with your collaborators

Collaborate with other organizations — your patients also need services that you don't offer and that would be difficult for you to develop

quickly. Ensure warm handoffs to other providers so patients don't fall through the cracks. Integration only works when all of a patient's care providers are continuously talking to one another, reviewing data, and developing joint care plans. It's important to meet with the leadership of every one of your collaborators in the community and educate them on your mission.

Even within the same organization, collaboration between primary and behavioral health staff is key. Try morning "huddles" that are common practice in primary care. Encourage huddles between behavioral health care staff and primary care staff so they work as a team to discuss who they're seeing that day and what they need to focus on with each patient. It helps everyone realize they are working together in the best interest of their patients and the cultural divide is bridged.

5. Stick with patient-centered care

A population health approach can and must be combined with a focus on the individual. Behavioral health's patient-centered care approach to care is key to success in any integrated care model. It's really about asking "What does this patient, this child, this adult, or this family need?" and then bringing the spectrum of services available in the community together into a comprehensive treatment plan to support recovery. There are no cookie cutter solutions.

6. Engage your patients

Behavioral health providers have the skills to reach people that are sometimes really difficult to reach, to build rapport with patients, and to engender trust. It's easy to expand these skills to help patients manage their physical health needs as well. There has been much talk about access to care, but engagement is equally important. Once patients gain access to the continuum of healthcare, providers need to stay in touch continuously and monitor their care. Providers must advocate for their patients and make sure they get to the next step in their care.



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7. Meet your patients where they are

Try to meet your patients wherever they are — literally — which may not always be within the walls of your clinic. See if you can deploy staff out in the community to engage with people in need of medical and behavioral health services as they go about their day-to-day lives. Build relationships with community partners so you can engage people at the library, at the community health centers, at the local Y, or wherever they might be. By meeting patients where they are, you can better understand the barriers to care — transportation, mistrust, financial struggles, lack of communication, etc. — and work to eliminate them.

8. Manage with data

If you can't measure it, you can't improve it! Establish adequate measures for physical and behavioral health indicators — AIC, LDL (bad cholesterol), body mass index, Patient Health Questionnaire-9 for depression, Generalized Anxiety Disorder 7-item scale, etc. — are all important to track. And train staff to use data to make clinical and care coordination decisions. Form a “reporting” team that can lead the data management efforts across the organization — and make sure the team includes clinical, billing, administrative, and IT staff. Avoid duplication —

“Collecting data does not mean you are tracking outcomes.”

see what data your organization is already collecting to report to multiple payers and try to streamline as much as possible.

But know that collecting data does not mean you are tracking outcomes. It's a major step to move from collecting data to applying that data toward performance improvement and population health management.

9. Make sure your EHR works across primary and behavioral health

Make sure you have an electronic health record that serves behavioral health and primary care needs. If organizations are collaborating to provide healthcare but using different EHRs, information cannot be shared and that defeats the very intent of integration. Again, remember the cultural chasm — primary care folks are accustomed to collecting hard data and placing it into EHRs but may struggle when they have to drop data into different fields when they collaborate with behavioral health. And behavioral health staff may be less accustomed to putting their data and notes into EHRs.

Most importantly, staff need to be trained to look at the EHR and be aware of what else is happening with their patients. If a social work clinician can go into the EHR of a client who has depression, and can see the results of a thyroid test administered in primary care, then s/he can rule out thyroid as a cause of depression. Imagine how much more effective treatment could be!

10. Learn from others

There's no need to reinvent the wheel. Many behavioral health organizations across the country have undertaken the integration journey through various routes and are happy to share lessons learned. Learning communities and technical assistance, offered by the National Council for Behavioral Health, have been invaluable to multiple organizations in networking and learning from colleagues and experts. As integrated care evolves, National Council trainings and consultations on new roles for staff, wellness management, and outcomes measurement have helped to steer many organizations toward success in integration and population health efforts. Ohio Medicaid Health Home participants welcomed the opportunity — offered through National Council technical assistance — to talk to others in their state as well as to gain a national perspective.



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HELP NOW

Changing the Paradigm for Behavioral Healthcare Access

Health reform, parity, and Medicaid expansion could increase the number of individuals seeking mental health services by as much as 50 percent over the next few years. Community behavioral health organizations cannot hope to effectively manage and engage the current and new populations seeking care without rethinking capacity and providing more timely access to treatment.

Behavioral health organizations can become a part of evolving integrated service delivery models only if they can

- 🔗 Be accessible — provide fast access to needed services.
- 🔗 Be efficient — offer high quality services that produce the highest level of client outcomes at the lowest possible cost.
- 🔗 Connect with other providers to share electronic health records.
- 🔗 Focus on episodic care needs and treat to target models.
- 🔗 Participate in bundled/case rate/ shared risk payment models.
- 🔗 Engage clients using natural support networks.
- 🔗 Help clients self-manage their health and wellness.
- 🔗 Reduce need for emergent/ high cost services.
- 🔗 Produce outcomes!

It all starts with adequate service delivery capacity to support timely access to treatment.

There are three levels of access:

PRIMARY ACCESS: How long it takes to provide face-to-face initial intake/assessment after call/walk-in for routine help. *MTM Services recommends same day/open access.*

SECONDARY ACCESS: How long it takes to provide face-to-face service with treating clinician following intake/assessment. *MTM Services recommends 3–5 days but no more than 8 calendar days from intake/assessment date.*

TERTIARY ACCESS: How long it takes to provide face-to-face service with psychiatrist following intake/assessment. *MTM Services recommends 5 days but no more than 10 calendar days from intake/assessment date.*

InterCommunity is just one of the behavioral health centers consulting with MTM Services that has exceeded the recommended standards for all three levels of access by implementing the “Help Now” model of care. Key to InterCommunity’s transformation was the move from a subjective, anecdotal awareness of its practice patterns to an objective, data-based awareness through the use of SPQM, the Service Process Quality Management dashboards. Data revealed patient engagement levels for specific services and scheduling practices of the clinical staff, all of which provided focus areas to address practice management concerns.

When MTM Services shares its recommended access standards through consultation with community behavioral health organizations around the country, the typical response is “We don’t have the funds to employ more staff to meet these standards.” The good news is that you do NOT have to employ more staff. The solution is in how you redesign the access to treatment processes

Learn more about SPQM at www.TheNationalCouncil.org/SPQM



to more fully realize your organization’s service delivery capacity that is already employed.

InterCommunity improved access to treatment with practically no change in the number of full time employees over three years:

Year	Assessment FTEs	Adult Clinician FTEs	Medical Team FTEs	Administrative Support FTEs	Total FTEs (Rounded)
2011	4.5	5.875	3	15.5	29
2012	5	5.875	3.62*	14.62	29
2013	5	6.875	4.77*	13.62	30

* Although InterCommunity’s medical providers increased over the 3-year period by a little more than on full-time employee (FTE), financially the center traded one psychiatrist for two APRNs at the same cost so their revenues went up but their costs stayed the same.

Implementing Help Now gives behavioral health organizations the competitive edge in a market where multiple players compete to meet the growing need for mental health and substance use services. In fact, the National Committee for Quality Assurance’s requirements for accreditation as a patient-centered medical home include “providing same-day appointments” and “providing timely clinical advice by telephone when the office is closed.”

Gearing up to offer Help Now allows an organization to evaluate and reconfigure tasks that get in the way of delivering direct service; to look at processes that aren’t working and fix or change them.

Setting up same day access, one of the most critical components of Help Now, takes 5 easy steps:

- 1 Determine your demand and optimal hours of operation.
- 2 Select your staffing/team model/back-up contingency staff.
- 3 Set a plan to handle your existing appointments.
- 4 Choreograph your wait time.
- 5 Communicate and go!

After implementing Help Now, organizations must start to use their appointment data to confirm their team’s planning assumptions. This data also monitors and ensures the program’s sustainability, especially when it comes to managing no shows.

Results from Help Now are impressive. MTM Services has worked with 169 organizations in more than 25 states and collective data show that:

- 1 Wait times for care were reduced by 44 percent on average, with some teams cutting wait time by greater than 90 percent.
- 2 Cost for the entire process reduced by 23 percent on average.
- 3 Intake volume increased 10 percent on average, with some teams implementing planned increases of 100–300 percent.

InterCommunity effectively used the Help Now model of care to improve access to quality treatment, reduce use of the ER and crisis centers, and dramatically reduce the cost of access to treatment processes.

DAVID LLOYD
 Founder, MTM Services

SCOTT LLOYD
 President, MTM Services

IMPLEMENTING HELP NOW, A CASE STUDY

InterCommunity is a private, non-profit, behavioral health center located in an impoverished urban community. We serve an indigent population with serious mental illness.

As of 2011, despite our best efforts, patients had significant delays in accessing care and no-show rates were 30–50 percent. Faced with projected cuts to grant funding, insurance reimbursement rates insufficient to cover service delivery costs, and increasing demand for services, InterCommunity had two options — turn away referrals or find a different way of delivering services.

Inadvertently, we had been choosing the first option. Individuals faced a 2-week wait between their first call requesting services and an intake assessment. Then after completing a 2.5-hour intake assessment, they were told that they'd be contacted to schedule follow up care. When contacted to start services, they often did not show up for their appointments. Medication evaluation no shows were common, and given the financial detriment, InterCommunity required patients prove engagement before they could schedule a medication evaluation. No shows were also common among those already on medication.

Psychiatrists had a productivity rate of only 47 percent despite having schedules that appeared to be full at the beginning of each clinic day. With psychiatrist schedules booked multiple weeks out, individuals who didn't show up for appointments needed medication refills to bridge the time until their psychiatrist's next opening. Although patients were getting their medications, they were not getting good care. The psychiatrists were frustrated and worried about continuing medications without consistent evaluations. InterCommunity was not delivering billable services. Everyone was losing.

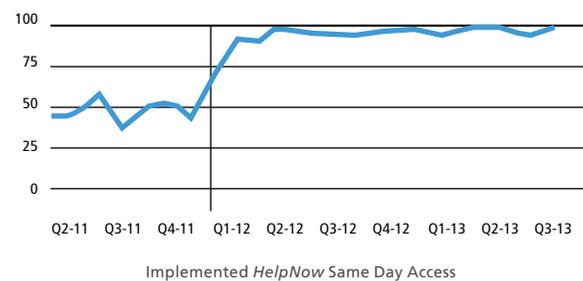
Committed to an alternative, InterCommunity consulted with MTM Services and implemented, starting in December 2011, the three-pronged Help Now model comprising:

- 🕒 Same-day access for intake assessments.
- 🕒 Daily walk-in therapy.
- 🕒 Medication management appointments within 72 hours.

The **switch from scheduled intake appointments to same-day access** eliminated the delay to obtain services as well as the 51 percent no-show rate for intake assessments. Figure 1 below provides graphical support for the significant change in actual service capacity provided with the same staff compared to the old scheduled model.

“Providing immediate access to therapy resulted in a 90 percent increase in demand for services.”

Figure 1: Intake Show-Rate



The initial intake process was shortened and included an individualized treatment plan and appointments for follow-up care within one week. Providing immediate access to services also decreased the likelihood that the presenting problem would escalate into a crisis.

The benefit of same day access, however, could only be realized if ongoing care was easily accessible. InterCommunity started offering **daily walk-in** groups that used a combination of crisis management and motivational-interviewing techniques to serve patients who were:

- 🕒 In pre-contemplative and contemplative stages — to build engagement as a first step of treatment.
- 🕒 Too vulnerable to wait for the next scheduled group or individual therapy appointment — to get immediate support.
- 🕒 Experiencing exacerbated symptoms or needing additional support — to get supplemental clinical services.
- 🕒 Out of regularly scheduled therapy services but still involved with medication management or community support services — to address occasional clinical issues or re-engage in services.

The three-pronged Help Now model comprising:

- ◆ Same-day access for intake assessments.
- ◆ Daily walk-in therapy.
- ◆ Medication management appointments within 72 hours.

These walk-in groups ensured that patients had access to therapy services that met their varied needs and levels of engagement. Providing immediate access to therapy resulted in a 90 percent increase in demand for services. Figure 2 provides an actual comparison of the number of completed initial intakes each month before and after the Help Now model was implemented.

Figure 2: Completed Intake Assessments

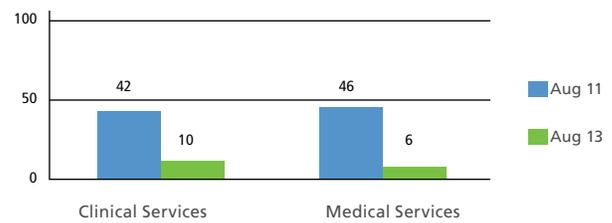
Year	Jan	Feb	Mar	Apr	May	Jun	% increase
2011	42	52	81	76	66	70	
2013	116	113	136	112	138	119	90%

If InterCommunity had continued to operate under the old model, this increased demand for services would have been overwhelming. However, with Help Now, InterCommunity has been able to meet the demand without increasing **staffing levels**. Help Now has led to significant decrease in no-show rates, which has helped to more fully realize the service capacity of each direct care staff. As clinicians no longer devote hours to managing no shows, their productivity has risen from 54 percent to 71 percent of paid time. And with productivity levels above 60 percent, InterCommunity is positioned to have the financial resources to hire additional clinicians as the demand continues to grow — a shift from surviving to thriving.

We created a **rapid scheduling model** where all psychiatric appointments are booked within 72 hours. With the traditional scheduling model, a patient might have received a 30-day supply of medication plus one refill and been given an appointment with their psychiatrist 55 days later. With Help Now, patients receive the same amount of medication. However, instead of being given an appointment, they are given a reminder card to call back in 52 days. When they call,

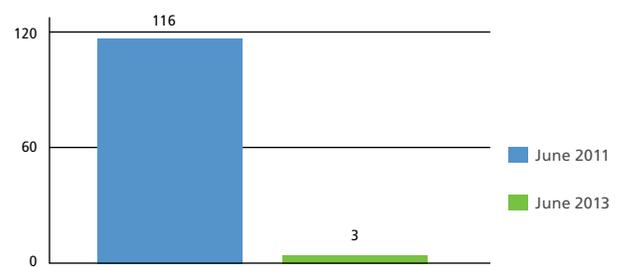
they are usually offered a same-day appointment. If their psychiatrist is fully booked for that day, clients are offered an appointment within the next two days. By limiting appointment scheduling to 72 hours, Help Now decreased the no show rate for medication appointments from 46 percent to 6 percent. Figure 3 provides a comparison of no show percentages for clinical services (initial assessments plus therapy) and medical services for the comparative period August 2011 and August 2013.

Figure 3: No-Show Percentage Comparison



In addition, Help Now enables rapid scheduling of new medication evaluations (initial psychiatric evaluations). Figure 4 provides a comparison of the number of days from first call for help to the initial Medication Evaluation in June 2011 compared with June 2013.

Figure 4: Days from First Call to Medication Evaluation

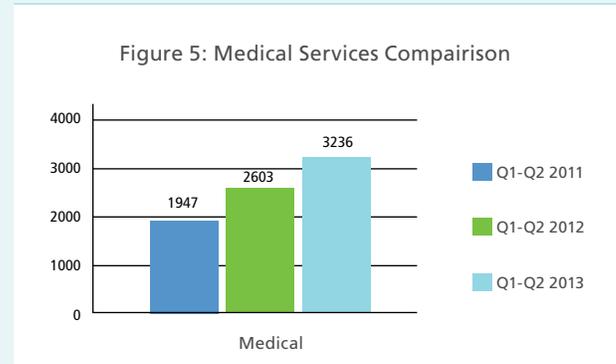


To support this scheduling, we hired a registered nurse to assist the psychiatrists and advanced practice registered nurse medication managers. This RN triages patients who present with unexpected medication issues or have a medication emergency.

Despite the changes, some patients still fail to show or do not initiate follow-up care until days after they have run out of their medications. To best resolve these issues, those who call for an appointment after a no show or who want to be seen on a day when their psychiatrist is fully booked are encouraged to walk in. Working with the RN, these clients are either seen when their psychiatrist has an opening on account of other no shows or are seen during the designated walk-in hour the psychiatrists have built into their daily schedules. This has enabled InterCommunity to use the psychiatrists' previously unrealized capacity.

“ By limiting appointment scheduling to 72 hours, **Help Now** decreased the no show rate for medication appointments from 46 percent to 6 percent.”

The psychiatrists’ productivity has risen from 47 to 72 percent of paid time, resulting in a 66 percent increase in services delivered. Figure 5 provides a six month comparison of medical service events delivered in 2011, 2012 and 2013 respectively.



The implementation of such major changes in scheduling and productivity could have resulted in staff turnover and dissatisfaction. However, InterCommunity avoided this outcome by **educating staff on the rationale for Help Now and involving them in its design.** In addition, leadership provided consistent staff support and supplied outcome measurements to track the effectiveness of changes.

Help Now helped to realize InterCommunity’s four core aims of better patient experience, improved health outcomes, financial viability, and positive staff experience:

- Surveys indicate a 94 percent customer satisfaction rating with 80 percent asserting that InterCommunity’s timely services prevented a need for inpatient psychiatric care.
- Improved capacity to provide access to treatment led to a decrease in ER visits/ hospitalizations at a savings of more than \$3.7 million.
- Staffing has been able to stay flat despite a 90 percent increase in intakes, 66 percent increase in medical services delivered, and 45 percent increase in clinical services delivered
- The significant increase in billable services, without increased staffing, has led to a 48 percent increase in third party revenue.

Staff feels so positively about the Help Now experience that they voted InterCommunity a Top Work Place in the state for the past three years.

Help Now has shown InterCommunity a way to migrate into integrated health settings and ensure that we can meet the demand for quality behavioral health services.

TYLER BOOTH
Chief Operating Officer, InterCommunity, Inc.

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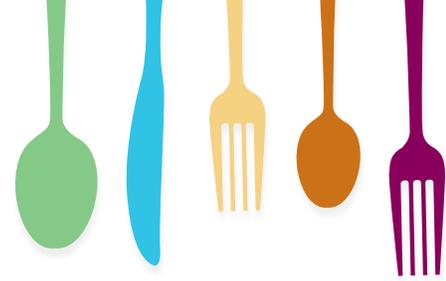
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Five Key Ingredients in the Integrated Care Recipe

Integrated models of healthcare seek to reduce care fragmentation by coordinating care, improving communication between providers, and tracking clinical outcomes. Primary care and behavioral health integration initiatives now have the benefit of a large body of research (now over 80 studies strong) as well as a growing wealth of field experience. These collective resources all support integrated care as one strategy in controlling healthcare costs, improving clinical outcomes, and improving the care experience for patients/consumers. Integrated care also helps to extend behavioral healthcare to many persons without access to convenient and affordable behavioral health services.

Successful integrated care implementation requires a deliberate, thoughtful, and structured implementation plan with new clinical roles, new partnerships, new procedures, new tools, and often a new funding model.

Over the last decade, the Advancing Integrated Mental Health Solutions Center at the University of Washington has partnered with many organizations in their efforts to implement integrated healthcare. Here are five key lessons from our most successful partnerships:

- 1 Leadership buy-in and high-level project promotion is important from the very start.
- 2 Focus on the business case and organizational partnerships early.
- 3 Use of structured quality improvement methodologies is critical to support the multiple layers of change required for success.
- 4 Every community is unique and requires careful adaptation of models used by others to meet their own unique needs. “Cookie cutter” implementations are often bound for failure.
- 5 Start small. Consider a pilot project or a limited target population to start with. A successful integrated care project is often quite “infectious” as people see its benefits.

Integrated models of care require clinical duties and roles that are typically new to providers such as performing medication reconciliation, using a care registry, systematically tracking care referrals and outcomes, and facilitating communication between providers. These new duties and roles must be carefully thought through in team-building exercises, and rolled out with adequate clinician training and support.

Implementing integrated care also requires new partnerships — between health plans, primary care service providers, mental health service providers, substance use treatment providers, and other community partners. Bringing all of these partners to the table in a productive manner is often a challenge, as they have different missions and cultures.

Obviously, no program can be sustained without appropriate financial support and careful development of a viable plan is critical. Although it is important to maximize the service revenue, our experience is that attempting to fund integrated models of care solely via more efficient billing or increased productivity is usually insufficient. Other strategies that capitalize on the medical cost offsets are often necessary such as blended funding, layered payments methods, and pay-for-performance methodologies that “reward” programs based on pre-determined outcome benchmarks.

All of this comes at a time of unprecedented changes in healthcare world. Providers are increasingly challenged with “change fatigue” brought on by a changing funding and regulatory environment combined with rapidly increased expectations for care outcomes.

It may seem like a tremendous effort is required to transform into an integrated care provider, but it’s certainly worth the effort. It has been a great opportunity for the AIMS Center to be part of the improved clinical outcomes and improved sense of purpose and meaning that can arise out of successful integrated care.

What’s next? Partnering programs are extending principles of integration to new populations, such as new mothers and children, older adults, uninsured, school students, and veterans and their families. Other programs are working to expand the scope of integration projects to include persons with severe mental disorders, diabetes, and cardiovascular conditions. Still others are including new clinician types into integrated care teams such as substance use providers, and peer clinicians. 2014 promises to bring not only intense change, but also multiple opportunities to bring effective mental healthcare to greater numbers of people.

MARC AVERY

Clinical Associate Professor and Associate Director for Clinical Services, AIMS Center and the Division of Integrated Care and Public Health, University of Washington School of Medicine

How Integrated Care Can Integrate



Reprinted from SAMHSA's
Recovery to Practice E-Newsletter
Issue 16, Jan 30, 2014

The integration of primary and behavioral health care is taking hold across the country, providing an opportunity for providers in both settings to bring full attention to the individual client and fully realize recovery principles of patient-centered care.

Primary and behavioral healthcare integration requires significant practice change, including new ways of running day-to-day operations, identifying how to pay for new services, and workforce training. Patient-centeredness is embedded in these major practice change initiatives, but change isn't easy. When working to integrate care, organizations often face ambiguity when they try to define what it means to be person centered or recovery oriented. Often, in a fast-paced clinical setting, this vague understanding can lead to inaction.

Similar to the recovery transformation occurring in the behavioral health field, primary care providers are moving to person-centered approaches to care. The Patient-Centered Primary Care Collaborative, a leading organization in the movement to transform primary care providers into patient-centered medical homes, defines patient-centeredness as a partnership among practitioners, patients, and their families to ensure that decisions are made in full consideration of patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care. Similar to recovery-oriented practices, this is an opportunity to fully embed collaboration as the norm in primary care as practices move toward a person-centered medical or health home.

For primary care providers, the integration of behavioral health professionals as part of the clinical team brings greater capacity to provide direct services to individuals with a range of mental health and substance use needs. In addition, the behavioral health professionals on the clinical team, including peer providers who emphasize strength-based recovery and resiliency, are also dispelling

“Partnership among practitioners, patients, and their families to ensure that decisions are made in full consideration of patients' wants, needs, and preferences.”

Person-Centered Care

common misconceptions, bringing creative ideas for engaging staff and families, and helping their colleagues understand what recovery looks like.

Specifically, in an integrated primary care setting, behavioral health providers can

- ② Demonstrate how recovery-oriented approaches for persons with mental illnesses and addictions help meet patient-centered medical or health home standards of care.
- ② Help the entire team recognize the possibility that anyone accessing services may have unresolved trauma underlying his or her distress.
- ② Provide skills training on Mental Health First Aid or focused psychological skills training, such as motivational interviewing.
- ② Embed the behavioral health goals agreed to by the person and any actions the person will need to take in his or her own self-care into the care plan.
- ② Acknowledge the strengths and learning derived from a person's lived experience.
- ② Promote a culture and language of hope and optimism, which leads to people feeling valued, welcome, and safe.

For behavioral health providers, the challenge is to ensure that recovery principles make their way into newly embedded primary care clinics and wellness programs in the same way that they are being incorporated across mental health and addiction services. Providers can start to make this shift in the following actionable ways:

- ② During physical exams, in addition to discussing people's medical concerns, ask them about their health goals.
- ② Offer training to primary care staff and, if possible, arrange for embedded primary care staff to shadow a behavioral health team to observe recovery-oriented services so that they can see them firsthand.
- ② Put in place peer-based supports, such as Whole Health Action Management (or WHAM) training, to empower people to achieve their wellness goals.
- ② Make sure wellness programs are strength-based instead of illness-based (healthy eating versus diabetes management).
- ② People and families take advantage of community resources like the YMCA and parks and recreation programs.
- ② Use patient surveys and focus groups to determine which health education and services individuals are most interested in accessing.

The SAMHSA–HRSA Center for Integrated Health Solutions and others are developing a growing number of resources to help providers address the clinical, operational, and administrative challenges faced in integrating primary and behavioral health. Taking the time to examine whether new integrated services are person centered, using resources such as self-assessment tools, is just as important as the other operational considerations if providers are to achieve the full potential of integration.

Person-centered and recovery-oriented approaches are critical to the success of primary and behavioral health integration. Together, we can ensure that integration, no matter the setting, includes a set of capabilities that support people in being at the center of their whole health and recovery.

SAMHSA-HRSA Center for Integrated Health Solutions

The SAMHSA-HRSA Center for Integrated Health Solutions promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings. CIHS is the first “national home” for information, experts, and other resources dedicated to bidirectional integration of behavioral health and primary care.

Jointly-funded by the Substance Abuse and Mental Health Services Administration and the Health Resources Services Administration, and run by the National Council for Community Behavioral Healthcare, CIHS provides training and technical assistance to 100 community behavioral health organizations that received Primary and Behavioral Health Care Integration grants, as well as to community health centers and other primary care and behavioral health organizations.

LAURA M. GALBREATH

Director, SAMHSA-HRSA Center for Integrated Health Solutions at the National Council for Behavioral Health



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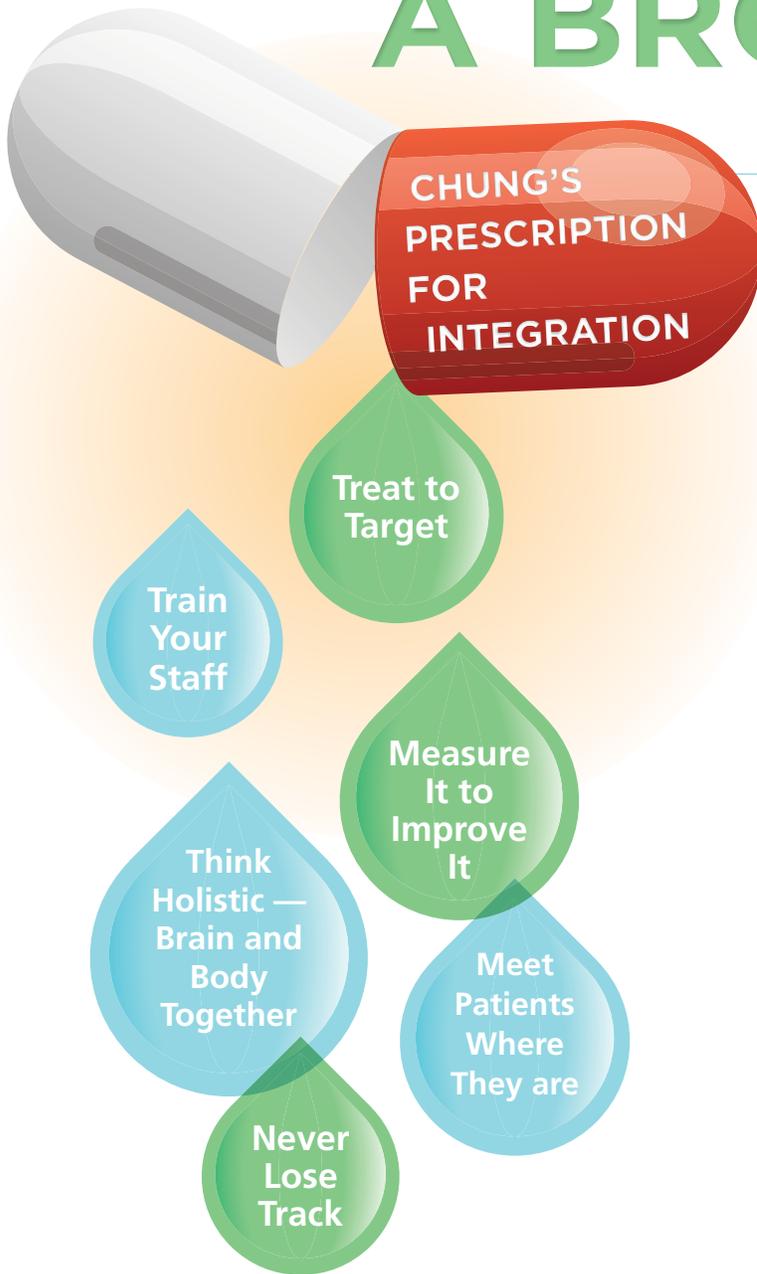


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To learn more about our services and our holistic approach, contact:

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A BRONX TALE:



“There’s too much treatment inertia in all of healthcare, not just behavioral health. We keep doing the same thing over and over again.”

Montefiore Medical Center provides care management and disease management services to about 250,000 patients in New York’s Bronx and Westchester counties through its Care Management Organization, funded through global capitation or shared savings and shared risk models. The center provides a continuum of services — hospital care, rehabilitation, outpatient care, professional services, home care, mental health counseling, community-based services, remote patient monitoring and many other programs.

The Centers for Medicare and Medicaid Services recognized Montefiore as a Pioneer Accountable Care Organization. Montefiore’s ACO is one of only 32 organizations in the nation to operate under this new model of providing Medicare beneficiaries with higher quality care, while reducing expenditures through enhanced care coordination.

Montefiore supports innovative programs that address critical health issues affecting the communities it serves; partners with community organizations and government leaders to improve health and wellness; and leads community development efforts to promote safe, productive neighborhoods.

Breaking the Silos

Montefiore has focused on population health for more than 17 years now. However, “Being like a quasi-health plan for many years we also carved up, if you will, our patients. Traditionally, we thought of our patients as those with primary medical needs and those with primary behavioral health needs,” explains Henry Chung, Vice President and Chief Medical Officer of the Montefiore CMO.

The CMO had a separate unit called University Behavioral Associates (UBA), which provided care management and a treatment network for patients who primarily seek mental healthcare. UBA offered contact capitation payment — when providers, mostly psychiatrists, in its network saw a patient, they received upfront payment to cover almost a year’s worth of visits. This was cost effective and helped to improve access to care. This reimbursement strategy fit within the quality framework of looking at process outcomes — like access — as opposed to real clinical outcomes.

Sally Ricketts, medical director of the Montefiore CMO, explains that being prepaid for managing a population allows provider

Overcoming Inertia in Healthcare



organizations to do things that they would not be reimbursed for in a fee-for-service world. For instance, a psychiatrist could supervise the social worker and provide medication advice and management through electronic medical records. The social worker could provide telephone-based as well as face-to-face therapy. Contact capitation is more patient-friendly and helps primary care providers ensure behavioral healthcare for patients who might not follow through on referrals.

While its behavioral health and medical services collaborated effectively, Montefiore realized — about three years ago — that people who need but don't voluntarily seek mental health services have a very high utilization on the medical side. Patients with depression, anxiety, post-traumatic stress disorder, and substance abuse drove excess medical spending and also had untreated chronic illnesses. The CMO formed the integrated medical-behavioral care management team to find these patients, work with patient-centered medical homes and doctors to jointly develop care plans, and deliver services in an innovative way.

The integrated medical and behavioral care management team focuses on patients who don't believe they need formal behavioral health treatment even though their doctors do. In addition, given Montefiore's population health focus, the team reviews data to find patients who have high complexity and behavioral diagnosis in addition to a medical diagnosis. Integrated team members might alert the primary care doctor and say, "We found this patient based on the utilization pattern and we really want your permission to reach out to them."

Staffing and Skills

How is the integrated medical behavioral care management team staffed? Ricketts is the behavioral health director and consulting psychiatrist. Daniel Alexander is the clinical manager and coordinates the referrals from about 21 primary care sites in the Montefiore network. A nurse who is also an experienced case manager helps to address chronic medical conditions for patients seen by the team. Two behavioral health managers, both licensed clinical social workers, offer therapy. The team includes a certified diabetic educator, given that diabetes is prominent in the population they serve. A patient educator addresses psychosocial issues that patients may face and helps them obtain benefits, housing, etc.

Social workers on the integrated team have a steep learning curve to understand how a person's medical health affects how they present from a behavioral health point of view notes Ricketts. They have to work on becoming conversant with the medical lingo.

In addition to training all team members in techniques like motivational interviewing, the integrated care team meets twice a week for an hour to discuss cases and much education happens during these discussions. Ricketts has a "supervision hour" once a week where she works on a case with team members using specific interventions to help everyone improve technique.

No Measurement, No Improvement

Under Chung's leadership, the integrated care team uses a treat-to-target approach. Validated measures like PHQ-9 for depression, GAD-7 for anxiety, PCL for PTSD, and AUDIT-C for alcohol use are used to continuously monitor behavioral health treatment outcomes. The nurse case manager uses similar approaches on the medical side.

In Ricketts' opinion, outside of academic settings, consecutive measurements of people's symptom levels and the degree to which those symptoms interfere with their ability to function does not really happen. So outcomes measurement is a new way for people in behavioral healthcare or other settings to think about treatment for mental illness.

Chung concurs. "There's too much treatment inertia in all of healthcare, not just behavioral health. We keep doing the same thing over and over again. When we don't measure, how can we tell if we're really helping the patient or not?" Population health is not about a bunch of providers from different disciplines getting together, it is about looking for outcomes, he reiterates. "We must have goals, and when we don't meet them, we must look at what else we can do for our population," says Chung.

On both the medical and behavioral sides, Montefiore's integrated care team members know what the targets are, whether it's an A1C reading or PHQ-9 — the blood pressure of depression. Team members monitor progress and when the targets are reached, they usually go into a maintenance phase where they have monthly contact with the patient for two to three months to make sure they're maintaining gains and using the skills they learned.

Once a patient has met their behavioral health goals, the integrated care team sends them back to primary care and asks the PCP to continue to screen for depression and monitor medications. The PCP knows to send the person back if they have difficulties or start to show symptoms of relapse. The team keeps track of all patients seen by the integrated team through their electronic medical records.

Short Is Sweet

In yet another departure from traditional behavioral health, Montefiore's integrated care team delivers short, solution-focused therapies. Patients are in the program for 3–6 months on average. Brief interventions like group therapy, problem solving therapy, motivational interviewing, cognitive behavioral therapy, and behavioral activation are used and patients are coached in self-management.

People with severe PTSD and severe chronic pain are the exception to short-term treatments. Some stay in the integrated care program for a year and are then willing to get specialty treatment. This is a good outcome for Montefiore, because these are people who would otherwise have suffered with many medical and social consequences.

“A holistic approach takes more than putting people together within the same four walls, it takes getting people on the same page.”

Avoiding Holes in Holistic

As a consultant on several statewide projects, Chung says it's encouraging that community behavioral health centers are bringing primary care into their facilities, and notes that there are more funding mechanisms to support integrated care. But he laments that social workers in behavioral health continue to see basic primary care as someone else's responsibility. They're not getting trained on the importance of monitoring A1C or on encouraging patients to get their colonoscopy.

Health management means that patients need to hear the same messages from all their providers. “A holistic approach takes more than putting people together within the same four walls, it takes getting people on the same page,” says Chung.

Ricketts agrees that people working in mental health settings must think about the whole person and understand how patients manage their medical problems directly affects their mental health outcomes. She recently called the psychiatrist of a patient with severe obesity

(BMI>50) to discuss how they might be able to help. The psychiatrist's response, “What could I do? She's non-compliant,” was not helpful.

Alexander adds that a whole person approach requires patients and providers talking to each other and sharing pertinent information. He's seen patients who are in the emergency room at least once a week with chest pain — diagnosed as an anxiety attack after a full cardiac workup. But the patients often believe it was cardiac-related and never mention it to their behavioral health providers. Patients must be educated to avoid thinking, “I'll talk about this only with my primary care doctor and I'll talk about that only with my behavioral provider.”

Providers must also learn to ask the right questions. Behavioral health providers are not asked to be the expert on diabetes or whatever medical condition their clients may have. But they can't ignore the medical conditions that are a big part of their lives. That's where true integration comes in, says Alexander.

Ricketts recalls the experience with a patient with severe depression whose diabetes was out of control. The patient went to see her primary care doctor, who increased her insulin dosage and frequency. The patient did not feel comfortable telling the primary care doctor that she was kind of needle-phobic. She had a history of trauma and couldn't bring herself to take insulin shots except maybe once every two or three days. But she talked to the integrated team and Ricketts was able to get the endocrinologist who works with the diabetes care management team to review the patient's record, figure out that it was possible to get this patient on all oral medications, and get that information to the primary care doctor. The patient now has a better chance to get her diabetes under control.

Engaging and Tracking

Patient engagement is a key factor in the population health management approach. Patients don't see the integrated team as the behavioral health provider they did not want to go to, explains Chung. “Our approach has been to meet the patient where they are, rather than talk about what their diagnosis is. That really has a big impact on keeping patients engaged.”

Ricketts has asked patients in the integrated program, “Would you have gone to see a mental health provider for your problem?” Many say they wouldn't consider setting foot inside a place like that. There are many reasons, ranging from literacy and trust to cost and access. “We're reaching this population that does not have the internal motivation to access the care they need,” Ricketts says.

The Montefiore CMO serves an indigent population that has many barriers to seeking behavioral health care, despite referrals from primary care. Another appointment, another copay, another transportation need can become daunting for patients. The integrated approach helps to overcome such barriers.

“We’re reaching this population that does not have the internal motivation to access the care they need.”

If the primary care doctor notices scores that cause concern on the PHQ-9, they indicate — through the electronic medical record or by calling a social worker — that they’d like someone to have a conversation with the patient. The integrated team then reaches out to the patient by phone. “This approach has really paid off in patients who would not come back for a second appointment. Getting them engaged by phone, working at a time that’s convenient for them, and presenting ourselves as an extension of their primary care doctor, whom they trust, has been very effective,” says Alexander. This approach encourages patients to talk to the care team about their needs and treatment preferences.

“Face to face appointments are limited and depend on patient preferences as well as clinical decisions. Reaching out by phone and communicating with the primary care provider really limit the number of in-person visits, which is usually a plus,” says Alexander. Often, the integrated team tries to piggyback face-to-face appointments with primary care appointments to avoid additional visits.

When he worked in a traditional behavioral health setting at UBA, Alexander observed that people came in initially but did not show up for appointments if medication was recommended. There was no one to educate the patients and talk to them about how they felt about medications. With the integrated team approach, Ricketts might recommend medication, but it’s the primary care provider who actually gives the prescription to the patient. This is less stigmatizing and everyone involved in the patient’s care knows what’s going on.

Did the patients fill their prescriptions? Are they taking their medications? Are they having side effects? Are they keeping up with their refills? The integrated team tracks all that and provides the information to the primary care provider through electronic medical records.

On the flip side, the primary care provider can check in with patients about their behavioral health treatment. When they open up a patient’s electronic medical record during a primary care visit, they see notes from the psychiatrist and social worker and can ask how their patients are doing.

Noncompliance or non-adherence — whether it’s about showing up for an appointment, addressing weight issues, or taking medication — must be seen as a symptom. “We need a patient-centered approach

where we ask ‘What’s the most important thing in your life and where does your health fit into that picture?’ It’s going to make a big difference,” says Ricketts.

Chung points out that integration of medical records plays a key role in Montefiore’s model. “If I call a patient for a session, I already know what their last A1C reading was. I know if they missed a primary or behavioral health appointment. I know if they’re struggling with compliance in a certain area of their medical care and how that plays into their depression. We work on this with our patients so they experience the holistic approach as well.”

INTERVIEW WITH

HENRY CHUNG

Vice President and Chief Medical Officer

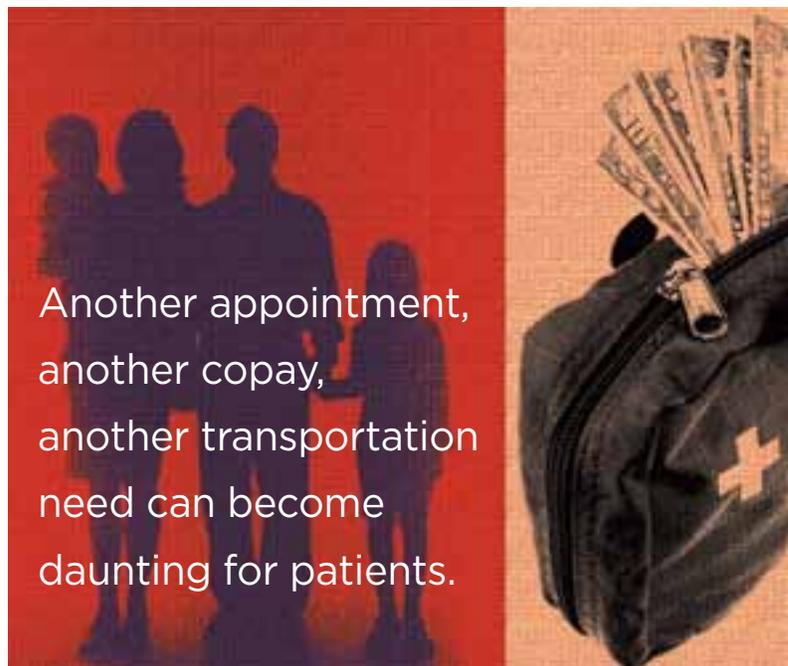
DANIEL ALEXANDER

Clinical Manager, Integrated Medical Behavioral Team

SALLY RICKETTS

Medical Director, Integrated Medical Behavioral Team

**Montefiore Medical Center Care
Management Organization**



Another appointment,
another copay,
another transportation
need can become
daunting for patients.

A Cultural Moment

Why a Hospital System is Big on Behavioral Health

When the Carolinas HealthCare System (CHS) — the nation's second largest not-for-profit healthcare system — called me about the position of clinical officer for behavioral health services, I was intrigued by their commitment to behavioral health. CHS had recently broken ground on a \$36 million, 66-bed psychiatric hospital in Davidson, North Carolina. Opened in April 2014, this is one of the first new inpatient behavioral health hospitals built in the U.S. in years, at a time when our national story is the steady drumbeat of bed closures, hospital closures, and the decimation of behavioral health budgets.

I decided to pick up my family and move halfway down the coast to the Carolinas for one reason. I came because there is a cultural moment here like none other in the country right now. There is something important happening here. It's a moment of great opportunity.

CHS' 42 hospitals and 900 care locations are well known regionally for excellent care, strong patient focus, and community involvement. Now our vision is not just regional, but for national leadership in the transformation of healthcare. What perfect timing for behavioral health to join up with such a bold, inspirational quest!

“There is a cultural moment here like none other in the country right now.”



Despite treatments that help 60-80 percent of people with mental illnesses recover, we are only effectively helping 5-10 percent of those who suffer. North Carolina spends 20 percent less on mental health than we did a decade ago, and our rate of emergency room visits for mental illness is two times higher than in the rest of the country. CHS is determined to change this equation. We believe that for any system to thrive, as we all become more 'accountable' for the cost of care, it must provide excellent care to those whose untreated illness drives cost — and untreated mental illness is a huge cost driver.

One year ago, we created a behavioral health 'service line' to knit together disconnected programs, assets, and strategies across three states. Our approach to integration is a chronic care model that starts in the primary care world, with hopes of catching people upstream, screening as many as possible to identify behavioral health disorders, and referring them to specialty care as needed. After all, 70 percent of visits to primary care have a behavioral health component and primary care providers prescribe the majority of psychotropic medications. And we realize system savings when, for example, depression is detected and treated early or rehospitalization is avoided for a person with diabetes and a behavioral health condition.

CHS has also made a major investment to bring Mental Health First Aid training to the communities we serve because we realize that education and early intervention are critical.

Our biggest initiative, with the greatest potential impact, is the CHS multimillion dollar virtual integration project to bring behavioral health services into our primary care offices. The integration of behavioral health into primary care is one of the most critical interventions to improve the care of individuals, families, and communities and to create an effective and sustainable approach to healthcare delivery.

We spent the summer of 2013 collecting data, engaging constituents, and bringing in a team of consultants led by Dr. Lori Raney from Colorado to help with design. Now we have great momentum, an energized team, and inspired and unique model for delivering integrated care. We started with the IMPACT model developed by Dr. Katon and Dr. Unutzer from the AIMS Center.

“ Our biggest initiative, with the greatest potential impact, is the CHS multimillion dollar virtual integration project to bring behavioral health services into our primary care offices.”

Given the size and scope of our integration project, spanning 225 primary care offices, we had to think outside the co-located box so we focused on making the project as virtual as possible. And virtual means everything from telepsychiatry to the most underutilized tool in healthcare: the phone.

We took the crucial role of the behavioral health provider from the IMPACT model, broke it down into its separate functions, and reformed it in a virtual team. Each of our 225 primary care offices will be assigned a team made up of a psychiatrist, psychologist, pharmacist, nurse, social work navigator, and coach. Each team will be deployed to multiple practices. When primary care providers walk into what they expect to be a diabetes checkup and encounter an individual with depression, they can pick up the phone, connect with the team, and get coached through appropriate next steps (e.g., obtain a PHQ-9, get the patient ready for a video interview with the psychologist for further diagnosis, get the patient on a depression registry, connect them to online therapy, review the medication algorithm).

The more time primary care providers spend in an integrated system, the more comfortable they become in treating the psychiatric issues themselves. We've also launched a behavioral health fellowship for primary care providers with an interest in treating behavioral health patients, including those with serious mental illnesses.

We're learning that integration through virtual care is about resource management and efficiency, but it is also about economy of skill and scale.

JOHN SANTOPIETRO

Chief Clinical Officer for Behavioral Health, Carolinas HealthCare System

THREE QUESTIONS WITH DR. JOHN SANTOPIETRO



Jennifer Thomas talked with Dr. Santopietro in the Charlotte Business Journal April 18, 2013 when the Carolinas HealthCare System broke ground April 12 on its \$36 million behavioral health campus to provide inpatient psychiatric bed capacity as well as outpatient treatment and coordination of care at CHS facilities.

Why does Carolinas HealthCare need to take the initiative?

There are three reasons. One is the moral reason, which is that our neighbors and family members with mental illness cannot be out there and not be treated. The suffering is absolutely tremendous with mental illness. The second is, it's a medical issue. It's your brain. It's an organ and it's connected to the rest of the body, so we have to treat it like an organ. Third, we need to integrate as a healthcare system with behavioral healthcare or there will be economic consequences in the future.

How will this campus improve access to care?

There are patients who are backed up in emergency rooms and elsewhere that need to have excellent psychiatric care on an inpatient basis, and there's no beds for it. This is one piece in the puzzle of building an integrated system.

How important is creating an integrated system?

Carolinas HealthCare has invested significant resources in virtual technology to get behavioral health into primary care. If you talk about access, the 50% of people who aren't coming in for treatment, that's a great way to get them in for treatment. A lot of those people don't want to see a psychiatrist, but they'll see their primary care doc. Once you do that, then you really move people through the system. You get people in primary care, and they don't end up in the emergency room.

INNOVATIONS

in Substance Use and Primary Care Integration

Substance use treatment organizations have a big challenge ahead of them: integrating their care with general medical care. Interviews with four organizations pioneering this process reveal that there's no cookbook approach — each provider found their own way. As Les Sperling, CEO of Central Kansas Foundation says, “If you’ve seen one successful integration program, you’ve seen one.” Here are four.

SSTAR Offers Services as an FQHC

Based in Fall River, Massachusetts, Stanley Street Treatment and Resources (SSTAR) entered the world of medical care in the 1980s, three decades before the Affordable Care Act made integration essential. Most patients were injecting drug users, and the large HIV population had nowhere to go locally for treatment. “We had to send people to Boston or Providence,” recalls CEO Nancy E. Paull. “So we opened a health center.” SSTAR went on to become a Federally Qualified Health Center by partnering with another health center in town, and now has 5,000 patients.

“ They don’t ship you off anywhere. **You can get everything you need onsite.** They find a way to meet your needs, no matter what they are.”

Recently, SSTAR opened an opioid treatment program (OTP) in another site where patients are treated with methadone as well as other modalities such as buprenorphine or extended release naltrexone. “The demand is tremendous,” she said, noting that the number of patients in methadone treatment has gone from 200 to 800. Paull explains why anyone who is in this program is also required to get primary care from SSTAR. “We want to know about their total health and ensure that there are no gaps in their care. They have so many other chronic conditions in addition to opioid addiction.

“Instant access” to the OTP is the next step already has same-day access for primary care. “We’re building a new facility, where people won’t even need to call for an appointment,” said Paull. “They can come in any day and be assessed, and then a treatment plan will be developed.” Not every patient who comes in with opioid addiction gets methadone. Staff determines, with the patient, what type of treatment is best.

Even “wellness” groups, if staff participate, can lead to better care because substance use, like mental illness, is a chronic condition and continuing care and vigilance are important.

Elise Kennedy, who was treated at SSTAR for substance use disorders, said, “SSTAR gave me options to recover every aspect of my life that addictions took from me. I was not a number, I was a person. Once you’re with SSTAR, you’re there. They don’t ship you off anywhere. You can get everything you need onsite. They find a way to meet your needs, no matter what they are.”

Central Kansas Foundation Embeds Staff in Primary Care

The Central Kansas Foundation (CKF) based in Salina, Kansas embeds professional staff in local FQHCs, says CEO Les Sperling. CKF staff screen every patient who comes into the FQHCs for substance use disorders. The screening is done by medical staff with the patient at the same time that vitals are taken. Of the 10,000 patients CKF screens each year, 21 percent are positive. The result goes into the medical record and when the physician sees that there is a positive screen, the CKF staffer is assigned to do the full screen using AUDIT (Alcohol Use Disorders Identification Test), a 10-item questionnaire that checks for hazardous or harmful alcohol consumption.

The substance use professional then engages the patient in what ranges from a brief educational meeting to a referral for specialty treatment. Not only is this a case-finding mechanism for CKF, but it helps the FQHC

keep its patients healthy by managing substance use problems early. About three percent of all patients in the FQHC get referred to CKF for outpatient or inpatient treatment.

Healthcare organizations understand that if they don’t treat people with substance use problems, they are going to fail at helping them recover from other illnesses. CKF is on call 24 hours a day, seven days a week, for the hospital. In addition, a CKF licensed addiction counselor is on the medical-surgical floor every day to find and help people in need.

Hospitals want to get people with substance use disorders out of their emergency rooms as quickly as possible, says Sperling. “It costs them a lot of time and money.” CKF started working with the hospital in 2009, says Sperling, noting that “you have to be persistent” when setting up an arrangement like this.

He stressed that when embarking on an integration project, it’s important to understand the medical culture and the value of a substance use treatment facility to that culture. “We’re driving down lengths of stay in the hospital,” he said. In 2011, the average length of stay for a patient admitted for the first time with a drug or alcohol problem was five days — last year it was three.

CKF had no startup funding, but placing staff in the hospital and primary care pays for itself, in revenue from the referrals. “You can’t just get a grant, because what do you do when the grant runs out?” says Sperling. Working with the hospital and primary care has resulted in a 238 percent increase in detoxification admissions since 2009. The commercial insurance business has risen about 280 percent. CKF is now in the middle of a capital campaign to expand beds.

Gosnold Helps the Local Hospital

The local general hospital sought help from Gosnold on Cape Cod, a substance use treatment provider based in Falmouth, Massachusetts. Raymond Tamasi, Gosnold president and CEO, recounts the first call from the hospital CEO. A patient, a daily drinker, went to the hospital for medical conditions, and alcohol withdrawal, which was not expected by hospital staff, ensued. The attitude of the staff changed once he was in alcohol withdrawal — the family felt he wasn’t treated as well. The hospital CEO told Tamasi she didn’t want this to happen again, and asked how Gosnold could help. It turned out that many of the patients came in for three-day procedures ended up staying two weeks because they went into alcohol withdrawal, and ended up in the costly ICU.



“Integration is what healthcare reform is all about because you can’t manage a person’s overall care without it.”

Gosnold started to help manage withdrawal in the hospital, and reduced ICU transfer rates for these patients from 50 to 10 percent.

For part of the project, nurses from the hospital came to Gosnold’s acute care detoxification unit to get a feel for the work — Gosnold paid them to be there for three days. In addition, Gosnold provided a nurse liaison and two other employees to the medical staff as consultants. “We taught the nursing staff how to talk to the patients about alcohol use, how to get more comfortable with it,” says Tamasi. “We helped them with the language, to normalize discussion of alcohol use as part of the general assessment.”

Withdrawal can be managed by prophylactic medications, so that other care could be provided without complications, said Tamasi. Of course, the nurses also needed to be taught how to assess withdrawal. “We explained that these patients weren’t being difficult, they were having symptoms of withdrawal,” he said. When the nurses understood that the patients in withdrawal were suffering, and they could help them with that, the nurses “got it,” said Tamasi. “Helping people with suffering is their *raison d’être*.”

Tarzana Runs Primary Care Clinics

Tarzana Treatment Centers opened its first primary care clinic in 1995, and now has five. The creation of primary care clinics was prompted by a healthcare crisis in Los Angeles County, where the federal government said there needed to be more ambulatory care so that people didn’t have to use the emergency room. At that time, Tarzana got funded for two primary care clinics, which are used by the general community as well. Everyone who goes to the five clinics is screened for substance use disorders using the UNCOPE screening tool and if they score positive, the primary care provider talks to them, explains Tarzana clinical director Ken Bachrach. If they need treatment, they are referred to Tarzana’s substance use treatment program.

Tarzana encourages all patients seen in its substance use programs to go to the primary care clinics it runs. Patients in residential

rehabilitation are automatically placed in Tarzana’s primary care.

What would Tarzana say to other substance use treatment programs that haven’t yet embarked on integration and want to remain specialty providers? “The train has left the station,” says Bachrach. “Integration is what healthcare reform is all about because you can’t manage a person’s overall care without it.” If high quality integrated care is delivered, costs will go down, and providers — specialty and primary care, hospitals and individuals — are going to be held accountable.

The federal Primary and Behavioral Health Care Integration grant Tarzana received from SAMHSA ends in October 2014. Jim Sorg, director of information technology for Tarzana, says that funding has been critical for care coordination. Care coordination facilitates essential communication between all providers involved in the care of a patient. And care coordination means being concerned about costs outside of one’s system. “Even though we’re not responsible for ER costs, we need to be concerned when one of our patients goes there,” says Sorg.

“We want to get away from the silos,” says Bachrach. “When people have multiple problems, care doesn’t magically get coordinated and integrated. That takes teams of care, and is not reimbursable under current models.”

Funding mechanisms for integration, logistics for implementation, and local opportunities differ, but the one constant is the need to provide care to the whole patient. It’s clear that there are patients in primary care who need, and aren’t getting, substance use treatment and vice versa. Integration is a win-win for the patients, primary care providers, and substance use treatment providers.

AARON M. WILLIAMS

**Director of Training and Technical Assistance
for Substance Abuse, SAMHSA–HRSA Center for
Integrated Health Solutions at the National Council
for Behavioral Health**

Population Management in Action: The Missouri Health Home



For 43,385 served in the first 18 months, that means a total savings of \$23.1 million.

Health homes are a prime example of population management in action. In fact, Section 2703 of the Affordable Care Act, which defines the health home, explicitly requires a population management approach. The law states that health home providers must be able to use health information technology to facilitate their work and to establish quality improvement efforts to ensure that the work is effective at the individual and population level.

In 2011, Missouri became the first state approved by the Centers for Medicare and Medicaid Services to create health homes in community mental health centers for Medicaid enrollees with behavioral health conditions.

The Missouri Health Home initiative focuses on patients with complex, high-risk and high-cost chronic conditions, with the goal of improving care while reducing avoidable emergency department visits as well as inpatient admissions and readmissions and associated costs. In addition to utilization data, the initiative measures success through improved patient clinical outcomes, functional status, care management, and care coordination.

Missouri's health home initiative is overseen by MO HealthNet, Missouri's Medicaid authority, in partnership with the Missouri Department of Mental Health. In addition to the initiative in community mental health centers, MO HealthNet developed a parallel primary care health home initiative, which began in January 2012.

Medicaid beneficiaries who were identified as meeting one of the three conditions outlined in the approved state plan amendment and who met the Medicaid spending threshold of at least \$10,000 were auto-enrolled and assigned to one of the designated health homes, as this particular population was deemed best able to achieve cost savings through better care coordination.

There are 28 community mental health center health homes operating at 120 locations caring for approximately 19,000 people. There are 24 primary care health homes operating at 103 locations caring for approximately 16,000 patients.

Each community mental health center must have a health home director, nurse care manager, primary care physician, and care coordinators/community support workers. The primary care physician, often a consultant, reviews the data to establish the priorities for disease management. This involves selecting chronic diseases for

intervention, pinpointing initiatives that will have the greatest impact on the care of the population, and identifying patients who require immediate attention. The care team works together to provide education to both medical and non-medical staff across the agency, people served, and the community. The community support workers work directly with enrollees to complete day-to-day tasks to maintain their health.

After 18 months of operation, evaluation shows:

- 6-9 percent reduction in annual hospitalizations
- 5 percent reduction in emergency room use
- Reduction of blood pressure and cholesterol, which is linked to reductions in heart attacks and stroke
- Improved blood sugar control, which is linked to lower rates of diabetes and complications due to diabetes

We saw a reduction in cost of services of \$51.75 per member per month, which includes the cost of providing the Health Home interventions. For 43,385 served in the first 18 months, that means a total savings of \$23.1 million.

To expand upon this success, in the coming year we will expand our initiative to include another 10,000 patients (both at the community mental health and primary care centers), and add providers for the primary care health homes. We are looking into developing a health home approach for children in foster care, and will be implementing an outreach program for persons with severe and chronic substance abuse problems.

An important piece of this initiative is for the health home to develop collaborative relationships between the psychiatric medical team, external primary care providers, hospitals, and other community linkages to improve care population-wide. Now, we're working with the Department of Health and Senior Services to identify individuals enrolled in a health home that are seen in the emergency department. This enables the health homes to function in real time.

JOSEPH PARKS

Distinguished Professor of Science, Missouri Institute of
Mental Health, University of Missouri St. Louis

DORN SCHUFFMAN

Coordinator, CMHC Healthcare Home Initiative, Missouri
Department of Mental Health

Integration Road Trip:

Visits with 10 SAMHSA Grantees



The SAMHSA Primary and Behavioral Health Care Integration (PBHCI) program provides four-year grants to 100 publicly-funded community mental health and other community-based behavioral health settings to coordinate and integrate primary care services. We checked in with 10 across the country to get a glimpse into their work and the progress they're seeing in their communities.



The Providence Center

Providence, RI

NELLY BURDETTE
Director of Integrated Care

Integrated care is a big part of what we do. Most people here have some understanding of what integrated care is all about. People really get it. Even before we received our grant, we were moving toward integrated care. We have strong partnerships with two Federally Qualified Health Centers (FQHCs). They have the same mission, are driven by the same values, and see the same kinds of clients that we do.

We connect clients to primary care services in either the community or at the center. Two nurses embedded in mental illness care teams focus on clients who have at least one of these conditions: obesity, diabetes, heart disease, and hypertension. The team's role is to educate clients, many whom haven't had primary care for years or go to the emergency room for care. I lead trainings with nurses bimonthly on different medical conditions. The goal is recovery and to get clients to have more control over their health.

Behavioral health traditionally does not have a strong focus on outcomes. Behavioral healthcare is more about the impact it can have on an individual's life. A challenge has been getting clinical staff to view collecting outcomes as a means of providing better care. The electronic health record collects clinical outcomes right away so we have proof of progress immediately. EHRs foster integrated care by making it easy to share information with both mental health and medical providers. We don't just collect data; we analyze it. We're a leader in the state in our ability to analyze data, and we're dedicated to integrated care. We've convinced people across the state that integrated care is the way to go.

One measure of success is that the entire organization has buy in to the idea of integrated care, starting from the front desk. When a client says "I need help with my blood pressure," we once told them that's not what we do. Now staff know we can provide an array of services.

International Center for the Disabled

New York, NY

AMY DIMUN
Project Manager

We provide people with disabilities and other rehabilitative and developmental needs with medical, speech and language, mental health, and vocational services. We noticed about 90 percent of our clients had significant nutrition and weight issues. We asked clients the top three things they could do to improve their health, and the overwhelming response was nutrition and weight management.

We started running weekly workshops to address overall wellness, including nutrition, weight loss, exercise, and meal planning. The workshops are open to everyone at ICD, including staff. All the vending machines now serve seltzer water, bottled water, and juice rather than soda, though some machines still sell diet soda. We replaced all the unhealthy snacks with more nutritious foods like nuts, granola bars, and baked chips. We placed signs on the machines explaining the changes. The bestsellers are now the healthier options.

We do a lot of one-on-one counseling to address medicine management, time management, and nutrition management with food journals. We don't simply hand them a planner, we spend a couple of weeks with them to develop the skill set of how to use it. We train our staff in motivational interviewing. We offer to walk them to the farmers market in Union Square, a half mile away. To help motivate them to eat healthier, we give them Farmer's Bucks. If they use it to buy \$5 in fresh produce, they get \$2 back to spend on more produce.

So far, there's been a total weight loss of 357 pounds for about 160 clients. One client lost 65 pounds, another lost 50, and another lost 30 pounds. Clients have made significant lifestyle changes, such as participating in a walking group, and trying different types of healthier foods like hummus. One client who takes a bus here gets off at a stop a couple of blocks away to walk the rest of the way. Others are taking the stairs rather than elevators. One client was planning to run the New York City marathon.

We see a lot of resistance to losing weight. Some clients say they simply cannot do it. Some feel like they don't have a lot in life to enjoy, particularly if they've already had to give up things because of substance use. Clients are honest with us and they'll tell us when they're ready to change. The key is getting them to take the first step. Clients like the fact that healthy eating is for everyone, not just clients. Having everyone involved in the wellness activities, both staff and clients are sending the message that this is a healthier place.

“ We do a lot of one-on-one counseling to address medicine management, time management, and nutrition management with food journals.”

Community Mental Health Affiliates

New Britain, CT

FRANCES CERASUOLO
Program Coordinator

The mission of Community Mental Health Affiliates (CMHA) is to improve the quality of life of adult patients who do not have a physician in the community through medical care, wellness education, and the integration of medical and psychological treatment.

CMHA has a long history of working with the Hospital of Central Connecticut, and some patients are already being shared between the two facilities. The SAMSHA grant allows for a primary care physician's office to be embedded in CMHA, about 50 feet away from the hospital.

A lot of thought by both facilities went into setting up the primary care office. The hospital and a physician at the hospital oversaw the development of the medical examination room. The decision was made to have one primary care provider for now. Right now we see about 200 patients, and by the end of the grant in two years we hope to be up to 500 patients.

The biggest success is the ability to have full access to all the hospital facilities. We can get so much more done for patients by having access to hospital services like x-rays. This is particularly beneficial considering that most patients have not had any medical care for years. So our patients are coming to a medical clinic at a mental health clinic, where medicine and psychiatry are integrated. It's helpful to have team members who understand how both facilities work.

Our patient population has a hard time with transportation, so it's helpful not to have to refer them to three different locations. Between CMHA and the hospital 50 feet away, they can get everything done at one time at one location.

The biggest challenge is information sharing. CMHA and the hospital have two computer systems. Just as we were working to share information in a timely manner, the hospital put in a new computer system. We are applying for a grant and, if we get it, we hope to have one system in a couple of years.

Since we partnered with the hospital, patient care has vastly improved. Before, patients were not being treated as a whole person. Integrated care has the best interests of the patient at heart. One of CMHA's patients who was just released from prison came into the Wellness Program. He was treated for bipolar and post-traumatic stress disorder. He had morbid obesity, weighing 440 pounds, with diabetes. Now he's much healthier, down to 338 pounds and taking appropriate medications. He's also been active into talking other clients into attending wellness groups.

“The biggest success is the ability to have full access to all the hospital facilities.”

Milestone Centers

Pittsburgh, PA

COREY LAKINS
Director, Healthcare Home Project

We collaborate with Squirrel Hill Health Center, an FQHC, to provide primary care and wellness services to a targeted population of deaf consumers. The goal is to make healthcare more accessible and demonstrate that prevention and early intervention reduce the occurrence of serious physical illness.

Our Certified Peer Support Specialist is deaf and works with hearing and non-hearing consumers. Her role is to support consumers in the project and assist them with their personal goals of both physical and behavioral health. She helps facilitate their doctor appointments, and assists with their socialization by involving them in movie, singing, and pottery groups.

I can truly say we see greater stability in their lives just from observing their interactions with other consumers. Some of the deaf consumers had not been seen by a physician for some time and came in with significant health issues. They may have come in with high blood pressure and diabetes that was out of control. Now their conditions have stabilized and their socialization skills have vastly improved.

We also provide wellness opportunities. We bring in an interpreter to programs on nutrition, how to read labels, diabetes, and safe sex. We work with our deaf population to address their unique learning needs. We work with them on sex education, STDs, sexual promiscuity, when to say “yes” and “no.”

We also see that serious health issues seem to go untreated for a long time and only get addressed when they come into our program. Significant heart issues and obesity tend to go untreated for much longer than the general population. This may be because of the language barrier with physicians. Communication is critical. You need an interpreter when discussing major situations.

If other agencies took the opportunity to recruit deaf consumers into their integrated care programs, it'd be to everyone's advantage. Deaf consumers go without proper care for long periods of time because of fear of the language barrier. It'd reduce the cost of healthcare to get them involved in integrated care so they do not have to go to the ER every time they're sick.

Cobb Douglas Community Services Board Austell, GA

DEBBIE STROTZ
Coordinator, The Circle & Integrated Health Programs

4 Corners is designed as a health home treating the whole person within a behavioral healthcare setting. We offer a wide array of services, including psychosocial rehabilitative services using an evidence-based recovery model. Client-driven goals guide the individual treatment plans.

Our philosophy is that the more we are engaged with each other, the more we can accomplish in our lives. Having peers working with peers furthers the recovery process. We're like one big happy family. Peers are involved in a number of ways, from providing breakfasts for clients to performing community outreach. We've recently started a blog that covers topics like smoking cessation and nutrition. We produced a cookbook, *Healthy Eating on a Limited Budget*, which was recognized by the governor.

The fitness center has been a huge success. It's gone from a handful of peers to now about 100 participants. A certified personal trainer works with them about 10 hours a week. Peers come to the fitness center introverted, some even have trouble walking. In a matter of a few weeks they start feeling better, and their blood pressure comes down. Their mental abilities improve the more they engage with folks and have peer-to-peer discussions. Even their medications are reduced. Soon, we will have a relaxation room, which will teach different types of techniques like deep breathing and aroma therapy.

Clients are engaged with a variety of services, and last year peers achieved 100% success in getting their physical health screenings. One peer got another into a hypertension group and has since lost 20-25 pounds and is taking fewer medications.

Our mission cannot be accomplished without peer involvement. Currently we have four peers on staff and plan on hiring at least one more. And they are very much part of the team, we don't separate them in any way. Everybody works together. Engaging peers helps us take the person-driven, holistic approach and helps people move forward. I've been here for 10 ½ years, and we've always been encouraged to work with peers. Even in places like the fitness center, peers can talk to another peer about nutrition and other issues. It becomes a comfortable environment to discuss an array of different things.

Something that's not a big challenge is retention. We treat our people well. It's about respect and working hard as leaders. Certified peer specialists are part of a team. It's important to identify and build on their strengths and to match them to the right job. People will be happy if they work in an area that they like.

Trilogy, Inc. Chicago, IL

ALICE GEIS
Director, Integrated Healthcare

Our building has been smoke-free for a long time, but we wanted to implement a 100% smoke-free campus. We focused our efforts on the exterior of our campus, like the picnic area and parking lot.

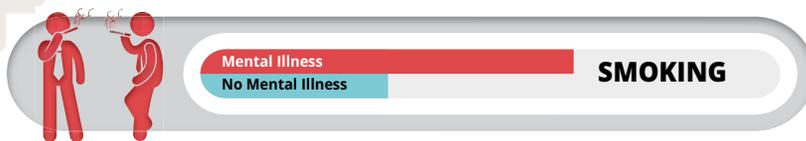
At first the idea was met with mixed reaction. Some people were concerned that prohibiting clients from smoking outside the building would only provide more stress. Others said that smoking often helps with the clients' symptoms. We started a "Breakfast & Learn" meeting for staff to air their concerns and get comfortable with the idea. We had a big display in the foyer which counted down the days to going smoke-free. It was important to address people's concerns and never blame a person who smoked.

Before our smoke-free campaign, all of our clients were asked about their smoking status at every visit. Smokers were asked about quantity and were encouraged to consider quitting. If they were open to using carbon monoxide monitors, we checked their exhaled air to determine their current levels, even during their psychiatric visits.

We started a "Morning Habit Group" at the drop-in center to discuss a wide range of health issues, including the impact of smoking. Staff worked with the Respiratory Health Association of Metropolitan Chicago to create a dedicated room for smoking cessation, the "Cessation Station." The station included a dedicated phone line in a semi-private area for clients to call the Illinois Tobacco Quit Line, bookcases with smoking-cessation materials, and free nicotine patches.

We have not heard any more concerns from staff, and several people in every department have quit smoking. Our clients are also happy about the change. They've said, "I know this will help me. Not constantly seeing people smoking outside might help me to not smoke."

Now it's becoming normal not to smoke within this population, whereas before it was normal to smoke. We see peers who have quit encouraging others to do the same. After 16 years in therapy, a client announced about a month ago, "I'm going to look into getting patches."



The Montrose Center Houston, TX

ANDREA WASHINGTON
Substance Abuse Treatment Program Coordinator

The Montrose Center empowers a community of primarily lesbian, gay, bisexual, and transgender (LGBT) individuals and their families to enjoy healthier and more fulfilling lives by providing affordable behavioral health and prevention services. In addition, we provide prevention services, support groups, HIV/AIDS services, housing, domestic violence services, and education.

The Empowering Mind & Body (EMBody) program includes a variety of services for people who look for a whole-health approach to wellness and recovery. The program helps LGBT individuals who are uninsured, underinsured, and underserved access primary care in addition to their behavioral healthcare at the center. These people have fallen through the cracks of the health system. We have victims of domestic violence, people who are HIV positive and a lot of substance abuse. The program also includes free wellness classes that are open to the entire community to help individuals reach whole-health goals. For people with substance abuse who have already gone through the early stages of change, this is a prime time to address other issues, like obesity, smoking, and diabetes. This is an opportunity to get them involved in wellness activities, like yoga, meditation, and walking groups.

Getting clients to participate in wellness activities is not a case of “if you build it they will come.” The change process takes time. The LGBT community has the challenge of a lack of family support. Either they’ve been cut off from their families or they don’t have strong bonds with them. This population likes to stay private. They’re aware of what being “outed” can mean. They’ll keep medical information away from providers. If a client is HIV positive, they don’t want to be treated differently or mistreated, and they may not want their dentist to know.

About 200 people have entered the program in two years. Getting clients to stay in care has been challenging, particularly those with persistent mental illnesses. And the challenge of working with a lower-income population is that people move, lose their jobs, and their change information frequently.

The program is going very well for those staying in care. One man in the substance abuse program really took control of his life and has been clean and sober for six months now. In the process he lost 25 pounds. Another person in medical care was overweight with high blood pressure. Their medication also caused high cholesterol. After switching medications, they addressed his cholesterol issue and he is feeling a lot better. He is now clean and sober and managing very well.

San Mateo County Health Systems

San Mateo, CA

CHRIS ESGUERRA
Deputy Medical Director

The Total Wellness project is a collaborative, peer-based care model integrating primary care with behavioral health coordinated by nurse care managers. We treat the whole person, serving as the neck that connects the head and the body. The idea is to promote a single coordinated client care plan, including behavioral health, physical health, and wellness goals.

One way to improve quality is to develop effective workflows that reinforce clarity, consistency, competency, and efficiency among staff, and to make sure that the processes in place are working well. Look at the data and look at outcomes, to see if clients are getting better. We start with baseline data, where is everybody on BMI, lipids — all this is tracked. Then we ask who needs what and determine how they are improving. We also ask our Consumer Advisory Group to provide feedback on the program and operations.

We’ve established a number of much-needed wellness activities and services, including peer-led groups in smoking cessation, well body and individual peer wellness coaching. Group participants have reported increased confidence in their recovery and peer consumers have played big roles in serving as role models for them. We’ve provided wellness trainings for all of our consumers, and so far seven hold ongoing employment.

There’s tons of data. We have a shared drive in the county so everybody can get at it. The key is to make it simple, easy to use, and foolproof. Right now the primary care and behavioral health systems have different electric health records (EHRs), so we need to try and centralize all files into a master sheet. Even though staff has access to information, with multiple EHRs it’s not easy to navigate. It’s a fractured system, with staff having to look in multiple places. The systems don’t talk to each other.

As we track data, we know that clients feel more socially engaged and connected with groups. Also, we need to pay more attention to our smoking cessation program. We know we have not addressed people’s chronic diseases; we’re just starting on diabetes control. There’s a lot of ambivalence around quitting — people need additional support. The key is selecting the right intervention at the right time.

It starts with designing the process. You must have standardized work processes. The other piece is connecting staff to each other through open forums and regular clinical team meetings where information is shared. Another key is peer involvement. Having their experience has been invaluable. Peers can often bring about changes in participants by serving as mentors.

Downtown Emergency Service Center

Seattle, WA

JIM HOPFENBECK
Medical Director

Our mission is to end the homelessness of the community's most vulnerable people through an integrated array of clinical services and supportive housing that allows men and women to reclaim their lives and reach their highest potential. We have two clinics that work with people living with serious mental illness. This population tends to have poor health, live shorter lives, and have metabolic conditions. They generally do not have access to primary healthcare. A primary care clinic was established inside the community mental health facility.

We attempt to engage clients at various levels. We invite them in and serve them a nutritious meal. Some may wonder, "What's behind this?" so we try and explain about primary care. We don't force them to take a full physical. We don't want to make barriers. We do a wellness check if that's all they want.

We see people who have not seen a primary care provider in a decade. They initially mistrust the providers, but providers learn to build rapport with clients over time. The challenge is to respond to them in a way to figure out what's bothering them. Give them encouragement and let them proceed at their own pace. It takes time and patience, but they should know we're still here to support them. Treat each person like a human being. Homeless people want a safe environment and want respect.

Case managers work on prevention with all clients and identify clients who may need primary care. Every client has a treatment plan with individual goals. We collect health markers on clients, which mark conditions like blood pressure, weight, and cholesterol over time. We're just concluding our second year, so the data is still in an early stage.

Some cases are bittersweet. We had one lady — very paranoid, delusional - who came in complaining of back pain but didn't want to take her medication. After persuading her to have a physical exam, the back pain turned out to be advanced cancer. We were able to support her during her last few months of life and get her into hospice care. Her medicine was donated. She died humanely with her pain controlled.

Don't underestimate how fearful people are, people who have avoided doctors for a long time. Understand the courage it takes for them to finally see a doctor or nurse. Also, never underestimate the challenges that the homeless face. You'll have to work very hard to build trust. Bring in peers for motivation and to speak about homelessness and drug abuse. Peers can say, "I've been there, but I was able to turn my life around."

Alaska Island Community Services

Wrangell, AK

DESIRÉ SHEPLER
Social Services Administrator

In Alaska, we have higher rates of smoking, obesity, and heart disease, along with other chronic conditions. Residents tend to place less of a value on physical activity. It's a real public health challenge to deal with a population with a different value system.

Offering comprehensive community-based behavioral health services to children, adults, couples, and families in isolated, island communities of about 5,000 people, Alaska Island Community Services (AICS) uses multiple strategies to encourage greater physical activity.

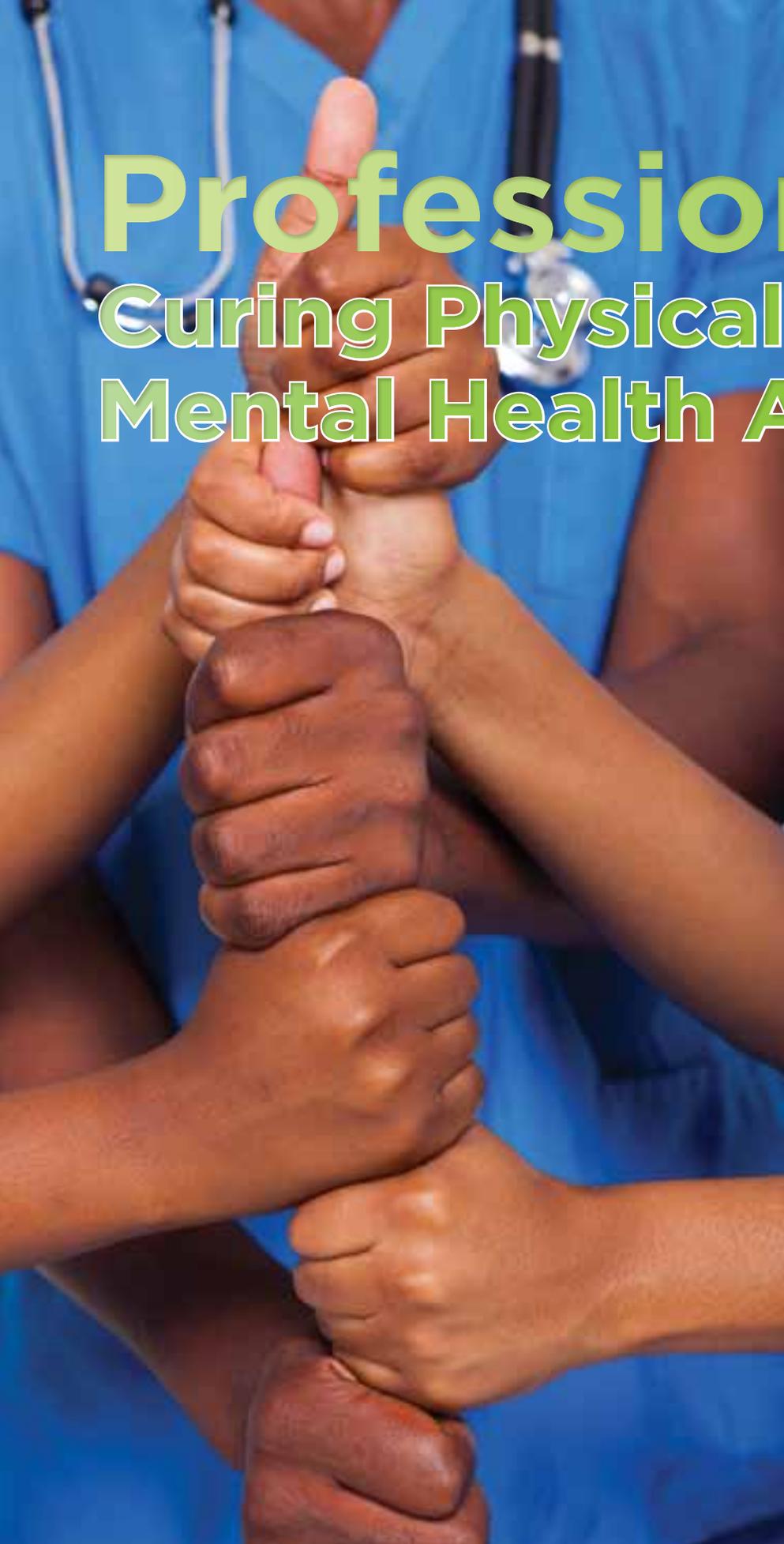
Exercise programs include twice-weekly walking groups and weekly Walleyball games, a sport similar to volleyball but with no out of bounds. AICS also offers free access to Parks and Recreation facilities and activities for enrollees of our Primary and Behavioral Health Care Integration program. Our clients are able to use the gym, weight room, swimming pool, bowling lanes.

Peers co-facilitate certain activities. They go along with us on walking groups and help other clients follow through on attending. Sometimes they lead the physical activities. We choose peers who are already known to the community with certain physical activities. We want peers who can relate well with clients.

It's a very small town and our agency has a good standing in the community. We are the sole provider of behavioral health services for the communities, so we have always had agreements with Parks and Rec to use their classrooms and facilities — all for free. The free access to the facilities is a major selling point. In a community like this, it's a real financial incentive. To have a partnership that doesn't cost us anything and does not affect us from a financial standpoint; we hope to continue that for a long time.

It can be difficult when you have a wide range of people who fall under different criteria, some more or less highly functioning than others. Sometimes when trying to create a group activity, you may have a higher functioning person not want to participate because they say "I'm not like those people." So you need to leave the door open for one-on-one activities. Also, being so small, everybody knows everybody. Some people don't want to be seen in a group activity because of preconceived notions of what people with mental health issues are like.

We're a very small, rural community, so we focus on our strengths. We go to consumers and ask them what they want, get feedback. Try to meet your clients where they are. Being small, it's easier to make changes on the fly. Our combined enrollment goal was 75 for the physical activity programs, and we now have just over that. There's been a tremendous amount of enthusiasm about the programs, people excited about Walleyball, people wanting to get together and walk.



Professionals of Curing Physical and Mental Health Ailments

Behavioral health has emphasized the importance of integrated care for many years now. We wanted to share the article below, published in *The Washington Post*, because it highlights how the concept of integration is gaining increased attention in the mainstream. The article highlights the integration initiative of Family Services, Inc. and their FQHC partner, Community Clinic, Inc., in Gaithersburg, MD. The initiative is funded through the SAMHSA Primary and Behavioral Health Care Integration grants. The National Council for Behavioral Health is proud to provide technical assistance and training to SAMHSA integration grantees through the SAMHSA-HRSA Center for Integrated Health Solutions that we operate.

All Stripes:

On a recent day at Family Services Inc., a low-income mental health clinic in Gaithersburg, clinic director Amy Van Grack was treating one of her regular patients when she realized the patient was homeless, pregnant, and hadn't seen a primary care doctor in months. So Van Grack walked the patient down the hall to meet with one.

In addition to therapists, counselors, and psychiatrists, FSI in December added a medical clinic to its site. The idea: Individuals with behavioral health disorders are more likely to get the physical treatments they need when a doctor is readily available, affordable, and near their mental health care provider.

In bringing on physician Sacari Thomas-Mohamed to head up the medical side of the clinic, FSI is at the leading edge of a trend toward what's called health care integration — the idea that medical professionals of all stripes should work together to treat the range of ailments a patient might be experiencing at one time. FSI is one of 93 clinics across the country that's been given part of \$174 million in grant money by the Substance Abuse and Mental Health Services Administration over the next four years to help them accomplish just that.

Although SAMHSA is still evaluating its grantees' results — the official report is due at the end of this year — the agency said the clinics have together seen improvements of 10 to 46 percent across a variety of their patients' health indicators, such as body mass index and blood pressure.

People with serious mental illnesses, such as schizophrenia, die 25 years younger than the general population on average, according to a

“Individuals with behavioral health disorders are more likely to get the physical treatments they need when a doctor is readily available, affordable, and near their mental health care provider.”

2006 study by the National Association of State Mental Health Program Directors. Factors such as transportation issues, fear of stigma and lack of insurance keep them from making and keeping regular doctors' appointments.

Three relatively young FSI clients died within two years, which inspired the clinic to apply for one of the SAMHSA grants in 2010 to help them start integrating.

“People under the age of 55 were dying of diabetes, heart attack and stroke,” FSI director Arleen Rogan said. “We wanted to see how to make a difference in that.”

FSI's program is an extreme manifestation of integrated care — most clinics opt for simply asking psychiatrists and doctors to compare notes or to share health records. But increasingly, clinics and hospitals are streamlining access to care for patients who have co-occurring mental and physical health disorders.

“With the advent of healthcare reform, services are going to need to be less redundant, more efficient, more patient-centered, less provider-centric,” said Mark McGovern, a psychiatry professor at Dartmouth University who has studied mental health integration.

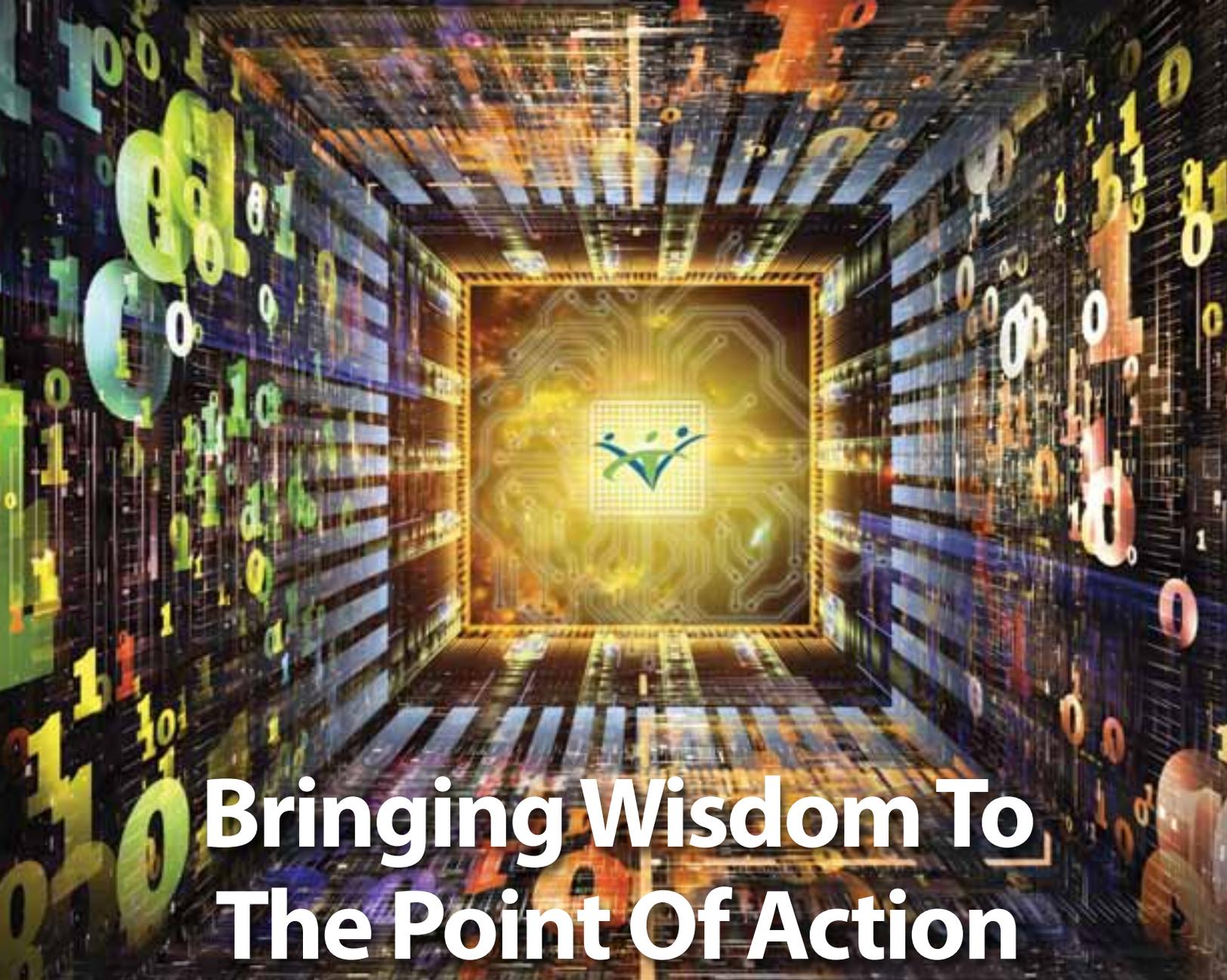
Integration predates the Affordable Care Act, but the healthcare bill did call for the creation of models that allow patients to be managed by interdisciplinary teams of doctors. Payments will also shift from services to outcomes, so doctors will have more incentives to work together to cure a patient for good.

Before the medical office opened in December, FSI's mental health patients could walk across the street to see doctors at a clinic that had agreed to collaborate with FSI's psychiatrists. They worked together on difficult cases, and they were making progress with dozens of patients who had co-occurring problems, such as obesity and depression.

Still, appointments at the health clinic were missed, prescriptions went unfilled, working moms rushed back to work after therapy sessions rather than stop in for a blood pressure check.

“Even though it's across the street, it might as well be across the country,” Rogan said.

Now if mental health workers suspect high blood pressure or diabetes, FSI staff members escort patients from the psychiatrists' offices straight to Thomas-Mohamed, who leaves open plenty of walk-in appointments to accommodate them. Therapists are taught to be more aware of somatic concerns, asking patients about blood pressure and smoking



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“They have too much else to deal with, and everything can overshadow the primary healthcare interest.”



cessation. They’ve also put therapists at the medical clinic across the street for patients who still see doctors there.

Other low-income clinics across the region have been moving in the same direction. In Fairfax County, the Community Services Board will soon begin operating a health center staffed by three medical workers out of the Gartlan Center, a site serving people with mental health and substance abuse issues.

In Baltimore, Mosaic Community Services, which operates clinics that provide mental health and substance abuse services, has also recently brought in primary care doctors and nurses to work in some of its 100 locations and sent its mental health workers to other primary care facilities.

Even though its medical services are FSI’s newest advancement, the center also provides housing services, counseling for battered women and drug users, group therapy and other treatments.

“They’ve been helping me for years,” said one patient who has schizophrenia and spoke on the condition of anonymity. “You get to meet people through the lunch programs and groups. I try to participate every day.”

If it sounds as if providing such comprehensive services to such an impoverished population would be almost prohibitively expensive, that’s because it is. FSI said that, while they are funded through grants and other mechanisms, they are grappling with how to pay for some of their services in coming years.

FSI’s \$2 million grant covers nursing salaries, some contractors, diabetes education and wellness programs, and it lasts for four years. When the grant runs out, they aren’t entirely sure what’s next.

In Maryland, for example, mental health clinics can’t bill for nursing services, Rogan said, and “we’re still trying to figure out how to fund the nurses after the grant runs out.”

Fairfax County’s Community Services Board has also felt the crunch, letting several vacant staff positions go unfilled. “Our staff is so stretched right now and working so hard to keep services going,” said Laura Yager, the board’s partnership and resource development director.

Then there are the challenges doctors face when treating a profoundly mentally ill population. Appointments take longer, past visits are forgotten, changes in habits or new ailments go unmentioned.

“People could be walking around with high blood pressure and thyroid problems, but they don’t think about them as problems because they have had them for so long,” Thomas-Mohamed said. “They have too much else to deal with, and everything can overshadow the primary healthcare interest.”

SAMHSA’s program started three years ago with 13 grantees, and there are now 93 around the country — mostly community mental health centers that want to bring on medical services. As the psychiatrists started trying to incorporate somatic concerns, the learning curve was steep.

“We had folks who didn’t even understand how they would start weighing people [on scales] — that was so far outside the scope of their organization,” said Trina Dutta, the lead for primary and behavioral health-care integration at SAMHSA.

But there have been signs of progress. Of the 592 people who have been enrolled in FSI’s three-year integration effort, many have seen blood pressure decline, weight stabilize and cholesterol levels drop. Fewer patients report being depressed, but the number of smokers has remained the same.

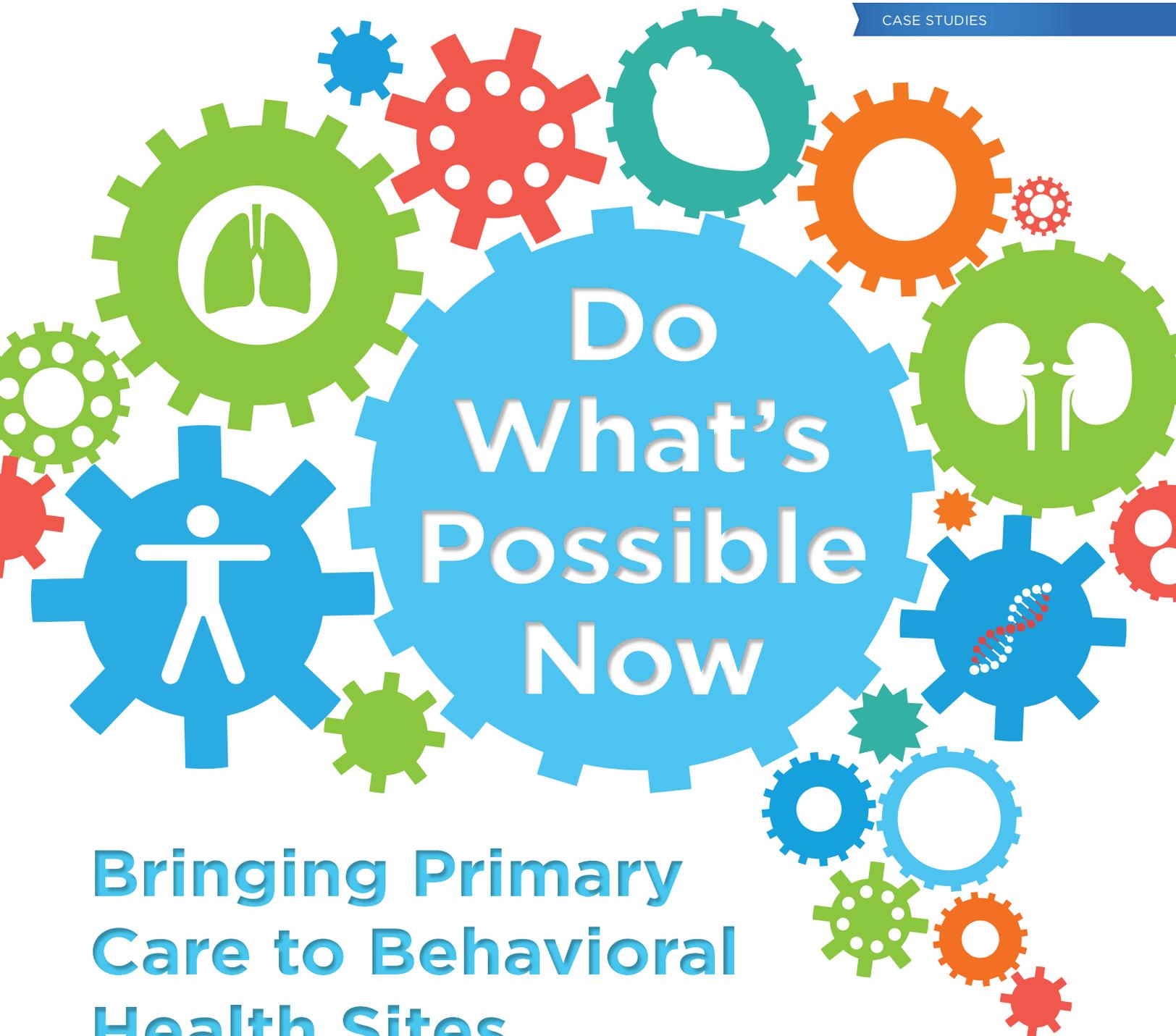
One 29-year-old man, an obese smoker with hypertension and hypothyroidism, lost 27 pounds through diet and exercise after a year with FSI. A 33-year-old woman who had schizoaffective disorder weighed 372 pounds, but with diet advice from an FSI nurse, she lost 31 pounds in a year.

In addition to nudging the numbers closer to the healthy range, experts say health integration represents an important step in making healthcare prioritize patients’ needs.

“There’s a difference between a system of care that’s provider-centered, rather than patient-centered,” McGovern said. “We have a back that might ache, but we also might be sad about a loss, and that affects how our feet and backs feel.”

OLGA KHAZAN

The Washington Post, February 18, 2013



Bringing Primary Care to Behavioral Health Sites

In today's competitive environment, should a behavioral health organization still try to deliver integrated physical and behavioral care to the population with serious mental illness whose care is publicly funded?

At NHS Human Services in Pennsylvania we say YES! Let's do what's possible now because the need is great.

NHS is one of the largest private non-profit behavioral health and intellectual/developmental disabilities providers in the country operating in seven states. We've implemented a variety of integrated care models in diverse settings with unique needs. Here, we describe

our initiative to embed primary care within NHS behavioral health programs in southeastern Pennsylvania. The initiative is based on collocation of services and an integrated care approach.

In Pennsylvania, funding for behavioral healthcare has historically been carved out of general healthcare, giving rise to all the challenges that come with having two separate healthcare systems and two sets of regulations. Turf guarding has been a barrier to integrated care proposals in the past.

Pennsylvania has not pursued Medicaid expansion under the Affordable Care Act, though it has recently submitted a proposal to the Center

for Medicaid and Medicare Services to use federal dollars to expand coverage for low income individuals and families through private insurers.

Despite funding constraints and environmental challenges, NHS decided to do what's possible now and pursue healthcare integration for the populations we serve by:

1. Partnering with mission-driven primary care practices to embed services onsite.
2. Using current staff — a limited number of nurse navigators, adult mental health blended case management teams, and certified peer specialists.
3. Blending and refashioning current resources into a multidisciplinary health home team.

A nurse navigator is attached to each of the adult mental health community-based case management teams; mental health case managers are trained as whole health care managers; and peers in recovery are trained as wellness coaches. Nurse navigators are the bridge between the primary care practice and the outreach capability of the health home.

Primary Care with Advantages

In pursuing a primary care partner, Federally Qualified Health Centers (FQHCs) seemed like the first choice, in light of their complementary mission and the fact that they serve many of the same individuals as those served by a community mental health centers. However, while FQHCs have been interested in partnering with behavioral health for many years, many are now preoccupied with growing infrastructure concerns and managing operational change and are not as focused on collaborative efforts. Therefore, NHS is pursuing relationships with smaller community-based primary care practices. We've identified primary care practices with a mission to serve underserved populations with chronic illnesses.

“Despite funding constraints and environmental challenges, NHS decided to do what's possible now and pursue healthcare integration for the populations we serve.”

One example is NHS' partnership with a primary care practice that was formerly focused solely on providing services to individuals with HIV/AIDS. The practice receives funding to do outreach and HIV testing and is now poised to begin treatment for hepatitis C. It has recently broadened its mission to include individuals with other chronic conditions. The practice sees the partnership with NHS as a natural extension of its services. This primary care practice has some advantages in extending services to persons with serious mental illness — it already provided longer office visit times given the complexities it dealt with and practitioners were already trained in motivational interviewing, a skill they use to help individuals with serious mental illnesses sort through decisions around their diabetes, COPD, cardiovascular conditions, and other illnesses.

This primary care practice has been providing services at NHS community mental health center offices with medical staff available three partial days a week. After eight months onsite, about 300 community mental health center patients are receiving primary care services and the number is growing weekly.

Strength in Numbers

NHS initiated a learning collaborative with other local behavioral health providers seeking to provide integrated primary and behavioral healthcare. We share information, strategies, and operational procedures in relation to developing behavioral health homes. And we've reached out to Medicaid behavioral health managed care organizations and physical health management organizations to establish shared savings agreements and/or specific support for currently unreimbursed aspects of health homes. We know we have a stronger voice if we advocate together on behalf of a larger pool of insured individuals.

We meet with insurers along with our primary care partners to underscore joint commitment to delivering integrated care. Through previous data analysis work with one of the large behavioral health managed care organizations, NHS data has been presented showing the risk stratification of the population with serious mental illness that NHS serves. In light of the fact that total physical healthcare costs for high utilizers typically exceed the behavioral health costs, this data underscores the potential for significant savings through integrated healthcare.

While the discussions with payers are under way, NHS and our primary care partners are continue to do what's possible each day in each of our health homes to expand integrated care.

DONALD L. THOMPSON

Executive Director of Operations, NHS Human Services Eastern Region



What Primary Care Needs from Behavioral Health

INTERVIEW WITH

KEVIN MCCABE, **Lead Physician, ChesPenn Health Service's Center for Family Health**

ANDREW KIND-RUBIN, **Vice President of Clinical Services and Chief Clinical Officer, Child Guidance Resource Center**

JOE SCHATZ, **ChesPenn Behavioral Health Consultant, Child Guidance Resource Center**

As integrated healthcare delivery becomes the norm, more FQHCs and health centers are contracting to get specialty behavioral health staff onsite. What opportunities do community behavioral health organizations have to "loan" staff to their healthcare partners? What does primary care expect and how is the culture different? Whose electronic health records are the services recorded in? How are they billed? Professionals from an FQHC and community behavioral health organization in Pennsylvania that partner to deliver quality care and achieve better outcomes share their experience with National Council Magazine.

NATIONAL COUNCIL: What's the model of collaboration between ChesPenn and Child Guidance Resource Center?

ChesPenn, a federally qualified health center (FHQC), contracts with Child Guidance Resource Center (CGRC) to offer onsite behavioral health services for its primary care patients. Joe Schatz, a CGRC employee, works full clinic hours at ChesPenn three days a week and reports to Andrew Kind-Rubin at CGRC.

For ChesPenn patients, the experience is seamless. They see Schatz as well as another staff member at their health center. Schatz documents patient encounters in ChesPenn's electronic medical records.

The full time primary care physician, Dr. Kevin McCabe, along with a full-time physician assistant, two part-time pediatricians, and a part-time OB/GYN, handles ChesPenn's primary care services.



NATIONAL COUNCIL: How did the collaboration come about?

CGRC started a dialogue with ChesPenn about colocated services 10-12 years ago — way before integrated care was defined. While this did not work out right away, over time Kind-Rubin became more aware of the nuances of integrated care by talking with leaders at the National Council for Behavioral Health, reading their literature, and attending their conferences.

In 2003, CGRC opened an office in Coatesville, PA and also entered into a relationship with the Brandywine Health Foundation that funded the construction of a building to house both ChesPenn and CGRC on different floors. CGRC then resumed the dialogue to integrate services at that location.

Billing codes were added to the fee schedule of the county managed care organization that CGRC contracted with to allow the FQHC to bill for Schatz's services. However, this did not come about easily. When CGRC started discussions with ChesPenn, the managed care organization in Chester County told them that they could not bill for behavioral health services within the FQHC. This could have stopped the collaboration. But persistence paid off. Philadelphia had implemented a model of billing for behavioral health delivered in primary care and CGRC used this as a model to get their managed care organization to add the required codes to their billing sheets.

NATIONAL COUNCIL: What behavioral health needs did ChesPenn see in its primary care patients?

Patients come to ChesPenn primarily with physical health needs. The organization serves 3,000 patients a year. Up to five percent of these patients may request a referral to specialty mental healthcare, but Dr. McCabe says 75 – 80 percent of patients have co-occurring behavioral health needs they may not even express. Joe Schatz — a nurse practitioner with a background in psychiatry — helps people with issues like depression, anxiety, and bipolar disorder. In addition, Dr. McCabe calls on Schatz to help when patients have issues with compliance or other barriers in reaching their goals. Schatz is able to spend more time with patients and figure out what their issues really are and how to help.

On Schatz's days at ChesPenn, his time is divided equally between scheduled appointments and walk-ins. Often, it's possible to walk patients in need over from their primary care visits to meet with Schatz and get them immediate help for behavioral health issues.

Before the collaboration, ChesPenn did refer patients to outside mental health services. But patients without insurance didn't really have any other place to go to. And others did not always follow through. Besides, while Dr. McCabe can treat for depression, he can't provide the care that is required in the 15-minute appointments that he is allowed with patients.



NATIONAL COUNCIL: Is three days a week with one behavioral health specialist onsite adequate to meet the needs of 3,000 patients?

Dr. McCabe says ChesPenn is not inundated with mental health needs. However, with more of Schatz, they could better address the health behaviors of the population they serve that have some common barriers such as poverty, lack of insurance, or lack of access to any form of specialty care. Schatz works with a ChesPenn health educator on smoking cessation and conducts groups to educate people with diabetes on self-management. Schatz's work is invaluable in helping people understand their illnesses and medications and indicates effective interventions for population health management.

Dr. McCabe offers an example — he might talk to a patient with diabetes and find that they are taking all their medicines. However, in a follow up conversation, Schatz might find that instead of taking blood pressure medications twice a day, someone is just taking it once a day. Or he might find out that a patient who is consuming excess alcohol does not like to take his blood pressure medications when he's drinking for fear of side effects. Another patient might present with anxiety because he is trying to stop alcohol and is suffering from withdrawal.

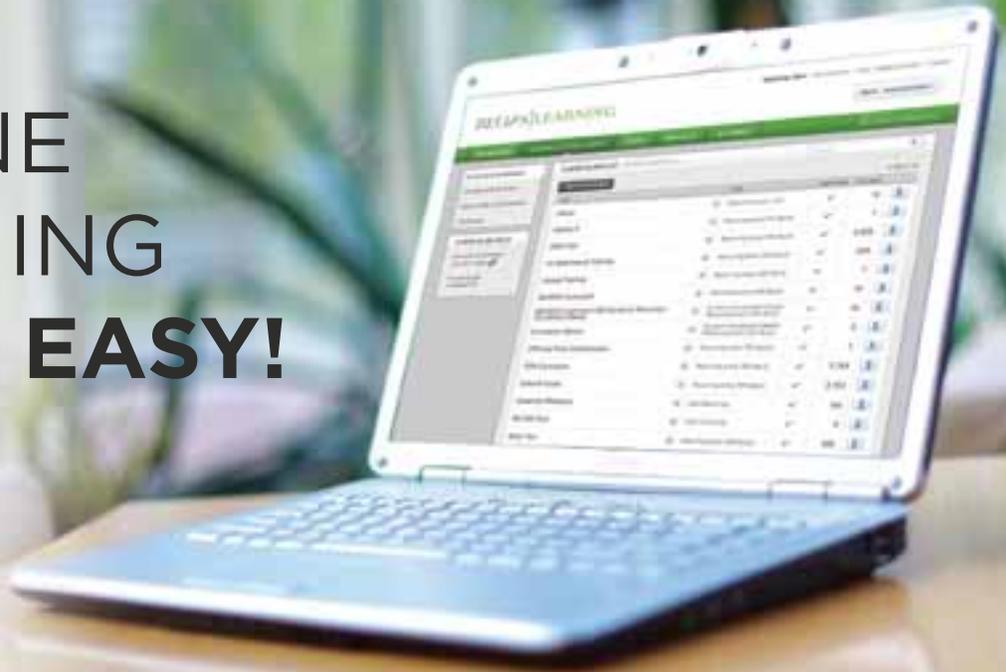
When Dr. McCabe feels patients are not reaching their goals and is not sure what the barriers are, someone like Schatz who is able to work with his patients can make a significant difference.

NATIONAL COUNCIL: What type of clinical outcomes data is collected? How has this been impacted by integrated care?

It's like speaking two different languages. While physical health tends to focus more on population-based or diagnostic-based outcomes, behavioral health tends to focus on individual or program outcomes.

CGRC has used different outcome measures with various programs and evidence-based practices. CGRC's largest outpatient clinic uses Ohio Scales for Youth — brief measures used to assess the outcome of mental health services for youth who are 5 to 18 years of age. The organization also provides multisystemic therapy services in several counties and uses their prescribed outcome tools. However, the partnership with ChesPenn has forced CGRC to re-evaluate, and Kind-Rubin is now looking for a screening/outcome measure that can be used to screen all patients and follow their progress as they're transferred to different programs or services within the agency. ChesPenn would also like to offer a screening tool the FQHC staff can use to formulate questions and make care-related decisions.

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“Schatz is able to spend more time with patients and figure out what their issues really are and how to help.”



NATIONAL COUNCIL: What type of barriers — cultural, financial, structural — were encountered in the collaboration?

Again, it was two separate worlds that had not intersected. FQHCs deal with the federal government while behavioral health organizations interact with the state and county as well as managed care organizations. Documentation and regulatory requirements are also very different, with enormous potential for rift and misunderstanding. It took help from expert outside consultants to work through it all and smooth the way.

Schatz explains that because he was a registered nurse before he became a psychiatric nurse practitioner, he was familiar and comfortable with the medical culture and did not have much difficulty acclimating to the FQHC climate. Licensed clinical social workers or clinical psychologists who may not have worked in a medical setting need a strong support network to cross the cultural bridge from behavioral health to primary care.

Kind-Rubin says, “If you’re going to do this as a behavioral health center, you have to step away to some extent.” Support must be offered to the team member at the primary care site but the behavioral health team must recognize that the team member is operating in a different culture and not insist on having things their way. ChesPenn sees Schatz as an integral part of their team partly because CGRC has gotten out of the way when needed.

Today, as CGRC works on its strategic plan for the next 4 years and considers how the organization will fit into new care models like ACOs, health homes, and certified behavioral health centers, the collaborative experience with ChesPenn is definitely an important advantage.

NATIONAL COUNCIL: What are the top takeaways for other FQHCs and behavioral health centers looking to collaborate?

Co-location, while it may seem more financially viable and lucrative, does not always work. Patients generally don’t pursue separate

appointments for behavioral health services. They’re more likely to bring up behavioral health concerns with their primary care practitioners than to walk into a mental health center. To meet patients where they are, behavioral health must integrate services into the primary care model through consultation, education, and short-term intervention. Longer-term intervention can be offered only when needed.

Kind-Rubin also says networking and learning from others is the key to success. He was a member of the National Council for Behavioral Health’s Executive Leadership Program. “Participating in this program provided so much information and connected me to so many people I could talk with. It opened my mind to other things that were going on nationally. Now I’m thinking about integration more nationally and globally than I was in just my little part of the world.”

NATIONAL COUNCIL: Why did ChesPenn collaborate with CGRC? Couldn’t they simply hire their own behavioral health specialist?

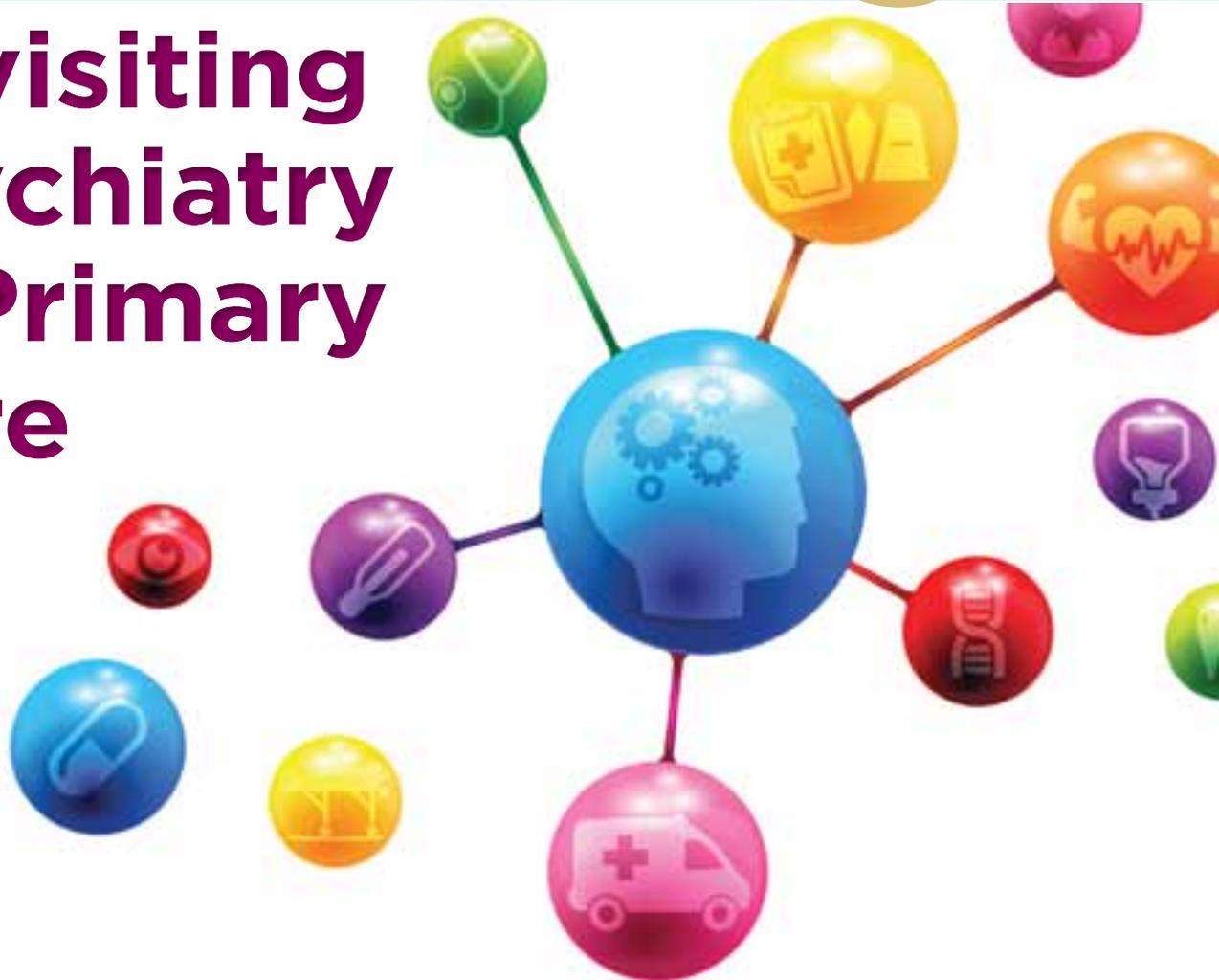
Schatz has the benefit of guidance and support from CGRC that strengthens his contribution at ChesPenn. Eventually, ChesPenn wants to have professionals like Schatz at multiple sites and would like to leverage the relationship with CGRC toward that end.

Kind-Rubin says the supervisory support that Schatz gets is critical. “At CGRC, this is what we do day in and day out, 365 days a year, and so we bring a breadth of knowledge and experience that hiring one person would not bring,” he explains.

Many people are not going to walk into a mental health center, may not need to, and their needs can best be met through an integrated care model within primary care. For those patients who would benefit from specialty mental healthcare but are not quite ready to go there, the relationship built by someone like Schatz in primary care, combined with interventions such as motivational interviewing, can move them in the direction of seeking the specialty care they would benefit from.

All in a Single

Revisiting Psychiatry in Primary Care



While it serves as the principal point of access to healthcare services, primary care is often ill equipped to manage the severity of mental, emotional, and behavioral problems that it encounters. Behavioral health is increasingly being embedded in the primary care delivery system and this has helped to improve access and quality. However, access to specialty psychiatry expertise remains a challenge. Referrals to psychiatry are frequently plagued by significant delays, lack of follow up, limited options, and poor communication and coordination. Many people find themselves in the “middle zone” of needing more than what primary care can provide, yet not requiring long-term psychiatric management by a specialist.

These realities led Cherokee Health Systems to develop an enhanced model of integrated psychiatry in primary care to complement our blended primary and behavioral healthcare services. This model allows us, without substantially increasing our psychiatric workforce, to:

- ① Increase access to psychiatric expertise at the point of primary care.
- ① Improve the quality of psychiatric care to the primary care population.
- ① Enhance the psychiatric knowledge and skills of primary care providers.
- ① Improve coordination and collaboration between primary care and psychiatric providers.
- ① More appropriately manage the primary care population’s psychiatric needs by preserving specialty psychiatric services only for those who need them most.

Visit

Our integrated care team includes primary care physicians, behavioral health consultants (psychologists and clinical social workers), psychiatrists, case managers, and support staff. Within our primary care setting, behavioral health consultants work alongside primary care providers to provide behavioral health services including assessments and brief interventions. The behavioral health consultant and/or primary care provider can consult with the integrated psychiatrist once a clinical assessment is completed and it is determined by the primary care team that psychiatric consultation is warranted. The consultant and/or primary care provider can present the relevant aspects of the case and target questions to the psychiatrist in person, over the phone, or via video conferencing.

Thanks to integrated electronic health records, the consulting psychiatrist can review the patient's chart for health conditions, medications, lab results, and other information and then develop an informed impression of the clinical issue at hand. At this point, the psychiatrist can prescribe medication; recommend further assessment or intervention; arrange to see the patient face-to-face; or refer the patient to specialty care. Patients get both medical and behavioral health services during a single visit, rather than receiving referrals for additional appointments and services.

"Katherine" is a 52-year-old who set up an appointment with her primary care provider because she didn't know where else to go. A year ago, her 19-year-old son died in an accident. She had no medical complaints other than feeling completely exhausted and generally "achy" from not sleeping. Almost immediately the physician engaged the behavioral health consultant, Jena.

Jena provided psychoeducation on grief and coping, as well as support and comfort while assessing Katherine's emotional stability and ruling out any suicidal ideation. Jena talked with Katherine about her support systems, and asked if she had checked out any groups for grieving parents. Katherine said she had, but didn't feel ready to engage. Jena encouraged her to continue to think about it. Katherine had a history of addiction to pain medicine and refused any type of sleep agent. Jena and the physician talked about the introduction of an SSRI to help Katherine through this turbulent time. They agreed that it would be best to consult with the psychiatrist. While Jena stayed with Katherine, the physician called the psychiatrist who agreed that a SSRI might benefit Katherine. Katherine returned in 7–10 days to check in with Jena, and reported that she had found a Compassionate Friends support group that she would check out before her next appointment. Clearly, collaboration and consultation at the point of care is of highest benefit to all.



Patients get both medical and behavioral health services during a single visit.

Our integrated psychiatry care model supports transfer of knowledge between team members. Psychiatrists participate in regular dialogue with primary care providers through weekly treatment team meetings, electronic 'tasking' of clinical communication, and Psychiatry Q & A sessions. Our behavioral health consultants receive comprehensive training on common medical conditions, psychopharmacology, and other skills and interventions. Teams share knowledge about patient care and best practices. This cross-fertilization of knowledge increases the comfort level in assessing and managing psychiatric issues in primary care and supports the eventual reabsorption of stabilized patients into primary care.

The bidirectional flow of patients allows for a dynamic continuum of care in which psychiatric providers can offer immediate access for urgent issues because they are simultaneously transitioning stabilized patients back to the primary care providers and behavioral health consultants.

EBONI WINFORD
Behavioral Health Consultant

PARINDA KHATRI
Director of Integrated Care

GREGG PERRY
Director of Psychiatry
Cherokee Health Systems

Walk-in Clinic Averts Behavioral Health Crises

RICHARD CRAVER IN THE
WINSTON-SALEM JOURNAL,
NOVEMBER 29, 2013



“ 40 percent of people having a behavioral health crisis don't need acute medical treatment.”

Novant Health Forsyth Medical Center provides emergency services, medical services, surgical services, rehabilitation and behavioral health services to the residents of Winston Salem North Carolina.

The center [Novant Health Forsyth Medical Center] saw the need to provide intervention care to local residents experiencing a behavioral health episode, but not needing hospitalization. The system's behavioral walk-in clinic at 175 Kimmel Park Drive, Suite 100, has had an assessment average of 115 people a month since opening in June 2012. It offers services around the clock.

As a result, those individuals are not showing up untreated and in full-blown crisis — whether mental health or substance abuse — in the emergency rooms of Forsyth and Wake Forest Baptist medical centers.

Todd Clark, director of behavioral health services at Forsyth, said the clinic was developed primarily after an internal study showed that 40 percent of people having a behavioral health crisis don't need acute medical treatment. About two-thirds of the clinic's patients have had a mental health issue, while one-third were treated for substance abuse.

The clinic is regulated as an ambulatory surgical center, but up-fitted to provide behavioral health care with 10 dedicated beds and a staff of a care coordinator, nurse and social worker/therapist. It offers treatment at lower cost than in an emergency department.

Clark said officials wanted to create a place where people can get away from their stress or bad situation as their circumstances begin to go out of control. “The goal is taking care of them for one to a few days as they go through their crisis. If they are experiencing, or begin to experience, a full-blown crisis, we will transport them to the hospital.”

“Many people having behavioral health episodes also wind up in emergency departments because they either lack health insurance or can’t afford primary physician care.”

Clark cited a recent example of a woman who had been fighting with her husband to the point of requiring intervention. He said during the assessment period, it was determined the woman had an undiagnosed case of schizophrenia that is now being treated.

Advocates, local and statewide, have complained for years about the increasing number of individuals having a behavioral health crisis ending up in emergency departments, often as involuntary commitments accompanied by law enforcement officers, or in jail. Officers are required to stay with the person, who often is handcuffed to a bed for safety reasons, until the individual has been stabilized.

Many people having behavioral health episodes also wind up in emergency departments because they either lack health insurance or can’t afford primary physician care.

Clark said the clinic has proven successful with treating people who are homeless and having a behavioral health issue. Because of security reasons, most homeless shelters don’t accept people who show up drunk or high. By treating the immediate substance abuse issues, the homeless have a better chance of being admitted to the shelters.

“We believe we are helping to reduce the patient volume in the emergency departments, freeing up beds for those with acute medical needs,” Clark said. “It’s also a place where people can go where they don’t feel like they are a criminal while they await assessment.”

More walk-in and short-term treatment options

Advocates have complained about local managed care organizations (MCO) doing a poor job of letting the public and first responders know how to access the behavioral-health system. Clark said the clinic is working with CenterPoint Human Services on raising awareness of the clinic as a primary intervention option.

Dr. Chad Stephens, CenterPoint’s chief medical officer, said the Novant clinic “is a wonderful alternative for those individuals who don’t have high medical acuity.”

After years of indifference and limited funding dedicated to intervention initiatives, the state Department of Health and Human Services is emphasizing such care. It’s become such a priority that DHHS officials have asked to be judged quarterly for how well it is reducing emergency department admissions, wait times, and readmissions related to behavioral health crises.

DHHS said that during fiscal 2012-13, there were about 150,000 ED visits statewide attributed to a behavioral-health crisis. Individuals experiencing a behavioral-health crisis spent on average 3½ days waiting in an emergency department to be admitted to a state hospital.

DHHS Secretary Dr. Aldona Vos unveiled Nov. 7 a statewide “crisis solutions” initiative that she said will encourage proven first-touch programs. A key piece of the strategy is creating more walk-in crisis centers and short-term residential treatment options, such as the Novant clinic. Vos toured the Novant clinic earlier this year and has cited it as an example of a successful intervention model, DHHS spokesman Ricky Diaz said.

Other programs include: developing mental health first-aid training aimed at troubled youths; individualized treatment and post-recovery programs for individuals treated in emergency departments; a statewide telepsychiatry program involving at least 60 hospitals; and advanced training for emergency medical services personnel to treat someone having a behavioral-health crisis.

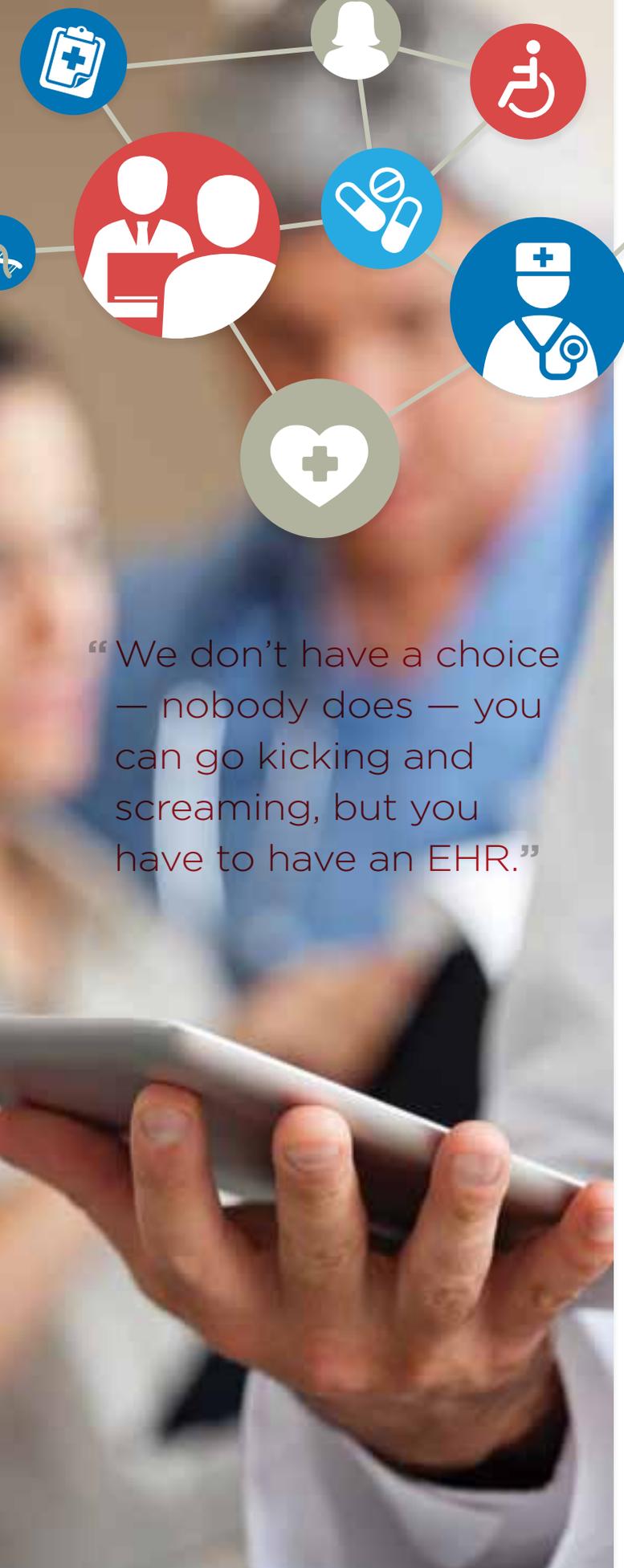
As has been the pattern with other DHHS initiatives announced this year, Vos provided few details in her prepared remarks on how and when these programs would be rolled out and customized in local communities, and how they would be financed.

Laurie Coker, a local advocate, is serving on the Crisis Solutions coalition. She is the director of the N.C. Consumer Advocacy, Networking and Support Organization. “I applaud Novant’s innovation and focus on solutions to a grave community problem,” Coker said.

“This sure beats citizens being forced onto a small unit where no individualized support is offered, and then possibly discharged seven days later if they have not either already been admitted or are no longer acting unstable, with no treatment having been begun before that discharge.”

“Even a wait in a supportive and safe environment can be a door to healing, which is what we should be striving for in the first place.”

Clark said it would hard for most local communities to provide a freestanding behavioral health intervention clinic. “It takes the financial commitment of a large health care system to make this work,” he said.



“We don’t have a choice — nobody does — you can go kicking and screaming, but you have to have an EHR.”

Connecting Healthcare Data Dots through EHRs

Integrating medical and behavioral healthcare requires interchange of patient information between providers, a process that can be laborious and impede timely access to quality care. Patients, especially those in crisis, can’t always be relied upon to give providers their accurate or complete medical or behavioral health history. Enter the modern world of technology, in which all patient data can be put in digital form and shared through the now ubiquitous computer. In addition, there are now incentives for practices to purchase software that makes joining the modern age easier. The following case studies show different ways very different agencies are using — and paying for — this technology.

Henderson’s “Direct Connect” with a Hospital

Henderson Behavioral Health, a multi-site community behavioral health system based in Lauderdale Lakes, Florida, partners with Memorial Healthcare System, to coordinate electronic health records (EHRs). The “direct connect” with the hospital means communication between Henderson’s EHR and Memorial’s.

While the most popular way to coordinate EHRs is through health information exchanges, there are complicating issues because there are multiple organizations, anytime there is a change, the patient would have to sign a revised release — and this is especially true for people with addictions because of the confidentiality regulation, 42 CFR Part 2.

In Henderson's pilot with Memorial, data will move back and forth between the hospital emergency room and the behavioral health facility. Key to the Henderson's interests is the bidirectionality of this data, which will facilitate referrals, explains Steven Ronik, Henderson's CEO. "We're testing it now," he said. Privacy is always an essential part of electronic medical recordkeeping, and is even more sensitive for mental health and, especially for substance use issues. The linchpin is the release, said Ronik — if a Henderson patient gets any services from any part of the Memorial system, Henderson only has to do one release. Currently the initiative hasn't been paid for, but under meaningful use incentives, it will be, said Ronik.

Coordinating care without the EHR, using paper, is inefficient, said Ronik. "It's labor intensive and very time-consuming, with phone calls and faxes back and forth," he said. "With the EHR, we're going to be able to get a referral instantly from Memorial, right into our crisis receiving area."

One of the reasons this data sharing is going to work is that Henderson and Memorial share a lot of patients. Another is that the software companies and the healthcare providers were all willing to take the risk to step into this new territory. "There are four stakeholders here — Henderson, Memorial and the EHR providers, Netsmart and Epic," said Ronik. "You had to have the leadership of all four on board, and that's what made this happen."

Here's how a case could work: A patient shows up at 3 am in the emergency room — when everything else is closed — in crisis. The staff at Memorial then sends an electronic referral which Henderson receives immediately. If they are a current Henderson patient, that would show up in the medical record. In any event, someone from the Henderson crisis center can go to the emergency room and pick up the patient immediately.

The module also will allow Henderson to connect to a HIE, and to make referrals to other organizations.

Henderson purchased its EHR with meaningful use dollars it had drawn down. "We don't have a choice — nobody does — you can go kicking and screaming, but you have to have an EHR," said Ronik.

Red Rock Makes the HIE Connection

Red Rock Behavioral Health Services was the first community mental health center in Oklahoma to connect with an HIE. The process that allows the transmission of Red Rock's medical records is called the Continuity of Care Document (CCD). Initially, Red Rock embarked on the project due to meaningful use incentives, and the first-year incentive payments came through on five of Red Rock's physicians, who participate in Medicaid. Red Rock also has seven full-time psychiatrists.

For the HIE, Red Rock first contracted with the Secure Medical Records Transfer Network (SMRTNET, Oklahoma's HIE), and then had weekly meetings with the HIE and Netsmart, whose EHR they use. "All three of us had to make changes," said Robert Lacy, MIS director of Red Rock, based in Oklahoma City. "It was only through the combined effort of all of us working together that we finally had it."

On August 1, 2013, the system connection was up and running, and since then Red Rock has exchanged 5,000 CCDs in the HIE. That means that 5,000 Red Rock patient records are now accessible to other entities, including hospitals and physicians who participate in the HIE. Currently, most data is accessed by acute care participating — hospitals

and emergency rooms. "We need to have a lot more private physicians using the HIE," he said. But even so, it's still valuable. "For the first time, a mental health agency is able to contribute these records to the physical health community, filling a gap."

Having patients' substance use and mental health data going to physical care entities is a benefit that's often unrecognized by behavioral health providers, said Lacy. "When clients come in to an ER, especially in a crisis or emergency, they may not give the information," Lacy explained.

“
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And the information exchange clearly benefits Red Rock's patients. At Red Rock's crisis stabilization centers, it may be days before a patient can give any medical history. "In some cases this medical information has been life-altering," he said. "They may be brought in because a judge has ordered them here, and they are unwilling or can't give information about medications they may be allergic to," he said. "We pull the HIE and find that information."

Red Rock is an opted-in agency, which means that every patient there is automatically opted in to the HIE. However, because of 42 CFR Part 2, which doesn't allow the transfer of patient identifying information about drug or alcohol treatment, "the second you have a substance use disorder diagnosis, you're opted out," he said. "And if there are



“The challenge is to break the process of kids riding the ambulance to the ER when all they need to do is go to urgent care or their primary care provider.”

any medications or diagnoses that might accidentally upload that information, such as a medication for smoking cessation, you're opted out,” he said.

The meaningful use incentive allowed Red Rock to purchase the software, which allowed one free HIE connection. Other connection costs were recouped through the first year. Oklahoma applied for federal dollars to help community mental health centers connect. “The HIE wants monthly dues for that service, and wants to charge you to make the connection to your software vendor, but that was all covered under the grant our state applied for and received,” said Lacy. There were no additional costs to Red Rock, and there was enough money left over to pay for a year of the monthly fees to the HIE.

YESS Tracks ‘The Toughest Kids’ with EHRs

Youth Emergency Services & Shelter, the largest emergency shelter in Iowa, has patients as young as a few days to age 17, with 60 beds and 32 more beds planned for the near future. The growth is largely on account of EHRs, an essential part of the agency's expansion to an integrated health home for 1,000 youths, mostly ambulatory patients, with severely troubled histories. YESS partnered with Magellan Behavioral Care of Iowa on this health home initiative.

The patients come from disparate backgrounds: runaways, adjudicated youth, children in need of assistance, children who need long-term treatment and are in and out of acute care, and youth who require restrictive detention. “It just so happens we're called an emergency shelter, but there's a blurred line between psychiatric care and shelter,” said CEO Stephen B. Quirk. A care manager at YESS coordinates

the primary care and behavioral health for these children and youth to ensure that all needed treatments are received and outcomes improve.

YESS got involved with EHR in an unlikely way — the agency's IT person passed away, and YESS “lost all the institutional knowledge,” said Quirk. “So we brought in a new EHR provider and at the same time became an integrated health home.”

YESS was able to take advantage of the part of the Affordable Care Act that supports Medicaid cost containment for pediatric care. “We told Magellan, you give us the toughest kids, and we will be an integrated health home. These kids would be Medicaid-eligible, they would have a serious emotional disorder and that would make them qualified to be assigned to an integrated health home,” explained Quirk.

After finding the youth and getting consent from the parents, YESS started getting baseline medical information (vitals), finding the primary care provider and the behavioral care provider, and then being the integrated health home to these 1,000 youths, making sure they got all the treatment they need, although not necessarily providing it themselves. “The challenge is to break the process of kids riding the ambulance to the ER when all they need to do is go to urgent care or their primary care provider,” said Quirk.

And Quirk wanted more than medical information from the EHR. He wanted to prevent these youth, especially the ones who had been adjudicated, from going to jail. “It's easy to track diabetes meds,” he said. “I want to track behaviors, I want to see what's happening with court records.”

Des Moines, a city of 500,000 people, has seven hospitals. According to Quirk, it only needs two. Three of the hospitals are brand new. But it doesn't have adequate behavioral care, which is one reason his agency is expanding. “We are oversaturated by acute care but completely underserved on psychiatric and behavioral care,” he said. “There's only so much the lone social worker in the hospital ER can do.”

The work is still in development. “We're mobile, we have staff with laptops, and the ability to connect that way,” said Quirk. YESS is using its vendor's server to store the records, although with adjudication there have to be paper records in addition.

Acute care costs \$1,000 a night, compared to the YESS per-day rate of \$157. That's success according to Quirk. And what really moved the project forward is Quirk's commitment to helping youth — doing better than incarcerating them when they really needed treatment.

“It's going to take a lot of us to be really smart to make this work,” said Quirk. “I'm laser-focused on kids. The stakes are very high.”

DAISY WHEELER
Consulting Manager, National Council for
Behavioral Health

IMPROVED CARE COORDINATION



Reprinted from www.healthit.gov

As medical practices and technologies have advanced, the delivery of sophisticated, high-quality medical care has come to require teams of healthcare providers — primary care physicians, specialists, nurses, technicians, and other clinicians. Each member of the team tends to have specific, limited interactions with the patient and, depending on the team member's area of expertise, a somewhat different view of the patient. In effect, the healthcare team's view of the patient can become fragmented into disconnected facts and clusters of symptoms. Health care providers need less fragmented views of patients.

Leveraging an EHR across the continuum of care allows for:

- Better integration among providers by improved information sharing.
- Viewable and up-to-date medication and allergy lists.
- Order entry at point of care or off-site.
- Standardization of data, order sets, and care plans helping to implement common treatment of patients using evidence-based medicine.
- Access to experts for rural health care providers by sharing best practices and allowing for specialized care through telemedicine.
- Population management trended data and treatment and outcome studies.
- More convenient, faster, and simpler disease management.

Electronic health record (EHR) systems can decrease the fragmentation of care by improving care coordination. EHRs have the potential to integrate and organize patient health information and facilitate its instant distribution among all authorized providers involved in a patient's care. For example, EHR alerts can be used to notify providers when a patient has been in the hospital, allowing them to proactively follow up with the patient.

With EHRs, every provider can have the same accurate and up-to-date information about a patient. This is especially important with patients who are:

- Seeing multiple specialists
- Making transitions between care settings
- Receiving treatment in emergency settings

Better availability of patient information can reduce medical errors and unnecessary tests. It can also reduce the chance that one specialist will not know about an unrelated (but relevant) condition being managed by another specialist. Better care coordination can lead to better quality of care and improved patient outcomes.

What's App

House Calls for Better Health

A close-up photograph of an elderly woman with short, reddish-brown hair, wearing glasses and a floral-patterned top. She is smiling broadly while holding a black mobile phone to her ear. The background is softly blurred, suggesting an indoor setting.

“The system enables individuals with chronic medical and psychiatric conditions to answer simple questions and connect with their healthcare teams daily.”

Buddy?

Despite the explosion of internet and mobile technologies aimed at helping people monitor and manage their own health and wellness — there are over 90,000 self-management apps in the market today — we're not sure what can be most helpful to people with serious mental illnesses. Although we're aware of the problems of chronic diseases and early mortality in the population with serious mental illness, there are only a few interventions proven to have impacts.

For the past year in Boston, Vinfen and several community partners have been evaluating the innovative "Health Buddy" telehealth technology. Support for the project has come from a Health Care Innovation Award grant from the Centers for Medicare and Medicaid Services, in preparation for the Massachusetts Demonstration to integrate care for individuals with dual Medicare and Medicaid eligibility. The project has established community-based behavioral health homes within existing outreach programs funded by the Massachusetts Department of Mental

Health, to improve coordination and delivery of efficient and effective healthcare and to

- ① Integrate primary care into behavioral health outreach teams.
- ① Improve participants' self efficacy and management of health.
- ① Reduce unnecessary utilization of acute care services.

One of the tools used in the project is Health Buddy. Health Buddy is a simple, convenient, clock radio-sized device designed to help individuals manage their physical and mental health needs on a daily basis in the comfort of their homes. Designed by Bosch Healthcare and evaluated in chronic disease management for the general population, it was used by the research team headed by Dr. Steve Bartels at Dartmouth, and successfully piloted with groups in New Hampshire. The system enables individuals with chronic medical and psychiatric conditions to answer simple questions and connect with their healthcare teams daily. It also prompts users to engage in actions to manage their conditions independently.

HOW HEALTH BUDDY WORKS: REAL STORIES

Diabetes: The care team monitored a series of Healthy Buddy yellow alerts indicating that a participant with diabetes was not monitoring her blood sugar levels daily. However, green alerts indicated that she did remember to take her medications daily. As a result, the outreach worker visited the person at home and helped to set up a system in her kitchen to take her morning medications and blood sugars at the same time, and record that she had done so on her calendar and in the Health Buddy. Her adherence to monitoring her blood sugar rose significantly.

Depression and Stress: A red alert indicated that a client with a newly chaotic home environment was experiencing a significant increase in depression and stress. The outreach worker met with the participant to coach her on options to decrease her anxiety. They formulated a plan on the spot to address and closely monitor her symptoms and to address the most negative home stressors. The reassurance of the daily support of the team through the Health Buddy system was a significant factor in supporting this individual.

COPD and Depression. An elderly participant typically visited her local hospital emergency room at least twice monthly during winter months to address exacerbated respiratory symptoms. Using her Health Buddy, yellow alerts indicated a pattern of increased respiratory symptoms which prompted a site visit and intervention by the nurse practitioner, leading to a diagnosis of pneumonia and treatment at home, and averting an emergency room visit.



“ We’ve averted 71 emergency room visits for a population that must often rely on emergency care in the absence of longer-term health management.”



Each day a new session is available for completion based upon an individual's unique conditions and parameters. During the session, an individual reports health status information and receives new information about causes, symptoms, and recommended actions. The data from each session is coded by algorithms based on level of urgency and sent to an internet site for review by the nurse practitioner and action to ensure proper disease management and overall improved health for the participants.

To date, 34 participants have used Health Buddy. Preliminary findings suggest that adherence is good. Roughly one-third of the project's participants use the Health Buddy 85 percent of the time and 15 percent of participants use the system 90 percent or more of the time. Project Director Elizabeth Cella notes, “Through December we have provided 183 interventions as a result of Health Buddy monitoring alerts, and estimate that we’ve averted 71 emergency room visits for a population that must often rely on emergency care in the absence of longer-term health management.”

Vinfen and its community partners are in discussions about sustainability with One Care Plans, which are insurers in the new Massachusetts Initiative for Dual Medicare Medicaid Eligible Individuals, and especially with Commonwealth Care Alliance, a non-profit managed care and disability health service provider and grant partner. The goal is to provide sufficient evidence to demonstrate the value of the Community Behavioral Health Home model to insurers and managed care organizations. With proven cost effectiveness, sustaining funds will become available through One Care Plans and the planned Massachusetts Medicaid Behavioral Health Home program scheduled to begin later this year.

BRUCE L. BIRD
President and CEO, Vinfen

INITIATIVES TO INTEGRATE SERVICES, IMPROVE CONTINUUM OF CARE

I couldn't agree more with Linda Rosenberg, National Council President and CEO, about the need for integration of behavioral health services with general healthcare.

Rosenberg recently wrote in her blog: "We're on a road we long dreamed about. Coverage expansion is happening, one way or another; the integration of specialty care and general healthcare is underway; and care coordination is the expected way to improve the health of high need/high cost patients. These trains have left the station. But what will the future look like?"

I'm happy to report that Rosecrance Health Network is on the train moving toward a future that looks ever more promising for clients. For too long, behavioral health services have been kept at arm's length from primary care. Think of how much better we can serve clients if we truly listen to them and assess their emotional needs alongside their physical health needs.

For more than two years, Rosecrance has had full-time clinicians "embedded" at the federally qualified health center serving this region. The goal is to offer behavioral health services to low-income individuals who turn to the clinic for primary care. The doctors have come to rely on Rosecrance as an immediate resource available to them when patients are in the office for primary care needs.

The clinic completed the loop about a year ago by embedding a physician assistant in our adult mental health center to offer primary healthcare to clients who exhibit a need. We were gratified when Blue Cross/Blue Shield of Illinois signaled its support of the partnership with a \$50,000 grant to Rosecrance. The grant was awarded specifically to serve clients with serious mental illness who also suffer from one of four chronic conditions: diabetes, hypertension, obesity and asthma.

Improving the continuum of care also has been the focus of other Rosecrance initiatives in recent years. We have worked closely with other regional providers of primary and behavioral healthcare to improve service delivery, regardless of the direction from which clients enter the healthcare system.

Last year, Rosecrance purchased a large outpatient counseling business from a local hospital and, at the same time, entered into a partnership to manage the hospital's psychiatric beds for adolescent and adult populations. We have close working relationships with emergency rooms in all three hospitals serving our community.

In addition, Rosecrance worked with providers in nine northern Illinois counties over the past year to establish a new Triage Center for clients in psychiatric crisis. Through the triage program, clients are quickly evaluated, stabilized and moved to the appropriate level of care. At the same time, Rosecrance received support from the state of Illinois to

serve more clients who need our short-term residential crisis stabilization services. The goal is to prevent unnecessary hospitalization and fill care gaps that previously existed in our region.

Now, Rosecrance is in the process of renovating a building in Rockford to house the Crisis Stabilization Center, which will be unique in Illinois. The purpose of the CSC is to improve the continuum of care by offering Triage services and the short-term residential program under one roof. The center also will offer detoxification services for clients with co-occurring disorders.

Our overall goal is to respond quickly, respectfully and professionally to our clients' varied needs and, to the best of our ability, remove any barriers between services that stand in the way of recovery for the whole person.

PHILIP W. EATON

President/CEO, Rosecrance Health Network



Rosecrance is a national leader in providing behavioral healthcare for children, teens, adults and families. Founded in 1916, Rosecrance is headquartered in Rockford, IL.

SYSTEMS OF CARE:

Wrapping Services Around Children

A holistic and integrated wraparound approach is critical to meeting the unique needs of each family.

We know that 7.4 million children and youth have a serious mental health disorder in the United States, which represents 10 percent of the birth — 18-year-old population. To organize services for these youth, the Systems of Care (SOC) framework was developed. First published in 1986, systems of care are coordinated networks of community services and supports that are created to meet the needs of children and youth with serious mental health challenges and their families. The concept emerged following Jane Knitzer's work, "Unclaimed Children," documenting the fragmentation of services showing that only a small portion of children who needed services actually received services. Historically, available services often only consisted of restrictive settings, with very few community-based treatment options. In addition, families were often blamed for their child's condition and no attention was given to cultural and linguistic competence in service delivery. The SOC concept was created with the goal of solving these systematic breakdowns, and has become a proven strategy to improve the lives of children and youth with serious mental health conditions and their families. In fact, the National Evaluation for the Systems of Care program has repeatedly found that involvement in SOC results in improvement in clinical and behavioral functioning, reduced law enforcement contacts, fewer days in inpatient settings, improvement in grades, and reductions in suicidal thoughts and actions.

The core values of SOC seek to ensure that service provision is family-driven, youth-guided, culturally and linguistically competent, individualized and community based, and that treatment is evidence-based with the goal of children, youth, and their families having the ability to thrive in the community. As an example, in one system of care community, parents were actively involved in all aspects of the service planning process for their child and family, including setting goals and objectives, identifying members of the child and family team, and selecting service options. Treatment team meetings did not take place if parents were not present. Making sure that parents and youth are part of service and system decisions is a core value of the system of care framework.

Children and youth with serious mental health conditions and their families are likely to need services from a wide variety of providers, including non-traditional natural supports in the community. A holistic and integrated wraparound approach is critical to meeting the

unique needs of each family. In a jointly issued Informational Bulletin by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare and Medicaid Services (CMS) in May 2013 (<http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf>), an endorsement was made of many of the services that comprise a system of care by stating “these services are not only clinically effective but cost effective as well.” Such services include intensive care coordination (“wraparound”), family and youth peer support services, intensive in-home services, respite care, mobile crisis response, and stabilization and flex funds. Services that comprise what systems of care are all about.

As an example, one system of care offered several service options to support youth transitioning to adulthood that included mentors, youth support groups, vocational training, and coordination with adult services. A designated transition coordinator worked with youth between the ages of 17–21 years old to identify resources for vocational training after high school. Similarly, schools have participated in systems of care. One program employed Positive Behavioral Interventions and Supports, an innovative multi-level evidence-based model. This program also offered nontraditional supports that maximized youth strengths, including sports and recreation, music and arts programs, mentoring programs, and specialized transportation services.

Between 1992 and 2010, 173 grants were awarded across America, including tribal nations, the territories of Puerto Rico and Guam, and the District of Columbia. In Fiscal Year 2010, consistent with SAMHSA’s Theory of Change, the program began to focus on strategies to expand and sustain the SOC framework, and to encourage more widescale

adoption of the approach in states, tribes and territories. As a result, SAMHSA issued System of Care Expansion Planning Grants and System of Care Expansion Implementation Grants. The intent of the one-year System of Care Expansion Planning Grants is to build upon the progress achieved in the Child Mental Health Initiative by focusing on strategies to expand the system of care framework to larger geographic areas to more broadly address the mental health needs of children, youth, and families/caregivers. The purpose is to provide the opportunity to develop a comprehensive strategic plan to expand and

sustain the SOC approach for children and youth with serious emotional disturbances and their families. The four-year SOC Expansion Implementation Grants support broad-scale operation, expansion, and integration of systems of care through the creation of sustainable infrastructure and services.

As part of the emphasis on system of care expansion and sustainability, SAMHSA focuses on a number of critical priorities

to address the needs of children and youth with serious mental health disorders, including workforce development, evidence-based practice, and trauma-informed care. SAMHSA also collaborates with other federal agencies on the mental health needs of youth in the child welfare and juvenile justice systems and to identify, engage, and address youth who have an early episode of a serious mental illness. Information about many of these issues and activities can be found at www.samhsa.gov/children. Information about available grant opportunities can be found at www.samhsa.gov/grants.

The system of care concept and philosophy has been a proven approach to improve outcomes for children and youth with serious mental health disorders. SAMHSA is now interested in ensuring that systems of care become widely incorporated into national, state, and local policy and across all child-serving systems. Child and youth mental health services work best when provided by using a strengths-based, individualized approach, that respects a person’s culture and language, and ensures that children, youth, and families have a voice and choice in their own plans. When this occurs, young people can demonstrate resilience, recover from disorders, and reach their full potential — that’s what systems of care do.

GARY M. BLAU
Chief

KRISTIN N. WILLIAMS-WASHINGTON
Government Project Officer

Child, Adolescent and Family Branch, Center for
Mental Health Services, Substance Abuse and
Mental Health Services Administration



Empire State Integrates To Face the

The proportion of people who are age 65 and older will double from 7 to 14 percent of the world's total population by 2040, according to a U.S. Census Bureau study. The over-65 population worldwide will grow to 1.3 billion. Global aging is changing the social and economic nature of the planet and presenting difficult challenges. The fact that, by 2020, for the first time in human history, there will be more people aged 65 and older than children under five in the world underlines the extent of this change.



Ten years ago, New York State realized that, like much of the country and the world, it had a geriatric problem. The number of older adults was expected to increase 50 percent by the year 2030, and, correspondingly, the number of older adults with mental illness was anticipated to grow from 480,000 to 740,000. Recognizing that the state was going to be hit with this elder boom — and that behavioral health and primary care providers would need to adjust their practices accordingly — in 2005 New York passed the Geriatric Mental Health Act, which established the authority and funding for demonstration programs that would integrate physical and behavioral health care for older adults.

Since that time, over three dozen programs have received seed funding to provide integrated health services for older adults. New York has not prescribed a single model for delivery of care. The state has supported bidirectional integration — both behavioral health clinicians in primary care offices and physical health-focused practitioners in behavioral health settings. Specifically, the demonstration programs are testing out varied implementation models, including:

- 🕒 Taking advantage of the full scope of practice of a psychiatric nurse practitioner in a mental health clinic to do an initial psychiatric and physical assessment at intake (as seen at Service Program for Older People).
- 🕒 Engaging an licensed clinical social worker to work with primary care providers to screen and assess for behavioral health disorders, and then provide onsite triage, comprehensive assessments, and

treatment as needed (as at Bassett Medical Center's Cobleskill Health Center).

- 🕒 Using peers as wellness coaches to work with clients on developing and carrying out personal wellness plans and to facilitate connections to different health services (as with Clubhouse of Suffolk).

The National Council for Behavioral Health has been front and center in working with the demonstration programs for the past two years. The New York State's Office of Mental Health engaged us to run the Geriatric Technical Assistance Center and help grantees develop an integration model for their organizations that works for their target population. Through individual and group coaching, in-person learning community meetings, monitoring of clinical and process measures, and resource development, our charge as the Geriatric Technical Assistance Center is to help organizations to create a program that is sustainable and will continue beyond their grant period.

LESSONS LEARNED

In many respects, the lessons learned while developing integrated care models for an older adult population are the same as with any integrated health practice:

- 🕒 It takes individual and collective leadership across the organization.



Elder Boom

Geriatric Mental Health Act integrated care demonstration program participants share success stories

Services Program for Older People (New York, New York)

“Ms. D., age 80, has been a clinic client for two years. She is overweight, depressed, and often complained to her therapist that she felt chronically tired and listless until mid-afternoon. When the Psychiatric Nurse Practitioner evaluated her, she learned that Ms. D. had not seen a medical doctor for six years – and that she had stopped taking the thyroid and blood pressure medications she had been prescribed. The nurse practitioner began to monitor her blood pressure on a weekly basis, and suspected that her fatigue was a symptom of hypothyroidism. She gently encouraged Ms. D to improve her diet, lose weight, and visit a doctor. Ms. D. is now back on her medications, has lost weight, and feels significantly better – so much so that she now feels she needs to see her therapist only twice a month, rather than every week.”

Report from Bassett Medical Center (Cobleskill, New York)

“We have been looking for an initiative which would allow us to bring mental health care to our primary care sites located throughout the region. This is a way of operationalizing our vision of psychiatry as primary patient care. The opportunity to integrate with medical primary care salutes this enterprise.”

Report from Clubhouse of Suffolk (Ronkonkoma, New York)

“This program gave us the opportunity to increase our use of peers. We have now elevated our use of peers and our expectations for peers and staff working in multidisciplinary teams. The program has also elevated awareness among both staff and members regarding physical health and the potential for change. Clinically we have seen improvements including lower rates of hospitalization (physical and psychiatric) for members participating in the program.”

- ① The most successful initiatives have been those where groups took on the mantra, “Integration everywhere!” and did not consider their integration initiative to be a discrete project, segregated from the rest of their services.
- ① True integration is about more than clinical services alone; it requires health behavior change, and both clinicians and clients alike struggle to embrace that.
- ① Like politics, all healthcare is local; what service array you develop depends on your client mix, what other healthcare providers serve your community, and state and insurer regulations.
- ① Sustainability — fiscal and organizational — requires “not giving up.”

What stands apart when developing programs that serve predominantly older adults, however, is the need for organizations to get comfortable with Medicare. Provider enrollment, covered services, regulations, and internal billing systems all need to be aligned. This has been a particular challenge for behavioral health clinics that have long relied on fee-for-service Medicaid as the primary, and often only, payer.

There are also clinical and care coordination considerations special to serving an older adult population. The concern of polypharmacy is higher among older adults; at the Service Program for Older People in New York City, “the [psychiatric nurse practitioner] works to avert drug interactions by reviewing drug protocols, dosages, and schedules. Most clients have multiple prescriptions (including psychotropic medications), and the NPP is alert to contraindications and dosage levels.” Some grantees have incorporated home- and other community-based visits into their service array, in recognition that particularly frail individuals may not be able to consistently make it into the clinic. One program is in the midst of changing its primary service location to a site that is less chaotic so that it is more accessible to their elderly clients.

An early phase of these programs, all of which were primary care sites adding behavioral health capacity, showed a high rate of improvement in anxiety and depression among the older adults who were identified and received treatment. Data is just starting to come in from the current demonstration programs, and it is too early to comment on outcomes with any appreciable certainty. Anecdotally, however, sites have already begun to see an impact on indicators ranging from smoking and anxiety to obesity and hospitalization rates. There is a lot of promise in the models being tried in New York, hopefully just in time to address the elder boom.

NINA MARSHALL

Director of Public Policy, National Council for Behavioral Health



Stemming the Flow of Persons with Mental Illness into the Justice System

THE PARABLE OF THE RIVER

One day, two villagers were walking along a riverside when one noticed a baby in a basket floating down the river. The first villager immediately rushed into the water and saved the baby from drowning. No sooner had the villager returned to shore than another basket containing another baby was spotted floating down the river. The first villager rushed back into the water and retrieved the second baby just in time. All of a sudden a third, fourth, and fifth basket were seen coming down the river, and then dozens more.

As the first villager frantically rushed in and out of the water to save each of the babies, the second villager began running upstream. Seeing this, the first villager yelled out, "Where are you going? We have to save the babies!" The second villager yelled back, "I know... I'm going to find out who's putting the babies in the water and to stop them before they send more!"

This parable illustrates the difference between public health approaches that focus on addressing discrete crisis episodes involving individuals versus emphasis on prevention and the well-being of the community as a whole. Both approaches are essential, and neither undermines the other. However the tyranny of the urgent, combined with limited resources, has historically dictated that policy and practice address immediate crises to the relative neglect of longer term prevention and population-based solutions.

People with serious and persistent mental illnesses, particularly those who become involved in the criminal justice system, demonstrate substantial disparities in rates of access to community-based mental health and primary care services. Service utilization patterns reveal disproportionate use of costly crisis and acute care services, with limited and inconsistent access to prevention and routine care.

Traditionally, mental health interventions are provided to individuals with serious mental illnesses only after they become involved in the justice system. While these interventions, such as problem-solving courts and jail diversion programs, have demonstrated remarkable effectiveness in reducing costs and improving public health and safety, research suggests that the prevalence of serious mental illness among criminal justice populations has remained largely unchanged.

The babies must be rescued from the river — that's critical. However, we need to determine the source — what drives people with mental illnesses into the justice system to begin with? What changes in policy, legislation, and service delivery models will help to reduce criminal justice involvement and improve access to care and recovery?

It is estimated that more than two million arrests each year in the United States involve people with serious mental illnesses. Roughly three-quarters of these individuals also experience co-occurring substance use disorders. As a result, jails have become places where a disproportionate number of people with severe behavioral health disorders spend significant amounts of time; their ties to the community severed, their treatment needs unmet, and their illnesses made worse.

Because services in the community tend to be poorly coordinated across treatment settings and difficult to access, many individuals are unable to secure the types of supports

“The tyranny of the urgent, combined with limited resources, has historically dictated that policy and practice address immediate crises to the relative.”

necessary to facilitate adaptive community re-entry and reintegration; let alone ensure that their full range of behavioral health and primary care needs are addressed. The result is high rates of recidivism to the justice system, compromised public health and safety, chronic homelessness, and disproportionate use of high cost and inefficient acute care services.

An analysis completed by the Florida Mental Health Institute at the University of South Florida examined arrest, incarceration, acute care, and inpatient service utilization rates among 97 individuals in Miami-Dade County, Florida identified as “heavy users” of crisis and institutional services. Nearly every individual was diagnosed with a psychotic disorder, had experienced chronic homelessness, and had a history of arrests for predominantly low-level, non-violent offenses.

Over a five-year period, these individuals accounted for nearly 2,200 arrests, 27,000 days in jail, and 13,000 days in crisis units, state hospitals, and emergency rooms. The cost to the community was conservatively estimated at \$13 million with no demonstrable return on investment in terms of reducing recidivism or promoting recovery. Comprising just five percent of all individuals served by local jail diversion programs, these individuals accounted for nearly one quarter of all program referrals and utilized the vast majority of program resources.

Solutions to the delivery of integrated behavioral health and primary care services that promote population health require a commitment to thoughtfully re-examining healthcare policy, legislation, and practice. There will always be a need for frontline services in the community to serve as the safety net for those who become entangled in the currents that permeate gaps in our systems of care.

However, if we continue to stand by the riverside of the criminal justice system without investing in policies, technology, and advances in understanding why people with mental illness get involved with the justice system, we'll miss a critical opportunity. We won't be able to redefine how we, as shared community stakeholders, can effectively manage what has become a steady, costly, and unnecessary stream of baskets flowing down the river.

JUDGE STEVEN LEIFMAN

Chair, Task Force on Substance Abuse and Mental Health Issues in the Court, Supreme Court of Florida and Associate Administrative Judge, County Court, Criminal Division, 11th Judicial Circuit of Florida

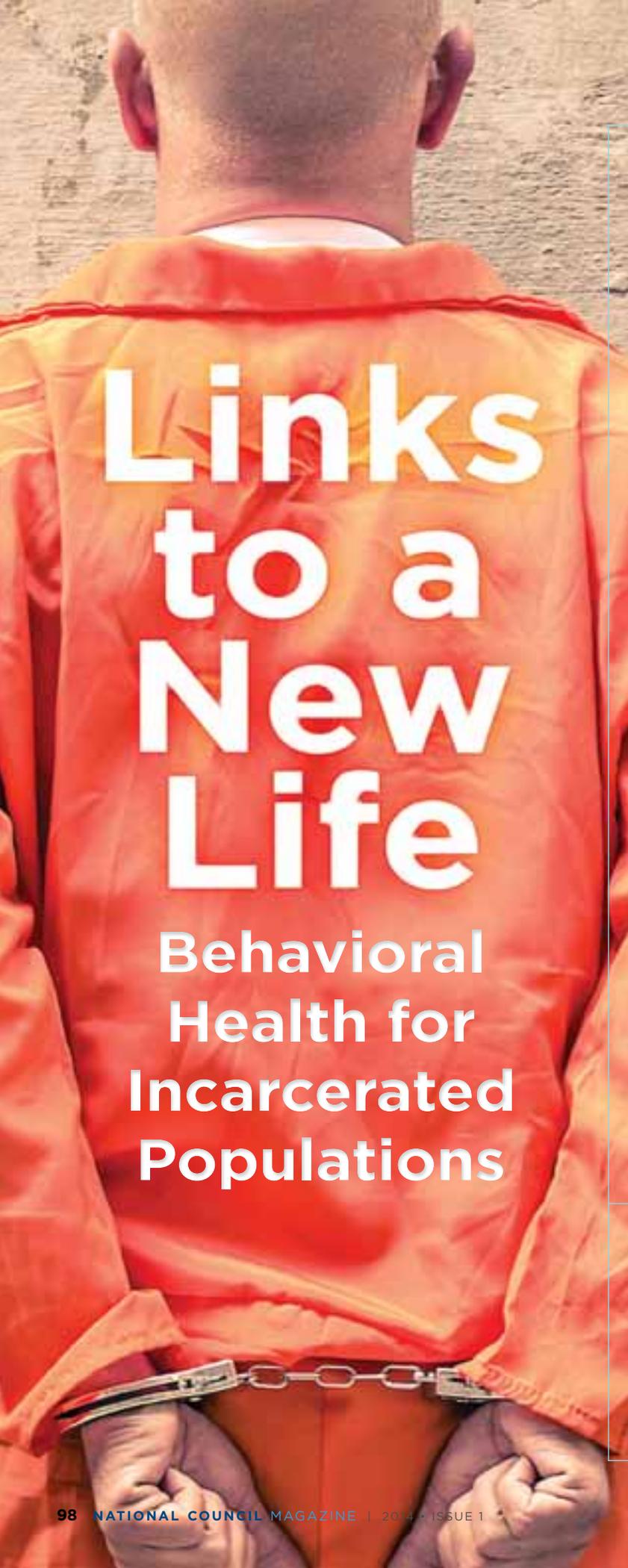
TIM COFFEY

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CONFERENCE

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Hear more from 2014 National Council Conference speaker Judge Steven Leifman. Visit www.thenationalcouncil.org/conference/natcon14-videos



Links to a New Life

Behavioral Health for Incarcerated Populations

Over the past four decades, the criminal justice system has been inundated with the consequences of untreated behavioral health conditions. People with substance use disorders account for at least half of all arrests, court caseloads, and incarceration counts. The justice system has become the single largest “consumer” of addiction treatment, accounting for nearly 40 percent of referrals to care. Today, the three largest mental health service providers in the country are jails: Cook County Chicago, Los Angeles County, and Rikers Island in New York.

The problems don’t end in jail, however. The days and weeks following release from incarceration can be deadly for people with serious behavioral health conditions. Studies show that drug overdose death rates are 12.7 times higher among people newly released from prison than among the general population, with the greatest danger in the first two weeks after release. After periods of abstinence, such as time behind bars or in residential treatment, the body has a reduced tolerance and is highly susceptible to overdose and death. The risk of suicide also increases after incarceration, possibly on account of high rates of underlying mental illness and the psychological stress of reentry, along with difficulty in obtaining continuing care and medications in the community.

Treatment providers and the justice system have shared interests in facilitating access to care for care. For the justice system, reduced recidivism and increased public safety are paramount. Rearrest rates are consistently lowered by as much as 50 percent for individuals who complete community aftercare programs after in-prison treatment.

Lack of adequate resources to pay for clinical services was often cited as a barrier to treatment — currently, about 90 percent of people who are booked at county jails do not have health insurance. The Patient Protection and Affordable Care Act and Medicaid expansion will gradually help to improve access to care.

Coverage alone will not reverse the trend, but it is a monumental first step. The criminal justice system must support enrollment, and offer screening and linkages to community-based providers to help improve outcomes and reduce recidivism.

“Partnerships between justice systems and treatment, combined with case management, can improve success for individuals.”

Treatment Alternatives for Safe Communities (TASC) is a statewide, nonprofit organization in Illinois that facilitates access to care and provides case management for people in the justice system who have substance use and mental health conditions.

TASC serves as a bridge between the criminal justice system and community behavioral health. By connecting these entities through case management and systems planning, TASC increases retention in treatment and reduces recidivism. Evaluation of TASC's services for courts and probation, for example, has shown a 71 percent reduction in arrests for drug and property crimes two years after individuals enrolled with TASC.

Madison County, Illinois, offers an example of how communication and collaboration between systems can save lives. Located in southwestern Illinois just outside of St. Louis, the county saw a rash of heroin overdose deaths in 2011-2012. In response, jail personnel, probation officers, treatment providers, and TASC convened to create the Madison County Opiate Alert Project, which involved closely tracking and coaching people who had heroin addictions during the highly vulnerable periods when they were released from incarceration or treatment. In the ensuing first year of the pilot program, not a single TASC client died from an overdose.

Partnerships between justice systems and treatment, combined with case management, can improve success for individuals, service providers, and justice systems. TASC provided services for more than 28,000 Illinois residents in FY13, including nearly 9,000 adults referred by county courts or probation services, and more than 6,300 in state corrections and reentry programs.

The ACA presents an opportunity to develop such partnerships on a large scale, so that linkages to community-based treatment are available every point in the criminal justice system, from law enforcement to courts, probation, and parole. Better access to community care will reduce relapse and recidivism, increase public health and safety, and improve the quality of life.

To learn more about how treatment providers and criminal justice systems can collaborate to improve outcomes, visit TASC's Center for Health and Justice at www.centerforhealthandjustice.org.

PAMELA F. RODRIGUEZ
President & CEO

DAPHNE BAILLE
Director of Communications

Treatment Alternatives for Safe Communities

SNAPSHOT OF TASC CRIMINAL JUSTICE PROGRAMS

FROM WWW.TASC.ORG

TASC advocates for diverting defendants with nonviolent charges into appropriate community-based services and supervision, including treatment for substance use and mental health issues when needed, as the cornerstone of our mission. The aim is to stop cycles of addiction, crime, and incarceration by helping individuals become, and remain, drug-free and crime-free.

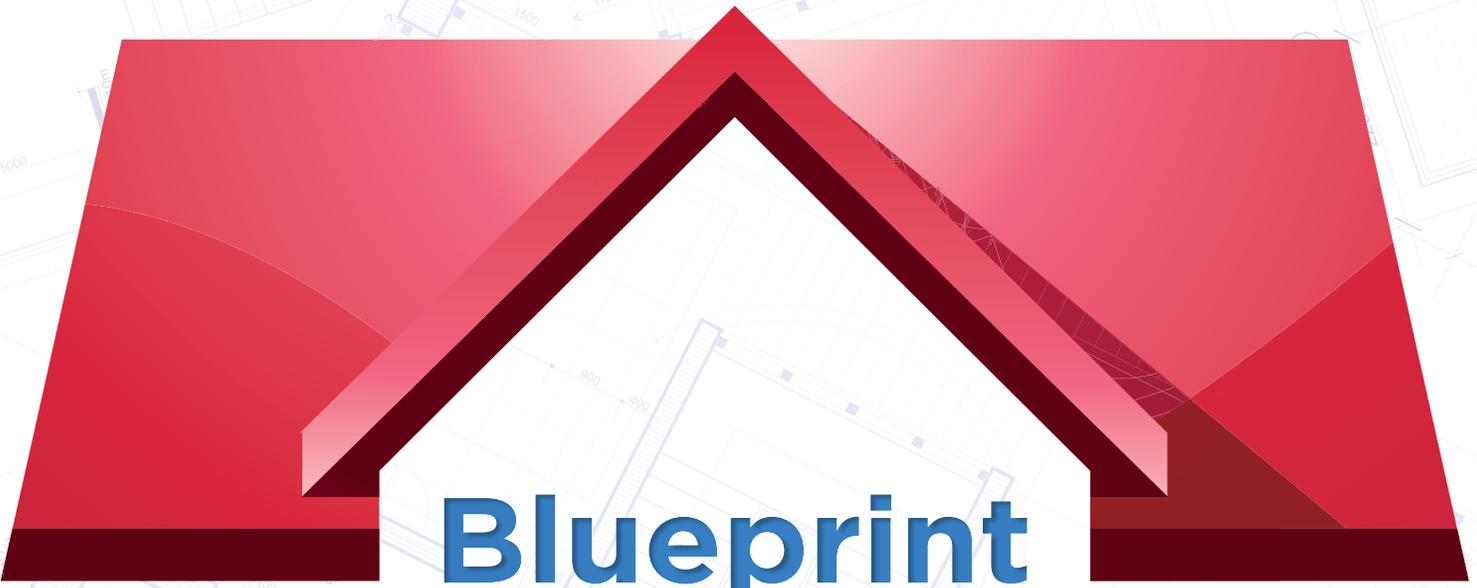
Several criminal justice programs address alternatives to incarceration; court advocacy and probation; screening, assessment, and referral; prison-based treatment and supports; as well as community reentry.

TASC works in collaboration with the Illinois Department of Corrections and the Illinois Department of Human Services, Division of Alcoholism and Substance Abuse to provide a range of services for men and women being released from Illinois prisons. TASC is the agency designated to conduct substance abuse assessments and make treatment recommendations and referrals for IDOC.

At selected state prisons, TASC provides pre-release services to assist clients in developing reentry plans and connections to community resources.

At the Sheridan Correctional Center and Southwestern Illinois Correctional Center, which are specifically designated as prison drug treatment and community reentry programs, TASC case managers provide assessments and connections to substance abuse treatment, mental health services, housing support, education, job training, emergency food and shelter, primary healthcare, and transportation. These programs serve as national models for reducing drug use and recidivism.

Upon release from these institutions, TASC provides placement into community-based rehabilitative services and clinical reentry management as former offenders navigate the complex transition from supervision to community reintegration and self-sufficiency. Continued case management services help reduce recidivism, support recovery, encourage productive self-sufficiency, and maintain long-term public safety.



Blueprint for Better Health: **SUPPORTIVE HOUSING**

Interview with Deborah Santis

President & CEO, Corporation for Supportive Housing

“Housing is a platform for improving healthcare,” says Deborah Santis, President & CEO of the Corporation for Supportive Housing. She quotes U.S. Department of Housing and Urban Development Secretary Shaun Donovan, who reiterates that housing is a platform for improving not just quality of life, but also for improving health outcomes, medical appointment adherence and treatment outcomes, and education outcomes. He often points to the success of supportive housing — the combination of housing with health and human services to help people who face the most complex challenges to live with stability, autonomy, and dignity.

“Housing is a platform for improving healthcare.”

Supportive housing is proven to improve housing stability, employment, mental and physical health, and school attendance; and to reduce active substance use. And supportive housing costs essentially the same amount as keeping people homeless and stuck in the revolving door of high-cost crisis care and emergency housing. It also enhances community safety and improves property values.

Reaching the Most Vulnerable

For more than 20 years, CSH has worked to advance solutions that use housing as a platform for services to improve the lives of the most vulnerable people, maximize public resources, and build healthy communities. CSH develops new models and demonstration programs that uncover innovative, data-driven methods to make supportive housing work better for the highest-cost, highest-need people. The focus is on individuals and families that are homeless and have chronic health challenges — especially mental and substance use disorders — that keep them from being stable in housing.

“We recognized that in order to be effective, supportive housing should be used as a tool to address those who are now on the streets as well as to prevent future chronic homelessness. We need to engage systems that are discharging folks into homelessness. These folks simply return to the systems they were released from when they have no housing options,” explains Santis. That’s why CSH focuses on people being discharged from state mental health hospitals, individuals coming out of jails and prisons, families engaging with the child welfare system, veterans returning to civilian life, and others.

Veterans are probably the greatest example of how using housing as an intervention can actually end and prevent homelessness. “We’re going

to see an end in veterans homelessness by 2015 for most, if not all, communities around the country and that’s because we, as a nation, have injected more resources and also because we know a lot more about this population and their needs,” says Santis.

CSH also has the Olmstead mandate high on its radar and works with communities to create a supportive housing plan to move people out of institutions. States and Medicaid spend an exorbitant amount of money to house people in institutions. Olmstead requires states to administer their programs, services, and activities “in the most integrated setting” appropriate to the needs of qualified individuals with disabilities, where they can fully participate in all aspects of community life. “We save when we take people out of institutions and we want to capture those savings and use them to create housing opportunities in the community,” explains Santis.

Services Can Only Be as Strong as Partnerships

The success of supportive housing is defined by strong community partnerships. “It really is the care coordination piece,” says Santis. To ensure better access to services for the most disenfranchised and disconnected people, we need to move away from developing all onsite services to accessing the healthcare infrastructure that already exists in the community.

CSH works with Federally Qualified Health Centers and community behavioral health organizations to forge the partnerships important to the success of supportive housing. Behavioral health has been a strong partner over the years. However, says Santis, “The FQHC world and the supportive housing world seem so foreign to each other, but it’s such a natural fit because FQHCs can’t serve vulnerable, low-income population without addressing the their housing situation.”

Managed care companies are taking on high-utilizer populations and recognizing that supportive housing is an effective model. They recognize that housing is a platform for improving outcomes and that partnerships with supportive housing providers will improve service delivery and help to contain costs.

To gauge the impact of supportive housing, you have to look at multiple systems, explains Santis. You have to look at emergency rooms, homeless shelters, jails, prisons, and crisis-based systems to see what cost reductions are being achieved as a result of supportive housing. That’s why success is built on true partnerships for implementation and evaluation.

“We save when we take people out of institutions and we want to capture those savings and use them to create housing opportunities in the community.”

“Another challenge is to ensure that indeed the most vulnerable, the people with the greatest need, get into supportive housing.”

Challenges in Expanding Supportive Housing

Santis likens funding for supportive housing to a three-legged stool. Federal programs like the Low Income Housing Tax Credit Program and state housing grants invest in the bricks. Section 8 and other HUD programs cover the operating subsidies like rent. But funding for services delivered under supportive housing has always been a challenge. HUD no longer provides service funding, which now comes primarily through state programs.

The fact that the housing and the health and human service systems haven't partnered well together has been detrimental to the growth of supportive housing. So CSH started to work with healthcare systems to figure out how to marry them up with the supportive housing providers and access physical and behavioral healthcare for recipients of supportive housing. “We started working with FQHCs and hospital systems dealing with frequent users, so that people ping ponging between the hospitals and shelters and the street could access services and not end up where they came from,” says Santis.

Santis notes that Medicaid is not adequately available to individuals in supportive housing. CSH hopes to tap into more Medicaid funding for the populations it supports by demonstrating — through grant-funded pilots — that supportive housing improves health outcomes and reduces healthcare costs while offering better service delivery mechanisms for high-utilizers.

Another challenge is to ensure that indeed the most vulnerable, the people with the greatest need, get into supportive housing. It's easy for providers to serve those with less needs because they're a little easier to serve. “If we really want to have great impact in reducing the number of our nation's homeless, we have to ensure that housing units go to the right people. Providers need the right resources and education in working with challenging populations,” explains Santis.

Some philosophical difference may also pose a challenge to supportive housing. For instance, offering housing only for people who are clean and sober does not help those who experience chronic homelessness on account of substance use. We need to educate supportive housing providers to create models of housing and to structure services and engagement in a way that welcomes people with substance issues and housing.

Supportive housing does not work for everyone, points out Santis. If you look at the housing stability metrics, about 90 percent of the people that go into supportive housing stay for two years or more. We know that there is 10 percent fallout. Supportive housing is supposed to recognize that people are going to fail and create a safety net for when they do fail, and how to think differently about engaging them.

Demonstrating the Impact

CSH's Social Innovation Fund Initiative (SIF), backed by a federal award from the Corporation for National and Community Service, is piloting programs in four communities — Connecticut, Michigan, San Francisco, and Los Angeles — that will result in a model of supportive housing linked to health services to save public dollars and improve lives. All communities use supportive housing as an intervention to reduce use of healthcare systems by high-utilizers.

In Michigan, Catholic Social Services of Washtenaw County is integrating the resources of key area supportive housing providers and data from county hospitals to provide housing and primary and behavioral healthcare coordination to homeless frequent users of crisis



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“The success of supportive housing is defined by strong community partnerships.”



health services in Washtenaw County, Michigan, and surrounding areas. Access to primary and behavioral health care is facilitated through a larger multidisciplinary care team comprising psychiatrists, medical doctors, medical case managers, substance abuse providers, homeless outreach workers, and shelter staff. A core group of intensive case managers — the Housing and Care Coordination Team — serves as the central organizing entity and owner of the coordinate care plan to effectively create a patient-centered medical home for people served.

In Connecticut, the Connecticut AIDS Research Association leads the implementation of the Connecticut Integrated Healthcare and Housing Neighborhoods, which creates a health home outreach model linking primary care, behavioral healthcare, and supportive housing. Individuals identified through a data match between the State’s Medicaid administrative data and Homeless Management Information Systems are provided with supportive housing linked to health services through a coordinated delivery system involving Federally Qualified Health Centers, local mental health agencies, and other providers. Care coordination is achieved through newly created patient navigator positions serving as boundary spanners across housing and health providers.

In Los Angeles, the Economic Roundtable has developed an innovative triage tool, or crisis indicator, that identifies homeless individuals in hospitals and jails who have continuing crises in their lives that create high public costs. The tool is developed for use in jails, hospitals and clinics where homeless individuals with high levels of need and high public costs are most likely to be found. A partnership consisting of 38 social service, housing, and healthcare organizations identifies, recruits, and provides supportive housing, care management, and integrated primary and behavioral healthcare to high-need, high-cost homeless individuals to improve their health and reduce avoidable visits to emergency departments, acute inpatient hospitalizations, and other crisis service use.

In San Francisco, the Tenderloin Neighborhood Development Corporation and partners San Francisco Department of Public Health and San Francisco Health Plan are expanding a highly successful Direct Access to Housing (DAH) program by identifying, recruiting, and providing housing and healthcare to homeless individuals with chronic health conditions who are high utilizers of crisis health services at the newly constructed Kelly Cullen Community supportive housing development. A “low threshold” program that accepts adults into permanent housing directly from the streets, shelters, hospitals, and long-term care facilities, DAH strives to help tenants stabilize and improve their health outcomes despite co-occurring mental health issues, alcohol and substance abuse problems, and/or chronic medical conditions.

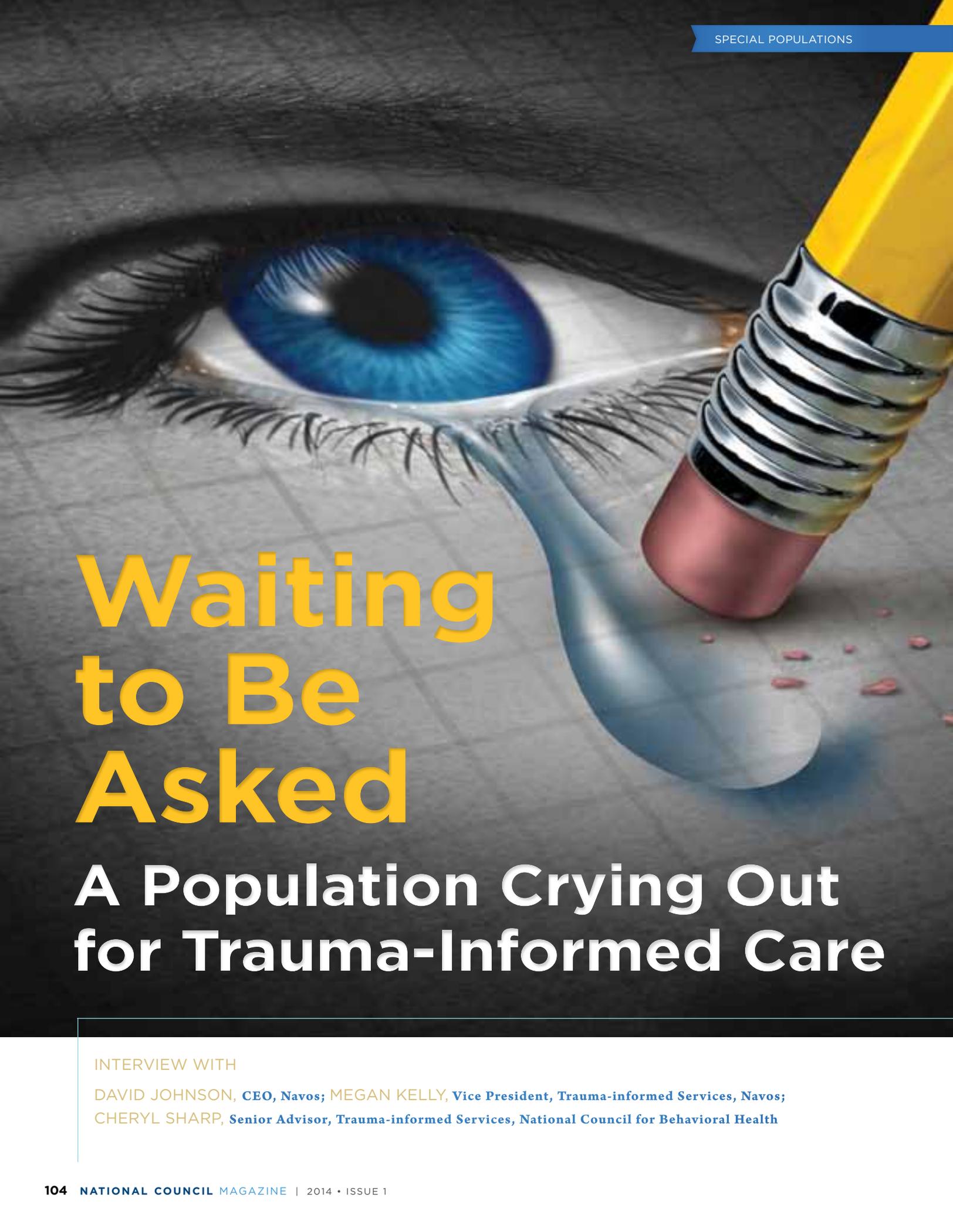
“Ultimately, what we’re trying to demonstrate through our SIF grant is that through supportive housing, there will be a cost reduction to the healthcare system and these cost savings should be captured and used to fund housing,” says Santis.

Top of the List

Every behavioral healthcare provider certainly should have housing in the mix, whether it’s a staff housing locator that helps people served or strong referral relationships with supportive housing.

Santis recalls the time she was at a transitional housing project and a gentleman who was in conversation with her said he’d love to get into housing. A case worker walked over and said to him, “No, no, no, no. We’re not having this conversation about housing right now. You’ve got another three months here.” Later, Santis told the case worker, “Housing cannot just be part of the conversation on the day this person is leaving your program. It’s one of the first conversations you have. You must think holistically about people’s needs.”

While the discussions with payers are under way, NHS and our primary care partners are continue to do what’s possible each day in each of our health homes to expand integrated care.



Waiting to Be Asked

A Population Crying Out for Trauma-Informed Care

INTERVIEW WITH

DAVID JOHNSON, **CEO, Navos**; MEGAN KELLY, **Vice President, Trauma-informed Services, Navos**;
CHERYL SHARP, **Senior Advisor, Trauma-informed Services, National Council for Behavioral Health**

Trauma is pervasive in our society. In the U.S., 61 percent of men and 51 percent of women report a history that includes at least one traumatic event, with many reporting more than one. Among people served by public behavioral health systems, a striking 90 percent have experienced trauma. People with mental illnesses and addictions whose trauma goes unaddressed have poor health outcomes, including exacerbated mental health problems, increased risk of heart disease, suicide, and substance abuse. It would be impossible to effectively manage populations served by behavioral health without factoring in trauma-informed care.

Navos, a behavioral health center in Seattle, Washington, is a National Council for Behavioral Health member and has participated in many national practice improvement initiatives, including a National Council Trauma-informed Care Learning Community. Navos implemented many of the best practices discussed in the learning community and helped people impacted by trauma have a better healthcare experience and get on the road to recovery.

Navos serves some of the most vulnerable people in King County, Washington. People who are economically disadvantaged, who struggle with basic necessities like housing and food, who have had adverse childhood experiences, who are more likely to be assaulted and mistreated as adults, and who are at high risk of becoming re-traumatized.

The journey to extend trauma-informed care to this vulnerable population began when Navos CEO David Johnson was at a National Council Conference and heard Tonier Cain speak. Cain, a victim of 83 arrests, and innumerable rapes and beatings, homelessness, and substance use, shared the story of how her life changed when a trauma-sensitive behavioral health professional, for the first time, asked “What happened to you?” instead of the usual “What’s wrong with you?”

Johnson was deeply moved and returned home with a new lens and vocabulary. He points out that behavioral health has always known that people have had trauma in their history but has not paid attention to how common it is. “Now we know what can be done to free people from the legacy of trauma,” says Johnson. Trauma-informed care offers a structured way of eliciting the stories and of helping people

understand how trauma might have shaped self-harming or self-defeating behaviors they’ve developed.

Navos’ mission to address trauma in the population it served began to take shape when Johnson met Megan Kelly, a long-time expert in trauma-informed care, and invited her to join his team as vice president for trauma-informed services. Kelly notes that creating such a position is unique for a behavioral health organization. “It speaks to how important trauma-informed care is to an organization, and it speaks to the impact

trauma-informed care can have on all employees, all consumers, and the community at large. Trauma-informed care is not just a clinical program, it’s a community and workforce program,” says Kelly.

Under Kelly’s leadership, Navos offers a range of specific, evidence-based treatments — such as Trauma-focused Cognitive Behavioral Therapy, Eye Movement Desensitization and Reprocessing, and Dialectical Behavioral Therapy — to help alleviate the impact of trauma and adverse childhood experiences. But trauma-informed care is much more than treatments and clinical practices, emphasize Kelly and Johnson. It’s a way of being, of understanding what people are going through, of talking, and of offering care.

How has Navos implemented this way of being? They started with sharing the trauma-informed culture, language, and vision with every one of their more than 650 employees. Everyone went through a 3-hour trauma-informed care training.

Just as a new employee coming to a mental health center is grounded in the organization’s mission and trained in everything from using electronic health records to compliance, they are trained in trauma-informed care to establish that these are values everyone at Navos holds dear and holds themselves accountable to in interactions with each other and with people served. As a result, says Johnson, it’s not unusual to have any staff, whether it’s an accountant or a data analyst, say, “Now wait a minute, the way you ran that meeting — or handled layoffs, or talked to me during assembly — was not in keeping with trauma-informed care.” All staff know they have a responsibility to confront behaviors that aren’t in keeping with the values they learn.



Among people served by public behavioral health systems, a striking **90 percent** have experienced trauma.



“It’s almost like they’ve been waiting for us to ask.”

Navos used an Organizational Self-Assessment offered by the National Council to guide its trauma-informed work. “The organizational self-assessment has given us a broader framework and a way to measure and take steps to make sure that we’re including all areas of trauma-informed care in our work,” says Kelly.

The trauma-informed culture is evident in practices and care environments across Navos. At an inpatient unit for adults who are involuntarily committed, Kelly trained staff to begin each day with a community meeting where they review the principles of recovery and trauma-informed care and talk about how they support safety. In the afternoon, staff reaffirms these principles and discusses specific situations. Kelly also helped to replace a seclusion and restraint room with a sensory “comfort room,” where patients can go and find scents, music, textures, etc., that they’ve identified ahead of time to help them feel safer. A children’s long-term inpatient program has a sensory comfort room that the children named Rainforest Cove.

Most importantly, Navos is finding that people who come through their doors for care want to talk about their experiences. “It’s almost like they’ve been waiting for us to ask,” says Johnson. When people have an avenue to talk about what’s happened to them, their mental health symptoms are mitigated and they view the world as a safer place.

How do you measure trauma-informed care outcomes? Kelly explains with a trauma-informed care system, an organization should see a decrease in the number of psychiatric diagnoses, an

increase in the diagnosis of PTSD, less use of seclusions and restraints, a decrease in assaults and incidences of violence, a decrease in lengths of stay, and a decrease in detentions and arrests. Ultimately, trauma-informed care enriches and enhances recovery from mental illnesses and addictions.

Navos strives to share the trauma-informed culture throughout the community. Kelly’s expertise is sought after by different agencies in the community. Navos established a trauma-informed care action team in King County and has trained schools, primary care agencies, domestic violence organizations, and other community partners in how to approach and work with the population that goes to them for services. “When we give people a lens to look through and a vocabulary to use, all sorts of really cool things get unlocked. Everyone is aware of and respectful of the trauma someone has to overcome and their capacity to overcome it. I’d see it as a catalyst that taps into the strengths and best part of everybody: the caregivers, the people with lived experience, the advocates, the policymakers,” says Johnson.

Johnson has three top takeaways for other organizations embarking on a trauma-informed care journey.

1. Think of trauma-informed care as a transformational experience for the whole organization and community, NOT as a nice little tool to have in the toolbox when working with a certain population.
2. As a leader, hold yourself accountable to be congruent with trauma-informed care, accept feedback, and be responsible about changing where needed.
3. Commit to resources in terms of funding, time, and people, even when times are tough. If you’re going to become a trauma-informed organization, you need to be prepared to spend five years doing so and to remain dedicated to making it happen.

Kelly adds that the lessons Navos has learned from experts and peers in the National Council Trauma-informed Care Learning Community have also been invaluable. She says trauma-informed care is growing, and we’re learning new things all the time — about the brain, about how people think and feel and react. Without the National Council, there isn’t a way to be part of that growth, according to Kelly.

“My dream is that some day we’re not talking about trauma-informed care. My dream is that it just is, and we don’t have to define it and teach people — it is a way of being. When trauma-informed care is passé because people are naturally doing it, then I’ll know we’ve arrived,” concludes Kelly.

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Learn more about trauma from 2014 National Council Conference Thought Leader Bruce Perry. Visit www.thenationalcouncil.org/conference/natcon14-videos



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Where Zero is the Perfect Number

“ The Henry Ford “Perfect Depression Care” Initiative has new data confirming that the initiative was associated with a dramatic (82%) and sustained (over 8 years) reduction in suicide within our HMO network patient population.”

Suicide is an important public health issue and the cause of much personal suffering. Yet only a few large-scale health services interventions have been evaluated or shown to be effective at preventing suicide. The Henry Ford “Perfect Depression Care” Initiative has new data confirming that the initiative was associated with a dramatic (82%) and sustained (over 8 years) reduction in suicide within our HMO network patient population. These results have implications for large-scale quality improvement efforts to reduce suicide.

The Henry Ford “Perfect Depression Care” Initiative was one of 12 national demonstration projects (and the only mental health proposal) selected in 2001 by the Robert Wood Johnson Foundation for its “Pursuing Perfection” Initiative, the goal of which was to demonstrate that the Institute of Medicine’s report *Crossing the Quality Chasm* could serve as a viable roadmap for rapid, dramatic improvement in healthcare.

With the support of the RWJF and the Institute for Healthcare Improvement, we launched an initiative to completely redesign depression care delivery using the Six Aims and Ten Rules from the Chasm Report. We set “perfection” goals for each of the Six Aims (safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity), and then leveraged the Planned Care Model to reengineer our mental healthcare delivery system using multiple Plan-Do-Check-Act cycle tests of improvement within four key domains — partnership with patients, clinical care, access to care, and information flow.

We placed a particular focus on evidenced-based interventions for suicide prevention, including means restriction, as well as rapid access to diagnostic assessment and effective biopsychosocial treatment of underlying mental disorders. At the same time we endeavored to cultivate a “just culture,” a culture of dignity and respect in which employees are encouraged to pursue audacious (rather than incremental) goals without fear of retribution should a project come up short of perfection. The key objectives were to learn and get better, and to pursue perfection, even if attaining it may not be possible.

More recently we have continued to build upon these strategies, with a particular focus on immediate access to care (e.g., implementing an “open access” model in our outpatient clinics), simplified screening for suicide risk, leveraging IT to accomplish assessment of suicide risk and weapons availability at every encounter, continuous updating of

evidenced-based care protocols, and diligently cultivating a just culture by “walking the walk, not just talking the talk” of pursuing perfection.

Using data from the state of Michigan, we confirmed that implementation of the Henry Ford Health System Perfect Depression Care Initiative was associated with a dramatic reduction (82%) in the suicide rate among patients receiving mental health care in our HMO network. These findings support our original report of a reduction in suicide rate, wherein suicide was determined solely from clinical data, and suggest that if such clinical data are assiduously acquired, then they are valid metrics sufficient to drive real-time quality improvement.

Our Perfect Depression Care Initiative comprised multiple interventions and as such, we are unable to identify the relative impact of the various individual strategies on our patients’ suicide rate. The 82% reduction in suicide rate seen in our patients is considerably larger than that estimated for individual interventions, perhaps suggesting that multiple strategies are contributing to the strong results. Controlled studies are required to elucidate this issue. Still, our findings indicate that the Chasm Report is indeed a viable roadmap for dramatic improvements in healthcare quality, particularly when coupled with a “just culture” that encourages innovation and aggressive improvement.

Our results also indicate that it is possible to sustain dramatic improvements in suicide rate, in this case over eight years. We believe that such sustainability has been achieved at least in part by leveraging a framework for sustainability, which consist of five components — clear goals, infrastructure, incentives, incremental opportunities for participation, and integration within a larger healthcare quality enterprise. Each of these components, especially integration, have proven crucial in our efforts to spread these improvements in mental healthcare processes to the general medical setting, where our Perfect Depression Care Initiative has resulted in newly identified cases of depression in approximately 15% of adults with chronic general medical conditions.

EDWARD COFFEY

**Vice President, Henry Ford Health System and
Kathleen and Earl Ward Chair of Psychiatry, Henry
Ford Hospital**

HENRY FORD INITIATIVE PREVENTS SUICIDE ATTEMPTS

From www.crainsdetroit.com, published October 18, 2010



For the behavioral health services division at the Henry Ford Health System in Detroit, zero is the perfect number. In the past 10 quarters, zero is the number of patient suicides the department has reported, a result of the Perfect Depression Care initiative that it started in 2001.

Equally notable, or maybe even more so, is that the nonprofit health system and HMO didn't employ entirely new strategies to produce those results. Instead, staff members changed the way they thought about what a perfect depression-care program would look like — and refused to accept the idea that patient suicide would be a part of that care model.

The concept used at Henry Ford could serve as a model for rural healthcare providers — whether in hospitals or clinics — because the program relies on a shift in thinking, rather than on costly resources or a surge in clinical staff.

“The bigger issue was this culture change that we eventually implemented which simply did not accept the notion that people would kill themselves, the idea that zero would be our goal,” says Ed Coffey, a physician who is vice president at the Henry Ford system and CEO of its behavioral health services division. The division has a staff of about 500 and provides mental health and substance abuse services through its integrated delivery system of two hospitals and 10 clinics that serves Southeast Michigan and adjacent states. “That to me was the biggest thing and the key lever that allowed us to accomplish the success we had,” he said.

The Perfect Depression Care initiative began as a demonstration project sponsored by the Robert Wood Johnson Foundation, which granted awards for programs that seek to transform health systems. “The idea was to try to get away from incremental improvement and do something ‘breakthrough,’” Coffey said. “It was their idea of pursuing perfection. We were very excited about that; what would ‘perfect depression care’ look like?”

As Coffey explains, the idea that a perfect depression program meant one without any suicides came from a nurse at Henry Ford who suggested the idea at a meeting. At first, a senior clinician in the room dismissed the idea as “crazy,” saying there would be no way to prevent patients from killing themselves if that's what they intended to do,

“What must our goal be? If it’s not zero, is it eight? Does that include your sister or my mother?”

especially because clinicians can’t be with patients 24 hours a day, seven days a week.

“We came to the conclusion that if someone really wants to do it, we can’t stop it,” Coffey said. “What must our goal be? If it’s not zero, is it eight? Does that include your sister or my mother?” And this goal of “zero defects” need not stay confined to mental healthcare services, but apply to other strategic initiatives within the system, Coffey says.

The Perfect Depression Care initiative includes six major tactics: commit to “perfection” (zero suicides) as a goal; develop a clear vision of how each patient’s care will change; listen to patients regarding their care redesign; conceptualize, design and test strategies for improving patient partnership, clinical practice, access to care and information systems; implement relevant measures of care quality, assess progress and adjust as needed; and communicate the results.

Within the first four years of the program, the annual rate of patient suicides in the behavioral health services department dropped 75 percent to about 22 per 100,000 — the average rate between 2002 and 2005 — from 89 suicides per 100,000 at the baseline in 2000, according to an April 2007 article in the *Joint Commission Journal on Quality and Patient Safety*. In the past two years, or the last 10 consecutive quarters, the department has not seen one patient suicide.

The program was recognized by the Joint Commission in 2006 when Henry Ford’s behavioral services division won the Ernest Amory Codman Award in the behavioral healthcare category.

“There’s nothing unique about the strategies,” Coffey said. “Everyone would say they’re doing the same thing. We assess the risk and do everything we can do to lessen that risk,” he adds. “I do think we have developed some unique tactics that have helped,” he says, adding that staff members do not spend much time making distinctions between levels of risk because they accept that any patient will be at risk.

For example, Coffey explains, there is a difference between a patient who needs “emergent” intervention — which describes a scenario in which a patient does not leave the office until a plan is established — and one who requires “urgent” intervention, which is for someone who could be seen the next day. “Even that — making that fine a distinction — is difficult to do as well,” Coffey said, adding that the real issue is that everyone is at risk,

and often assigning “low risk” can lead to a false sense of security.

With that in mind, staff members try several things at one time to address the problem, which often makes it hard to know which “change” is working.

One intervention the team uses relates to the availability of weapons. Because the majority of suicides results from impulsive acts, it is important to make it harder for patients to act on those impulses, Coffey says. For this, patients are asked about the types of weapons they have access to at home and are asked to check again and then call a staff member. If a staff member from the department does not hear back, he or she will follow up. “It’s unbelievable what people find that they didn’t report,” Coffey said. “Sometimes, they really didn’t know.”

As Coffey explains, the department leaves the definition of weapon to the patient and family. So, while guns would be included for sure, if there are other potential weapons in the home, patients are encouraged to remove those also.

Staff members within the behavioral-health department at Henry Ford complete a course on suicide risk and prevention and must score 100 percent on the follow-up test or receive additional education, according to the article in *JAMA*.

Adequate training for healthcare professionals is an area that needs to be developed, according to Paula Clayton, medical director at the **American Foundation for Suicide Prevention** in New York. Clayton’s previous experience includes serving as chairman of the psychiatry department at the **University of Minnesota**. At the foundation, which was established in 1987, she oversees research and education.

“I think you need to train the medical community — the nurses, the secretaries in doctors’ offices,” she said, adding this is because many people who are depressed seek care from their doctors, especially the elderly, of whom 50 percent have seen their doctor in the same month as their suicide.

BY JESSICA ZIGMOND
for Modern Healthcare



Serving Our Veterans

Veterans with mental health conditions, particularly those with high risk, high cost, or high utilization patterns must be identified early in to enable effective treatment

The James A. Haley Veterans' Hospital (JAHVH) in Tampa, Florida and its satellite clinics comprise one of the busiest networks in the Veterans Health Administration, serving 116,000 veterans, and includes the nation's largest polytrauma rehabilitation center.

Holistic Telehealth

JAHVH incorporates a telemental health program using a disease management model for patients diagnosed with a chronic mental illness and/or medical conditions. Considered a best practice, the program uses technology to facilitate a holistic, interdisciplinary approach to the care of veterans with mental illnesses who may have difficulty accessing traditional in-person care and who may need monitoring of symptoms between in person visits.

Veterans with mental health conditions, particularly those with high-risk, high-cost, and high-utilization patterns must be identified early in to enable effective treatment, prevent unnecessary inpatient admissions, and improve outcomes of existing outpatient care. We assess these veterans to determine if they meet criteria to incorporate telehealth/telemental health as part of their treatment.

JAHVH identifies veterans that meet any of these criteria:

- 🕒 More than two admissions to a mental health facility
- 🕒 Multiple emergency department visits for psychiatric concerns
- 🕒 Multiple appointment no-shows
- 🕒 Chronic suicidal ideation or high-risk flag
- 🕒 A diagnosis of depression, schizophrenia, bipolar, or PTSD
- 🕒 Currently prescribed a psychiatric medication
- 🕒 Difficulty complying with medications
- 🕒 Require close monitoring to improve compliance

The veteran must consent to enroll in the telemental health program, must have a home telephone or cell phone, and have the ability to use technology or a family member willing to assist.

Home telehealth supports remote monitoring of patients with a primary health concern (e.g., hypertension, diabetes, congestive heart failure), and home telemental health is used to assist in monitoring and follow-up of mental health concerns (e.g., depression, anxiety, PTSD, bipolar,

schizophrenia). Health informatics, disease management protocols, and telehealth technologies are incorporated to facilitate access to care and to improve the health of targeted populations. Additional telephone-based care methods are available, such as a TeleMOVE program, which assists veterans with weight management.

Population Management Approach

The implementation of a population management approach to healthcare must involve every level of an organization, including senior leadership, line staff, policymakers, finance, and electronic health records staff to support the effort. At JAHVH staff are trained in the appropriate use of screening tools and processes to identify veterans that benefit from the integrated and population-based model of care. Care is coordinated within an interdisciplinary treatment team that provides effective and evidence-based psychotherapies to veterans.

In primary care clinics, routine screening for trauma, anxiety, depression, and substance use is done annually or more often if symptoms are reported by the veteran or observed by staff. The stepped assessment process begins with a brief (2-6 item) questionnaire administered by a nurse. Positive screens are followed by assessment of symptom severity by a primary care physician. If needed, further assessment is conducted by a behavioral health provider embedded in the medical setting. Patients with complex or long-term treatment needs are triaged to specialty mental health services.

Care coordinators work on behalf of the veteran to facilitate symptom management, improve quality of life, and ease caregiver burden. They are case managers who use health informatics, telehealth technologies, and disease management strategies to coordinate care. They also assist the veteran in navigating the VA system by providing a single/additional point of contact.

The population management approach has yielded several benefits as noted by providers — decrease in unnecessary phone calls, decrease in no-show rates, increased patient engagement (the veteran is reminded of follow-up appointments during their contact with the case manager and through the telehealth equipment), improved utilization and quality of care, and more efficient use of resources. There have also been decreases in unscheduled visits to the emergency room, urgent care, and acute care.

The population management approach has increased access to care and improved patient satisfaction. It empowers veterans to take control of their healthcare and their lives by teaching them self-management skills and expanding knowledge of their diagnosis. It has shown to improve symptoms of depression, PTSD, schizophrenia, and bipolar disorder and to enhance communication and collaboration with providers and access to care.

Lessons Learned

We have made a number of improvements since first implementing the telehealth and telemental health programs. Education about the

telemental health program during the veteran's initial introduction is essential. Health system leadership and staff (division chiefs, medical directors, clinic leaders, primary care providers, psychiatrists, psychologists, nurses, and other clinical and administrative staff) must understand how a population management approach works. Their knowledge of the program and ability to convey its benefits to the veteran builds trust and improves the therapeutic alliance. We ensure staff have the knowledge and skills to use the screening tools and data generated from the electronic health record to refer candidates to the telemental health program.

As with any newly-developed program, it is important to establish measurable goals prior to program implementation. Use data as a baseline and monitor goals to ensure the program is effective. Ongoing review of the data and utilization patterns of the population is required. Short PDSA (plan-do-study-act) cycles allow the organization to respond and to modify and improve the program as it moves forward.

Establish policies and procedures that specify the clear lines of responsibility between teams. This facilitates warm hand-offs and clarifies communication around shared workloads. Patients should also be engaged beyond a warm hand-off to other providers. Many veterans are unfamiliar with the technology used in telehealth programs. Having face-to-face educational sessions before enrollment with the veteran and their family in using the equipment is very important. Care managers monitor home telehealth data on a daily basis and identify trends and symptom outliers. They then incorporate a note into the electronic health record (with provider alerts, as necessary) to help adjust patients care as indicated.

Diversity of available vendors is necessary if the home telehealth equipment of one of the vendors fails or becomes incompatible, as veterans must not be suddenly deprived of the care they depend on. Implementing a mechanism for the telehealth equipment data to interface with the electronic health record is important. Not all home telehealth technology incorporates mental health and vital signs and not all are compatible with electronic health records. JAHVA works with vendors to automatically incorporate the information collected into the patient's electronic health record.

JAHVH's telehealth strategies can serve as a model for other organizations ready to embrace a population health model and empower veterans to manage their health, even from a distance.

MELANIE PEREZ

Military Sexual Trauma Specialist/Coordinator

CARI GREB

Lead Telemental Health Nurse

ANDREW PHILIP

Behavioral Health Consultant

James A. Haley Veterans' Hospital



“ I made a decision to quit smoking so I have the lungs to exercise, so I can have a physically healthy future, and in turn, have a mentally healthy future.”

Carla was sick and tired of being sick and tired. After a half dozen recent trips to the emergency room and witnessing a smoking buddy’s death, Carla decided it was time to quit smoking — at age 70, after 52 years. “Seeing this person drop dead from a massive heart attack was a rude awakening. She was overweight, a heavy smoker, four years younger than me. It was very depressing. I had to come to terms with myself that I’d rather be able to breathe, and have some quality of life left after 70 years, than snuff out my life with something as poisonous as smoking.” Carla hopes to share her story and help young people. “I want to cry sometimes when I see young kids smoking. The main thing that has helped me has been returning to the club, using my hands. I’m washing pots and pans, anything I can to do keep my hands busy. Anyone can do it, but it has to be for yourself.”

Certified Peer Support Specialist Sahra Colford has quit smoking after 20 years. She believes it’s important to be a good role model for people she serves. “I am working on that total recovery package. I need to be both physically and mentally healthy for my own future and also to give hope to others about what is possible. For me, the first step to physical health is freedom from nicotine. I made a decision to quit smoking so I have the lungs to exercise, so I can have a physically healthy future, and in turn, have a mentally healthy future. They go hand in hand and now I can tell others I did it!” said Colford.

Carla and Sahra are trailblazers at Northern Lakes Community Mental Health where we’re starting a 12-month groundbreaking project to promote tobacco-free living among people with mental illness. The project’s primary goals are to train mental health professionals to better screen for tobacco use, support and assist persons with mental illnesses to stop using tobacco, and assist Northern Lakes to realize its vision of a tobacco-free culture.

“Persons with mental illnesses can and have successfully quit using tobacco, dramatically improving the quality and length of their life.”

The effort is being made possible by an American Lung Association “Expanding Smokefree Communities” Community Transformation Grant (CTG) through the Centers for Disease Control and Prevention. Northern Lakes is one of only five grant sites in the country.

Under the grant, we’ll develop policy, incorporating the five As (Ask, Advise, Assess, Assist, Arrange) into our protocols and electronic medical records, and educate and provide cessation support to staff and the persons we serve.

A change initiative of this magnitude requires many hands and broad support. We established a core leadership team of 10 staff who attended the CDC’s CTG Action Institute in Dallas, Texas, in December. The group attended three days of intensive presentations and workshops and returned with an understanding of tobacco cessation best practices and a workplan.

“I took that trip as my cue to begin my own journey to quit,” shared Colford, who was on the team of ten. “I couldn’t be a smoker at an event with the American Lung Association! I quit the day we left for Dallas.”

The core team has presented to the Board of Directors and trained all managers. Michigan Department of Community Health posters focusing on smokers with mental illness are posted throughout Northern Lakes’ four offices. Quit resources, both national and local, are being collected on a special web page.

Northern Lakes has also assembled a strong community leadership team with more than 60 partners from a variety of agencies committed to the success of the project. They’ve have been invaluable in providing perspective as well as data for the community needs assessment.

Over 40 percent of people with mental illness use tobacco and 70 percent of those tobacco users with mental illness want to quit. Jim Harrington with the American Lung Association in Michigan, said, “Asking each person if they use tobacco, advising them to stop if they do, and helping them with cessation resources is critical to their success. Persons with mental illness can and have successfully quit using tobacco, dramatically improving the quality and length of their life. In addition, because tobacco use can decrease the effectiveness of many psychiatric medications, those people with mental illness who quit may respond better to treatment or need less medication for their mental illness. This project will definitely save lives.”

GREG PAFFHOUSE

CEO, Northern Lakes Community Mental Health

The Centers for Disease Control and Prevention

continues its long-standing dedication to improving the health and wellness of all Americans through the Community Transformation Grant program. CTG is funded by the Affordable Care Act’s Prevention and Public Health Fund. CDC supports and enables awardees to design and implement community-level programs that prevent chronic diseases such as cancer, diabetes, and heart disease. CTG expects to improve the health of more than 4 out of 10 U.S. citizens — about 130 million Americans.

CTG works to create healthier communities by making healthy living easier and more affordable where people work, live, learn, and play. Awardees are improving health and wellness with strategies that focus on areas such as:



Tobacco-free living



Active living and healthy eating



Clinical and community preventive services to prevent and control high blood pressure and high cholesterol.

Awardees may also focus on disease prevention and health promotion, including social and emotional wellness (e.g., facilitating the early identification of mental health needs and access to quality services) and healthy and safe physical environments.



Bridging the between Primary Care

“To practice
successfully in
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health
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Game changing advances in science and genetics have demonstrated that there is no distinction between mental and physical health. This, combined with significant reforms in the way that healthcare is delivered and paid for has spurred unprecedented levels of collaboration and silo busting. Behavioral health practitioners are eager to become part of primary care teams and primary care practices are welcoming them with open arms. However, once in practice together, gaps between the two professional cultures result in the collaborative relationships being slow to develop.

Imagine it's Monday morning at a large primary care practice anywhere in America. The waiting room is teeming with patients. There are six medical providers — four adult, one pediatric, and one OB/GYN, each expecting to see three to four patients an hour. Their appointments will range from acute illness to chronic conditions, from well visits to annual exams. The plan is to assess, treat to target, and get to the next patient. Each of these providers recognizes that health is driven by behavior, stress and self-care, but they are moving at the speed of primary care and they just can't get to it all.

Luckily, this forward-thinking practice has a behavioral health provider on their team to pick up where the medical care leaves off. Every day, the behavioral health provider reminds the primary care providers about the opportunity for collaboration, but referrals or “warm handoffs” are slow and behavioral health is most often tracked down during a mental health crisis. The behavioral health provider feels underutilized and the primary care provider can't seem to figure out how to make use of this valuable professional. Both parties feel that the collaboration just isn't working out and they're discouraged. What is needed is a radical shift in how each professional sees the other and the situation.

Behavioral health practitioners are trained and viewed as specialists. That's where the cultural gap starts. Primary care providers are generalists. They're trained in many areas of health and manage a vast array of problems — when they reach their limit, they refer patients to specialists. To practice successfully in primary care, behavioral health professionals must act as generalists. This means continually disabusing their colleagues of the notion that they're only there to treat serious mental health problems. Behavioral health professionals in primary care must cast a wide net that includes using evidence-based clinical



Cultural Divide and Behavioral Health

interventions to motivate health behavior changes such as improved self-care, stress reduction, behavioral activation, medication compliance, smoking cessation, pain management, weight management, and support for substance use disorders. Often, chronic conditions that present in primary care and are hard to treat because they are complicated by depression, anxiety, and trauma.

Behavioral health providers must learn a new language, acquiring basic medical knowledge, and learning to work in a highly targeted manner on a wide variety of problems. Instead of slowly exploring and uncovering past motivations, the goal in primary care is to restore optimal daily functioning. Behavioral health in primary care is NOT “mental health lite” or a triage and referral model. Instead, the behavioral health provider is joining their primary care colleague in working in the present moment and bringing a high-level skill to help people get better.

The primary care provider also needs to get into the habit of routinely referring to behavioral health for a variety of conditions. This works best when the practice determines situations that will trigger automatic referral to the behavioral health provider such as all poorly controlled diabetics, all pain patients, and all smokers. Inclusion of behavioral healthcare into daily practice can also be accomplished by building “behavioral health” into medical algorithms and treatment guidelines.

Working in primary care also means using a population-based care model in which services are made available to as many members of the population as possible. In specialty care settings, such as outpatient mental health, the mental health clinician generally provides intensive services to a select few. A critical component of successfully bridging the

cultural gap between primary care and behavioral health is to look for opportunities to improve population health. For instance, the behavioral health and primary care provider might jointly identify depression as a condition that affects a large percentage of the a healthcare practice’s patient population. Screening tools are identified, a tool to measure depression is selected; an evidence-based intervention is implemented by both providers. Using the Plan-Do-Study-Act model, the quality improvement team monitors outcomes and make changes.

When practicing in primary care, the behavioral health provider must be ever present and flexible. If the behavioral health provider waits in their office for referrals, chances are they will find themselves with little to do. Primary care operates in a culture of proactive and assertive communication and action. Instead of reminding the primary care providers of their availability, behavioral health providers should actively seek out opportunities to identify patients in need — for instance, they can conduct depression screening while the patient is waiting in the exam room. When the behavioral health provider is seen as a hard working professional who will go the extra mile for the patients and the providers, they are seen as team members and not as visitors.

When the cultural divide is bridged, the behavioral health provider is seen as an invaluable colleague and primary care no longer practices without their input.

SUZANNE DAUB

Senior Integrated Health Consultant
National Council for Behavioral Health



When The Doctor Needs a Consultation

Telemedicine usually refers to providers connecting with patients. That puts the burden on the patient to have the technology and connectivity, or to travel to a facility with this capability. Project ECHO, based at the University of New Mexico Health Sciences Center in Albuquerque, connects rural clinicians with specialists to build local capacity for community clinicians to treat behavioral health concerns. In turn, local providers can meet clients where they are, either in a clinic or in the community.

Project ECHO started as a way to increase access to specialty treatment of hepatitis C. Primary care clinicians participated in weekly discussions via video or teleconference with specialists in hepatology, infectious disease, and pharmacology. These sessions gave community clinicians an opportunity to ask questions and plan patient care according to evidence-based guidelines. The project demonstrated that through tele-mentoring and consultation, community clinicians were able to treat hepatitis C virus infections just as effectively as specialty clinicians.

Through a three-year grant from the GE Foundation, Project ECHO trains nurse practitioners and community health workers to screen for, diagnose, and treat mental health and substance use problems in

community health centers. The grant, ECHO Access, funds salaries for eight teams of two in eight community health clinics across the state. The clinics have to be treating people who don't have good access to mental health and substance use services, and need to have enough patients who have primary diagnoses of mental health and substance use for a full-time nurse practitioner.

Finding clinics who fit this need was not difficult, as the recent Medicaid audits at behavioral health centers in New Mexico created a flood of individuals with mental illnesses and substance use disorders who had previously only seen specialty providers into already overwhelmed primary care centers.

During weekly mentoring and knowledge-sharing clinics, teams present their cases to the specialists and to each other, discuss new developments relating to their patients, and determine treatment. Every week, the care teams get a presentation on a relevant topic such as the treatment of unipolar depression or alcohol withdrawal. It's like a medical fellowship. To participate in the weekly presentations, the clinics only need a phone, tablet, or computer with a built-in camera and internet connectivity. If a clinic has any concerns with their bandwidth or in connecting, Project ECHO has dedicated staff to facilitate connectivity.



“ Specialists are rare, and this highlights the role of specialists in consultation and teaching, ultimately giving many more patients access to care.”

Family nurse practitioners learn to screen for, diagnose, and treat unipolar and bipolar depression, anxiety disorders, post-traumatic stress disorder, psychosis, and addiction to alcohol, opioids, and tobacco. Community health workers learn to conduct screening, brief interventions, basic case management, and health education. Both learn motivational interviewing, how to conduct support groups, and techniques to promote positive social behavior and development of health life skills and habits.

The teams get patients through referrals from universal screening for about 13 different concerns, including substance use, depression, anxiety, and psychosis, and through referrals from other providers in the clinic.

The whole point is to take the knowledge outside of the specialist and disseminate it as far as possible. Specialists are rare, and this highlights the role of specialists in consultation and teaching, ultimately giving many more patients access to care. Specialists serve as mentors and colleagues, sharing their knowledge and expertise, while the community provider maintains the relationship with the patient and provides high-quality specialty care. Providers are encouraged to feel comfortable asking specialists any question, any time.

New Mexico is among the ten most rural states in the country. Many parts of the state are healthcare professional shortage areas, and many do not have any behavioral health services available. New Mexico also has some of the highest rates in the US for accidental lethal overdose and alcohol-related mortality, and some New Mexico communities have the highest rates of heroin use in the country.

Before, if a primary care provider in rural New Mexico had a patient with opiate dependence, depression, or bipolar disorder, they would refer them to mental health specialists in Albuquerque, where they would have to drive 200 miles for that appointment in six months

and hopefully get some help. If somebody is referred from an Indian reservation, not only is it geographically difficult, but often there's a lack of cultural understanding when they interact with physicians or practitioners. Staying in their community also means they get holistic care.

In many rural and underserved areas, nurse practitioners and other non-physician clinicians provide the bulk of primary care. By default, they frequently are also the practitioners to whom patients turn when they have behavioral health problems. However, most of these team members had not previously treated individuals with mental illness or substance use disorders. Initially, they had a lot of anxiety and a very low sense of self-efficacy, but in a short amount of time, they gained confidence in what they're doing, and are now able to treat very complex cases. They're willing to try things that might have been frightening before, like starting somebody on a med they've never started them on or learning a new technique.

And the clients are also feeling very engaged by the community healthcare workers — somebody who they relate to, who can sit down and really talk to them, not just about resources, but also about their level of motivation for change and what's getting in the way.

Challenges include finding the staff and making sure that they don't just get involved in the clinic's daily routine. When you put a primary care provider in a clinic, it's easy for them to make the assumption, “Well, they can take care of all these other patients that we're overwhelmed with, too.”

The model was designed with sustainability in mind. All mentoring is provided at no cost, and ECHO hopes the clinics will be able to continue it because they don't have to pay for specialty care. By dedicating their time 100 percent to focus on mental health and substance abuse — the hope is that it fills a need, improves the health of the patients, and allows the rest of the providers in the clinic to spend time focusing on other priorities, like diabetes and hypertension. None of these clinics knew how to bill for the treatment of mental health or substance abuse disorders; they're billing successfully now.

At the end of the grant, ECHO hopes the model will prove not only effective, but also valued. The model is something that can be scaled and replicated around the world — and the hope is to introduce it to any area where mental health and substance use services are difficult to get.

INTERVIEW WITH

DAN DUHIGG

Medical Director, Project ECHO, and Assistant Professor, University of New Mexico

CRISTINA CARLSON

Psychiatric Clinical Nurse Specialist, Project ECHO

Beyond the Bedside:



As integrated care continues to advance, questions around workforce are a cause for much discussion and concern. These questions include supply, competencies, workforce makeup, scope of practice questions, and changing roles for all professional disciplines in these settings. As a nurse and integrated health consultant, I often get asked about the role of nurses in the new integrated care workforce.

Historically, nurses have always been present in community mental healthcare. But over the last 15-20 years, their roles were reduced to giving injectable medications or performing task oriented and/or billable functions. In an integrated care environment, what we're moving toward is really taking advantage of the full skills of a registered nurse.

By the virtue of their training, nurses work holistically with patients. There are more roles for registered nurses and advanced practiced nurses within the mental health organization than ever before. Specifically, there are three main areas in which nurses today help with mental healthcare:

PRESCRIBER PARTNER: A registered nurse must be able to help those prescribing medication. Here, the nurse is essential in helping patients understand the effects and side effects of their medication. In addition to monitoring vital signs, the nurse is a critical component to helping to remove the barriers to medication adherence and in helping patients advocate for themselves in a complex system. Telephone triage and follow up, coordinating care across multiple specialties, and creating an environment of compassion are all roles that nurses fill in integrated care settings.



CONSULTATIVE: As case management moves to care management, and the entire care team begins to look at people in terms of their whole health, the registered nurse can be used as a consultant to case management teams and to other staff within the organization. In this role, the nurse attends team meetings and listens for issues where mind and body connect. This might be the person with diabetes and depression or the person with acute anxiety and asthma. The nurse explores with the staff whether the appropriate screening has been done, whether mental health interventions are keeping the potential physical health issues in mind, and is available to see the person in complex situations.

In addition, the nurse can identify population-based education needs for the team. A team might have a high percentage of people with diabetes and so the nurse could provide some targeted education on different aspects of the management of diabetes. The nurse can also support the coordination of physical and behavioral healthcare by providing strategies to work with primary care and when necessary, stepping in to support the development of the relationship.



Nurses in Integrated Care

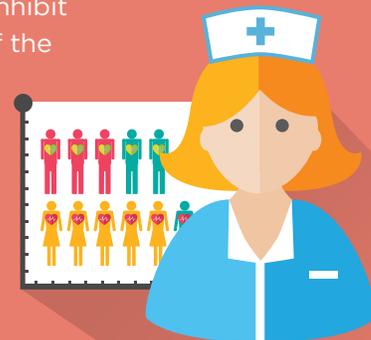
DIRECT CARE: Because of their training across multiple scientific and psychosocial areas and because of competitive market forces, nurses are expensive to hire and maintain and there is a shortage of nurses available to work in community settings. This scarcity and cost of the resource makes it imperative that they function largely in the roles outlined above. But there are situations where the direct care services of the nurse are invaluable.

For instance, let's say that you're serving someone who really doesn't have any family and now has been diagnosed with cancer, and they need to see multiple specialists and then they need to make treatment decisions. For a period of time, the nurse could step into the direct care role and help that person navigate the healthcare system. They can be the listening ear for the treatment options, as well as advocate for that person in the system. They can ensure the patient is having their needs met. Once the treatment protocol is established and the person is beginning to move forward, then the nurse can transition the direct care back to the case/care manager and return to the consultative role.



POPULATION HEALTH: Registered nurses can also have a role within the population health arena. They can help a team of case managers take a look at the pressing physical health issues of the population being served. In this role, the nurse looks at the needs of a whole group or a community and evaluates the way the community is impacting the health of people. They then offer ways to help to mitigate that impact.

While these roles are effective and necessary, there are factors that inhibit registered nurses from filling these roles in mental healthcare. One of the reasons is that mental health providers often cannot compensate nurses properly. Behavioral health providers must make the effort to compensate nurses at the market rate, and then they can track the impact of the nurse has on productivity and outcomes.



JOAN KENERSON KING

Senior Integrated Health Consultant, National Council for Behavioral Health

Nurse-Family Partnership Impacts Future Generations

Imagine a teenage girl, pregnant and struggling with depression. Then she meets a nurse with Nurse-Family Partnership who visits her in her home to guide her through her pregnancy and prepare her to be a mom. The teenager often cries and talks to her nurse about her explosive relationships with her mom and her unstable boyfriend. On doing the Edinburgh Postnatal Depression Scale with her nurse, the teenager scores high for depression. The nurse encourages her to get the support she needs, and calls her provider to set up treatment. During this critical time of pregnancy, the teenager was able to get treatment, while having the support of her nurse who empowered her to get healthy.

“The more vulnerable first-time moms NFP reaches in a community, the greater the impact on population health.”

Young women, like in the teenager's story, are especially vulnerable to symptoms of depression and anxiety. During pregnancy, there is a window of opportunity where a mom-to-be wants to be the best version of herself to provide a brighter future for her child.

Nurse-Family Partnership is a public health program that pairs a first-time, low-income mom with a nurse who provides her with home visits throughout her pregnancy until her child's second birthday. The nurse builds a trusted relationship with the young woman and offers her holistic care at home. Through client-centered care and motivational interviewing, the nurse helps the mom set her own goals to achieve her dreams for the future.

The nurse assesses her client's health and history of substance use, sexual abuse, and other forms of trauma. When armed with better healthcare knowledge, the client is empowered to make healthier choices, which may include stopping smoking, drinking, and abusing drugs. In addition, the nurse provides her with resources in the community and makes referrals for treatment.

“For a client that is using drugs or alcohol, the nurse helps her to understand why it is important to be sober, helps her to understand the importance of interactions with her child during those first two years when her child's brain is growing rapidly

and when bonding is happening,” says Sharon Sprinkle, NFP nurse consultant manager.

“The mom helps set the blueprint for all future relationships,” says Sprinkle. “Not only are we impacting what is happening with the mother today, but the nurse impacts future generations by helping her understand the importance of her physical and mental health.”

Infant mortality and pregnancy outcomes are key measures of population health. Nurse-Family Partnership is able to reach vulnerable patients, many with mental health challenges, to prevent risky health behaviors, improve birth outcomes, and help reduce infant mortality. The more vulnerable first-time moms NFP reaches in a community, the greater the impact on population health.

NFP's integration with needed behavioral health services for first-time moms is essential to achieving optimal outcomes. The NFP program through the Los Angeles County Department of Public Health provides a mental health therapist that accompanies NFP nurses on home visits. Other NFP programs have challenges identifying mental health providers that will see low-income clients on Medicaid.

“NFP is a public health approach to mental health which avoids high-cost care downstream,” said Dr. William Arroyo, medical director for the Children's System of Care at the Los Angeles County Department of Mental Health.

NFP is a smart investment that saves communities money. According to the RAND Corporation, every \$1 invested in NFP can return up to \$5.70 in return for the highest-risk families served.

Nurse-Family Partnership is based on over three decades of proven research by NFP founder Dr. David Olds, who tested NFP through randomized, controlled trials. The trial results were stunning. Women participating in NFP had a 79 percent reduction in preterm delivery for women who smoke. Children participating in NFP had a 59 percent reduction in child arrests at age 15; 48 percent reduction in child abuse and neglect; and 67 percent reduction in behavioral/intellectual problems at age 6, among other outcomes. In addition, the family's self-sufficiency improved. Today, Nurse-Family Partnership serves more than 28,000 first-time, low-income moms in 43 states and six tribal communities.

With its strong evidence of effectiveness, NFP is well positioned to participate in new integrated delivery models that encompass both primary care and behavioral health services. Through the provision of care coordination and health supportive services in the home, NFP can help integrated delivery systems achieve healthy outcomes for first-time moms and ensure a healthy start for their children.

If you're interested in connecting with your local NFP program or bringing NFP to your community, visit www.nursefamilypartnership.org.

NANCY BOTILLER

Chief Operating Officer, Nurse-Family Partnership

Taking Community Healthcare into the Community

Community health workers, promotores de salud, peer health promoters, lay health educators, outreach workers — natural helpers that make up the lay healthcare system are known by different names in different cultures and communities. Safety net healthcare systems rely on community health workers who bring unique qualifications and perspectives to population health management. Community health workers live in the communities in which they work, speak the language, and understand what's culturally relevant and meaningful in terms of family values, health, and spirituality.

An Institute of Medicine report says community health workers “offer promise as a community-based resource to increase racial and ethnic minorities’ access to healthcare and to serve as a liaison between healthcare providers and the communities they serve.”

Given that more than 133 million Americans — 45 percent of the population — live with a chronic medical condition such as diabetes, heart disease, obesity, arthritis and cancer — community health workers play a critical role in helping people manage these conditions. They are the link between the recommendations that are made during medical appointments and the follow through that occurs at home. Community health workers coordinate care in partnership with the healthcare system and become part of individual's support network. They are trained to educate patients, identify resources, and provide case management.

The increasing need for integrated health services places community health workers in a unique position to support behavioral health needs, particularly in racial and ethnic communities that have traditionally underutilized healthcare services. When community health workers are trained to understand mental health and substance use challenges and support health behavior change, they can work with patients outside the doctor's office, for improved health outcomes.

“Community health workers coordinate care in partnership with the healthcare system and become part of individual's support network.”

Consider the example of Ed, a 55-year-old Latino man with a 7-year history of type 2 diabetes. He missed his healthcare appointment 3 months ago and comes to the healthcare center complaining of “out of control sugars.” He also mentions that he recently lost his job, is behind on his rent, and his car is on its last leg. He's worried that if he can't find work soon, he will be homeless. He has not been consistently taking his medication or using his glucometer to check his blood sugar. He does not identify himself as depressed, but screening indicates clinically significant depressive symptoms.

A medical provider might urge Ed to redouble his efforts to take his medication. A behavioral health provider might focus on stress management and problem solving to help Ed manage his anxiety and depression and take the right steps toward stabilizing his living situation. Each of these interventions are valid and important. And with integrated care all interventions could be employed at once.

It's easy to see how a community health worker could bridge the gap by working with Ed at home. The worker can provide health education at home, walk through Ed's daily self care routine with him, review the cycle of fluctuating blood sugar levels affecting mood, explain how mood impacts self care tying and help Ed manage both his physical and mental health while trying to find work. The community health worker can also screen for depression, teach Ed to use his glucometer, provide informal counseling, accompany Ed to the local food pantry, and help him connect to social service supports. The worker can also give the healthcare team a whole new perspective on Ed's life, his strengths, and realistic and culturally appropriate expectations.

By ensuring follow up, immediate management of challenges, and continuous monitoring, the community health worker can ensure better results.

Community health workers can also educate providers about the community's health needs and the cultural relevancy of interventions.

SUZANNE DAUB

Senior Integrated Health Consultant
National Council for Behavioral Health

The National Council for Behavioral Health's Community Health Worker Training is an in-person, 2-day group training that expands the skills of community health workers to support people with concurrent physical, mental, and substance use disorders. The training helps participants understand the signs and symptoms of common mental and substance use disorders; learn the basics of counseling, cognitive behavioral therapy, and motivational interviewing; know how to make referrals and recommend supports for mental health services; and learn about mental health promotion, including stigma reduction and recovery. To learn more about the training, email Daisy Wheeler at DaisyW@thenationalcouncil.org.



WHAM!

Whole health self-management is an evidence-based practice that promotes treatment efficacy and cost savings. Research on self-management frequently uses the Patient Activation Measure to gauge knowledge, skill, and confidence in tracking four levels of activation:

Level 1 Starting to take a role

Level 2 Building knowledge and confidence

Level 3 Taking action

Level 4 Maintaining behavior

People are no longer content to receive healthcare in traditional settings such as doctor's offices and hospitals, but increasingly expect to access healthcare services where they are, when they need it, and "on demand." Increasingly, technology makes it possible and cost effective to link patients to providers and provide continuous feedback and information on health behavior anywhere the patient is, and this is driving both the location of healthcare and the types of services provided. Providing self-management education and support in the community is a way to build on this growing opportunity.

Introduced in 2012 and delivered nationwide by the National Council for Behavioral Health, Whole Health Action Management (WHAM) training

is a peer-delivered intervention — based on a SAMHSA-HRSA Center for Integrated Health Solutions curriculum — to activate mind-body self-management in people with behavioral health disorders who have, or are at-risk of having, serious physical chronic illnesses. WHAM addresses both physical and behavioral health conditions and promotes resiliency for secondary and tertiary prevention.

WHAM activates whole health self-management to maintain new health behavior using five keys to success:

- ① A person-centered goal founded on 10 science-based whole health and resiliency factors
- ① A weekly action plan that breaks the goal into small, achievable successes
- ① A daily/weekly personal log
- ① One-on-one peer support
- ① A weekly WHAM peer support group

Development and implementation of the WHAM curriculum is rooted in evidence-informed practice. A research study, the Health and Recovery Peer program, led by Emory University researcher Dr. Benjamin Druss, influenced the curriculum development. The training includes a session on health risk, screening, and resources designed by Dr. Peggy Swarbrick, a pioneer in the training of peer wellness coaches for behavioral health.

Self Management, Peer Support, & Health Behaviors

Renowned for decades of research on promoting resiliency through stress management using the Relaxation Response, the Benson-Henry Institute for Mind Body Medicine at Massachusetts General Hospital recommended the following 10 science-based whole health and resiliency factors that the WHAM person-centered goal planning focuses on:

- 🕒 Stress management
- 🕒 Healthy eating
- 🕒 Physical activity
- 🕒 Restful sleep
- 🕒 Service to others
- 🕒 Support network
- 🕒 Optimism based on positive expectations
- 🕒 Cognitive skills to avoid negative thinking
- 🕒 Spiritual beliefs and practices
- 🕒 A sense of meaning and purpose

After completing person-centered planning that documents individual strengths and supports, participants choose one goal they most want to pursue. The training then engages in a six-step process called IMPACT to write the goal in a concise format that is strength-based — focusing on what's strong rather than what's wrong — to create new health behavior.

The IMPACT goal is designed to go into a treatment plan for sustainable Medicaid billing (if approved in a state's plan of services), and promote peer support for success. In the U.S., peer support traces back to as early as 1772 when Native Americans began forming support groups to activate self-management of alcoholism. Research in the field of physical health has documented the impact of peer support: a Stanford Medical study on metastatic breast cancer found that women who engaged in a weekly peer support group lived on average twice as long as women who did not.

After setting a whole health goal, WHAM introduces a weekly action plan that breaks the goal into small, achievable weekly successes to create new health behavior reported at weekly peer groups. The action plans can be documented in health goal progress notes.

WHAM teaches several skills considered essential to whole health self-management. The first skill is how to elicit the Relaxation

Response to manage stress. According to the Benson Henry Institute, “between 60-90 percent of healthcare visits are related to mind/body stress-induced conditions.” A second key skill focuses on how to combat negative self-talk that can undermine activation of self-management. The skill of shared decision-making is introduced through role plays and one-page work sheets provided as handouts. Shared decision-making is defined in WHAM as “the collaboration of a medical professional and recipient of whole health services to determine the treatment and self-management actions for maximizing whole health.”

WHAM is designed to be implemented by the rapidly growing peer workforce. Georgia was recently approved to bill for a Medicaid service called “peer whole health and wellness” delivered by peer coaches trained in WHAM. The impact of these new peer coaches is being researched by Dr. Judith Cook at the University of Illinois at Chicago in a federally-funded, randomized study. A WHAM Implementation Manual was recently released to promote fidelity to the WHAM process when delivered at local sites by peers who have gone through the 2-day training. WHAM is also available in Spanish.

The National Council for Behavioral Health's WHAM — Whole Health Action Management — is an in-person, 2-day group training that equips peers to help the people they serve set and achieve whole health goals to improve chronic health and behavioral health conditions. Based on a curriculum from the SAMHSA-HRSA Center for Integrated Health Solutions, WHAM trains peers in person-centered planning and to facilitate 8-week support groups. After WHAM training, peers will be able to

- 🕒 *Identify strengths and supports in 10 science-based whole health and resiliency factors.*
- 🕒 *Write a whole health goal with weekly action plans.*
- 🕒 *Facilitate 8-week WHAM peer support groups to change health behaviors.*
- 🕒 *Use tools for shared decision making.*

The program also provides a participant guide, weekly action plan pocket guide, pedometers, training posters, handouts and entry to a peer listserve for shared learning. To learn how you can bring a WHAM training to your center, email Daisy Wheeler at DaisyW@thenationalcouncil.org.

LARRY FRICKS

Deputy Director, SAMHSA-HRSA Center for Integrated Health Solutions at the National Council for Behavioral Health

New Roles for Case Managers in Integrated Health Systems

Over the last 24 months of consulting and training on healthcare integration, I've seen visionary behavioral health organizations that are starting to morph case management into a "whole health" approach that we might describe as care management.

Why should we care about making the change from case management to care management?

- 1. People with serious mental illnesses and substance use disorders continue to die prematurely on account of untreated physical illnesses.
- 2. Healthcare reform is here; payment and delivery systems are changing rapidly and new systems are built on the platform of integrated care.

“Moving from case to care management can fill some of the gaps in our healthcare system.”

Currently, the US has a SICKcare system, not a HEALTHcare system. Nearly 45 percent of Americans have one or more chronic conditions. More than half of these people receive care from three or more physicians. Treating these conditions accounts for 75 percent of direct medical care in the United States. Our system was built for acute care, not for chronic care, which is what most people need.

Moving from case to care management can fill some of the gaps in our healthcare system. When you look at Wagner's Chronic Care Model, it's clear that helping people manage their own wellness is the key to helping them live with a chronic illness over time. Each individual needs to figure out their own plan and case managers can help them with that planning.

It's important to bring access, understanding, and knowledge of the community and the resources to support management of chronic illness. Case managers in behavioral health have the skills to provide this level of service. They need to expand knowledge so they can address physical illnesses in addition to behavioral health challenges.

Take the example of the person-centered health home, which is intended to offer superb access to care, engagement in care, clinical information systems, care coordination, team care, patient feedback, and publicly available information. The care manager in a health home is ideally suited to address three key aspects:

1. **ACCESS TO CARE:** The need for care is not just 9-5, Monday – Friday, with long wait times. Case managers are skilled at working in the community, meeting people where they are, and creating that easy access to needed supports and services.
2. **ENGAGEMENT IN CARE:** It takes time for people to engage and connect. But health behavior change happens only when the engagement is strong and trust has been built. Case managers have experience connecting with people who have a hard time connecting.
3. **CARE COORDINATION:** Case managers can engage directly with primary care providers to follow their patients. This supports a population health management approach that ultimately produces better outcomes.

How can case managers provide this level of care?

HEALTHCARE INTEGRATION: First, behavioral health must realize that we can no longer focus only on a person's mental health. When someone's physical health is compromised, it impacts his or her mental health.

HEALTHCARE PROVIDER PARTNERSHIP: Case managers must connect with other healthcare providers from whom their patients seek care. And case managers can know they've established successful partnerships when other providers start calling them about the people they serve.

SUPPORT HEALTH BEHAVIOR CHANGE: Case managers must develop expertise in supporting people to change their behaviors. They must learn to offer effective guidance and support when a doctor says, "exercise more" or "change your diet."

SMALL CHANGES, BIG EFFECTS: Case managers can help people manage their health and wellness by breaking down big changes into small, manageable goals.

Care managers are in a new world of healthcare. They're taking existing case management skills, integrating them with healthcare, and expanding them to look at chronic disease management as a whole health issue. They're becoming experts in health behavior change. Most importantly, they're building relationships, because positive change happens only in the context of good relationships.

JOAN KENERSON KING

Senior Integrated Health Consultant, National Council for Behavioral Health

The National Council for Behavioral Health's Case to Care Management Training is an in-person, 1-day group training that equips case managers with the expanded skills they need to act as health navigators, support health behavior change, and provide basic interventions for common health problems for persons with serious mental illness and chronic health problems. Case to Care Management training helps participants understand the differences between physical and behavioral health culture; apply basic chronic care principles to managing heart disease and diabetes; help people change health behavior and increase self-management; help people prepare for primary care appointments, and build strong partnerships with primary care providers. To learn more about the training, email Daisy Wheeler at DaisyW@thenationalcouncil.org.

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