

National Council

MAGAZINE SHARING BEST PRACTICES IN MENTAL HEALTH & ADDICTIONS TREATMENT | www.TheNationalCouncil.org

SPECIAL TEAROUT SECTION

ABCs of Wellness

Health Tips for Persons in Recovery

BREAKING NEWS

**SAMHSA-HRSA Center
for Integrated Health Solutions**

**Mental Health First Aid: A Radical
Efficiency in Health Promotion**

Linda Rosenberg, Meena Dayak

A Journey in Bidirectional Care

Barbara Mauer

Who Pays for Integrated Care?

Kathleen Reynolds

"Show Me" the Integration

William Kyles, Kimberly Connor

**Wellness: It's More Than
Being Well**

Peggy Swarbick, Lauren Spiro

Recovery and Wellness

**Real People,
Real Stories**





**A Complete
Electronic Health
Record for
Community
Based Staff**

- Completely Secure
- No Broadband or Internet Fees
- Concurrent, Client Centered Documentation
- Enhanced Compliance and Efficiency
- All the Benefits of Echo's Award Winning EHR

www.echoman.com

800.635.8209

info@echoman.com



BREAKING NEWS

- 3 SAMHSA-HRSA Center for Integrated Health Solutions

EDITORIAL

- 6 Mental Health First Aid: A 'Radical Efficiency' in Health Promotion
Linda Rosenberg, Meena Dayak

ENVIRONMENT AND POLICY

- 10 Consider the Environment: A Public Health Perspective on Integration
Benjamin Druss
- 11 Policy Update: The Victory Is Won, the Crusade Continues
Charles Ingoglia
- 12 National Council Leads the Way: A Journey in Bidirectional Care
Barbara Mauer
- 18 Survival In the New Health Ecosystem
Dale Jarvis
- 20 Substance Use Treatment: New Links in the Chain
Rick Harwood

IMPLEMENTING INTEGRATION

- 22 Reform Means Planning for Healthcare System Wellness
Laura Galbreath, Jeff Capobianco
- 24 Who Pays for Integrated Care?
Kathleen Reynolds
- 25 Pledge for Wellness
SAMHSA 10 X 10 Campaign
- 26 If You Don't Measure It, You Won't Manage It
Jeff Capobianco
- 28 Learn Together: The Power of Collaboration
Kathleen Reynolds
- 30 Behavioral and Primary Health Integration State Snapshots
- 30 Champions in More Than Football
Molly Brooms
- 31 Whole Health Plans Embark in the Sailing Capital
Herbert Cromwell
- 34 Great Examples from the Great Lakes State
Mike Vizena
- 35 "Show Me" the Integration
William Kyles, Kimberly Connor
- 38 In the Comfort of Their Own [Healthcare] Homes
Aileen Wehren, Beth Wrobel

National Council Magazine, 2010, Issue 3

Whole Health

PDF available at www.TheNationalCouncil.org



 **NATIONAL COUNCIL**
FOR COMMUNITY BEHAVIORAL HEALTHCARE

National Council Magazine is published quarterly by the National Council for Community Behavioral Healthcare, 1701 K Street, Suite 400, Washington, DC 20006.

www.TheNationalCouncil.org

Editor-in-Chief: Meena Dayak

Specialty Editors, Whole Health: Kathleen Reynolds, Laura Galbreath

Editorial Associate: Nathan Sprenger

Editorial and Advertising Inquiries:
Communications@thenationalcouncil.org or
202.684.3740.

The National Council is the unifying voice of America's behavioral health organizations. Together with our 1,800 member organizations, we serve our nation's most vulnerable citizens — more than 8 million adults and children with mental illnesses and addiction disorders. We are committed to providing comprehensive, quality care that affords every opportunity for recovery and inclusion in all aspects of community life.

- 40 Life As An FQHC
- 40 Where Patient Outcomes Drive Payer Outcomes
Dennis Freeman, Bob Franko
- 42 Where One Plus One Equals Three
John Van Camp
- 44 Where Interaction Shapes Integration
Inman White, Rick Roberts
- 46 Ending Separate Histories: Innovation in Integration
Benjamin Miller, Larry Green
- 50 Progress Notes from SAMHSA Integration Grantees
Care Plus NJ, Center for Children and Families, CODAC Behavioral Health Services, Shawnee Mental Health Center, Southeast, Inc.
- 56 From Case Managers to Health Navigators
Kathleen Reynolds
- 57 Staff Training Persists Despite Cuts: Many Agencies Turn to Online Formats
Essential Learning Advertorial

WELLNESS INFORMED CARE

- 58 Wellness: It's More Than Being Well
Peggy Swarbrick, Lauren Spiro
- 60 Peers Lead by Example
Meghan Caughey
- 62 Personal Trainers Keep "Recoverers" In-SHAPE
Kenneth Jue
- 63 Building a Stronger Foundation for Recovery
Vinland Center Advertorial
- 64 When Psychiatry Saved a Foot
Meena Dayak Interviews Jeanie Tse
- 66 Wellness Self-Management for Chronic Illnesses
Anthony Salerno, Paul Margoiles

FROM THE FIELD

- 68 Wellness and Health Promotion Spotlight
AspenPointe, Cherokee, Chrysalis, Cobb Community Services Board, Community Support Services, Genesee County, Hartford Dispensary, Lexington Clubhouse, Jefferson Center for Mental Health, Mental Health Resources, Providence Center, Skyland Trail, Stepping Stones Clubhouse, Truman Medical Center-Behavioral Health, University Behavioral HealthCare, Western Montana Mental Health

Recovery & Wellness: Real People, Real Stories

- Maxine Brown 5
- Patrick Stumer 17
- Joyce Boyd 27
- Cheryl Sharp 33
- Karl Riggans 37
- Allison Gaiter 47
- Lisa Coley 55
- Versie Reeves 71
- Ron Otto 77
- Cynthia Morse 91

ABCs of Wellness

SPECIAL SECTION

- > Staying Well, It's as Simple As Your ABCs...and D & E
- > A of Wellness: Know Your A1c
- > B of Wellness: Know Your Blood Pressure
- > C of Wellness: Know Your Cholesterol
- > Personal Health Screening Form

HEALTH PROMOTION

- 82 Bringing Mental Health Into the Mainstream, Worldwide
Vijay Ganju
- 84 Making the Workplace Mentally Healthy
Clare Miller
- 86 Stress Busters: Promoting Mental Wellness
David Shern
- 88 Addressing Depression In the Workplace
Julie Totten
- 89 New Research in Employee Health and Wellness
UNICARE Advertorial
- 90 Innovations Beyond Our Borders
Francis Silvestri
- 92 Smartphoning Your Health: A Sampling of Wellness and Medical Apps
Harvard Health Letter



[BREAKING NEWS]

SAMHSA-HRSA Center for Integrated Health Solutions

National Council to Provide Training and Technical Assistance for Health Integration

The National Council for Community Behavioral Healthcare (National Council) has won a competitive cooperative agreement from the U.S. Department of Health and Human Services (HHS) to establish the Center for Integrated Health Solutions. The Center will address the comprehensive health needs of clients with mental illnesses and/or substance use disorders by improving the coordination of healthcare services in publicly funded community settings. The Center is funded jointly by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources Services Administration (HRSA).

The Center will provide training and technical assistance to 56 organizations that have collectively been awarded more than \$26.2 million in SAMHSA grants as well as to community health centers and other primary care and behavioral health organizations.

According to HHS Secretary Kathleen Sebelius, these grants are part of an unprecedented push by the Patient Protection and Affordable Care Act to help prevent and reduce chronic disease and promote wellness by treating behavioral health needs on an equal footing with other health conditions.

"The National Council is honored to have this opportunity to assist dedicated safety net healthcare providers across the country," said Linda Rosenberg, MSW, President and CEO of the National Council for Community Behavioral Healthcare. "We are grateful for this important federal investment in saving and improving the lives of persons with mental health and addiction disorders. We congratulate the grantees and look forward to working with them, with the larger healthcare community, and with consumers of services to eliminate barriers between mental and physical health. Together, we can ensure people receive the right care at the right time, in all settings."

According to a 2006 national survey, persons with schizophrenia, bipolar disorder and major depression have lower than average life expectancy and die, on average, at the age of 53 — often from untreated and preventable chronic illnesses like hypertension, diabetes, obesity and cardiovascular disease. Lack of access to primary care and specialty medicine is a critical factor in these tragic outcomes and the new HHS grants provide an opportunity to address this public health emergency.

SAMHSA Administrator Pamela S. Hyde, JD said, "The Substance Abuse and Mental Health Services Administration is excited about the possibilities that healthcare reform brings to individuals, families, communities, and providers. Our continued collaboration with the National Council for Community Behavioral Healthcare and other organizations is critical to ensuring the successful implementation of health reform. The new grants allow us to bring needed healthcare services to patients in a coordinated and convenient manner and can go a long way in helping to improve health status."

The Center for Integrated Health Solutions will focus activities in six core areas: workforce development; knowledge application; knowledge development and dissemination; healthcare reform and policy analysis; prevention and health promotion; and quality improvement, performance measurement and data collection. An important

“Together, we can ensure people receive the right care at the right time, in all settings.”

goal of the Center is to increase the number of practitioners, consumers and families, trained in behavioral health wellness and recovery practices. The National Council is fortunate to have as partners in the Center, a diverse array of national associations, universities, and consumer-based agencies that have been the architects of the movement to integrate primary and behavioral healthcare.

“HRSA supports the work of Community Health Centers across the nation, assuring that patients living with mental health or substance abuse concerns can get the screening, treatment and referral for all their healthcare needs,” said Mary K. Wakefield, PhD, RN, Administrator of HRSA. “As health centers and other safety net providers work to meet the full range of patient healthcare needs, HRSA wants to assure that technical assistance and training are available to support those efforts.”

Over the past 10 years, the National Council has served as a critical source of information and field-tested resources for healthcare organizations, policymakers, and community stakeholders working to provide primary and behavioral healthcare across delivery systems. Clinical, organizational, collaborative, and financial tools for integrated care can be found on the National Council website at www.TheNationalCouncil.org.



NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE



SAMHSA-HRSA Center for Integrated Health Solutions

Making Integrated Care Work

The Center for Integrated Health Solutions promotes the expansion of collaborative healthcare efforts by disseminating lessons learned by early adopters, reducing barriers, and facilitating mutual information-sharing. Visit today to check out popular reports and resources such as:

- >> Behavioral Health/Primary Care Integration and the Person-centered Healthcare Home
- >> The Four Quadrant Model on Clinical Integration
- >> Financing, Policy, and Integration of Services
- >> From the Field: Case Studies of Primary Care and Behavioral Health Integration
- >> National Council Learning Communities, Learning Collaboratives, Listserves, and Virtual Networks
- >> Links to Integrated Health and Wellness Promotion Experts
- >> Wellness Programs and Tools, Tobacco
- >> Cessation Resources, Consumer-led Initiatives

And More...

www.TheNationalCouncil.org



RIPPLES IN THE POND Maxine Brown, Community Partnership of Southern Arizona



University of Arizona student Maxine Brown, a participant of the university's Recovery thru Integration, Support, and Empowerment (RISE) program's Camp Wellness, was being treated for depression when a friend suggested she exercise and go for walks. "I wasn't interested. I could barely walk a block back then," Brown recalls. She was taking medication for a bad back, and arthritic pain coursed through her body. She had weight to lose that she had been unable to get rid of on her own. "I wasn't moving or dealing with the pain," she says. It was a never-ending cycle: How could she improve if she couldn't move?

Until that time, Brown had dealt with life's obstacles the way she always had — with food. "The choices of foods that I make now are the opposite of what I used to prepare," she says. They are also easier to prepare and tastier than she thought they would be. "Just some oatmeal with blueberries or a cold bean salad with corn and kidney beans. Who knew it could be that simple?" she says. And delicious. Brown had never tried hummus before. Now, it's her favorite snack food. "It's the program," Brown insists. "It's simply amazing — I can't thank them enough."

The program has had an astounding ripple effect. Brown has been spreading the word — the gospel of good food and health — to diabetic friends and her daughter. "This program has changed my perception of myself as well as this world. I don't have to go to the doctor as much, and I don't have the same problems — the aches and pains. I got my blood pressure under control, and I've lost some weight. I'm feeling empowered. It's up to me. I realize that I have to stay the course," she explains.

Brown enjoys going to the gym whenever she can and has even made some exercise buddies in the process. "I put on some headphones and listen to the music while I walk," she says, adding that her classes taught her everything from basic safety to gym etiquette. "If I had walked into a gym on my own, I wouldn't have known what to do. I'd never used a gym before." Brown hadn't realized how important exercise was, or what an amazing experience it could be. But that never meant she wasn't willing or able to learn. She's tried some dancing and some zumba. "I caught myself thinking in a class, this is a different world," she says, her voice steeped with emotion.

"It can't just be all about the mind and forget about the body," she insists. "What I've learned here doesn't just affect me. It helps others in ways that can't be measured. This was an unbelievable gift, this program. It really made me aware of life. And it made me realize that life could be fun."

***Camp Wellness**, which began in December 2009, is the first step in a whole health initiative by the Community Partnership of Southern Arizona, which administers public behavioral health services in Pima County. The camp is a contract program of the CPSA. It targets CPSA members with serious mental illness, enhancing their knowledge and skills and helping them integrate healthy choices into their lives. The partnership receives funding from the Arizona Department of Health Services / Division of Behavioral Health Services, the Arizona Health Care Cost Containment System, and the Substance Abuse and Mental Health Services Administration.*



Mental Health First Aid: A ‘Radical Efficiency’ in Health Promotion

Linda Rosenberg, MSW, President and CEO and **Meena Dayak, MA**, Vice President, Marketing and Communications —
National Council for Community Behavioral Healthcare

As states continue to suffer the residual effects of the greatest recession of our generation and the resulting deep cuts to human services, we are all looking for ways to do more with less. The search for population-based health interventions that “different, better, and cheaper” has become the new mantra, not only in the United States but around the world.

When the budget ax recently fell on public services in England, the concept of “radical efficiency” started to gain traction. “Radical efficiencies,” modeled in a new report by the National Endowment for Science, Technology and the Arts, call for transforming the public’s experience of services they receive. The idea is not merely to tweak existing services, but to generate new perspectives on old problems to ensure a genuine shift in the nature and efficiency of the services.

The perfect example of a “radical efficiency” here in the United States is our Mental Health First Aid USA public education program. The 12-hour course is designed to give ordinary people the skills to help someone who is developing a mental health problem or who is experiencing a mental health crisis.



A tenet of the course is that early intervention prevents mental illness from becoming more severe. The course is not so much about prevention as it is about preventing escalation. Participants learn communication skills and gain knowledge about referrals to help people at onset or in crisis.

As we all know far too well, anyone, anywhere can experience mental illness or encounter others who are having problems. Mental Health First Aid owes much of its success to the fact that it is capable of working and spreading effectively throughout society.

Some of Mental Health First Aid's many benefits are that the program is self-perpetuating and self-sustaining. Certified instructors become program ambassadors and train the public in their communities, while maintaining fidelity to the national program and receiving ongoing technical and marketing assistance. Primary support comes through people paying to participate in the 5-day Mental Health First Aid instructor certification course. Once qualified, an instructor can choose to charge people to participate in a Mental Health First Aid course or offer it for free. The savings come from people seeking help early in their illness, reducing the severity of their condition, and the long-term burden to the health system.

Mental Health First Aid has been immensely successful in communities and organizations that have embraced it. Having finished the training at a mental health center in Kansas, a participant remarked, "You know, I have been working in long-term care for over 20 years and I have attended a lot of workshops. Usually, they spend most of the time talking about depression, schizophrenia, or whatever and then spend next to no time on what to do about it. This class has told me what to do."

Similar case histories from across the country have proven that Mental Health First Aid is a win-win proposition. The High Plains Mental Health Center in Hays, Kansas, has already completed 10 full trainings since 2009 with an average class attendance of 30 people.

"The numbers are not the only measure of success, however; these participants are enthusiastic and thoughtful and become our best source of advertising," says Ken Loos, a Mental Health First Aid instructor and the High Plains Mental Health Center's manager of community prevention, education, and outreach. "They tell their friends and neighbors, but they also tell colleagues in other communities."

Loos says that while participants have raved about the content of Mental Health First Aid, the largest benefit has been the reduction in the stigma of mental illness.

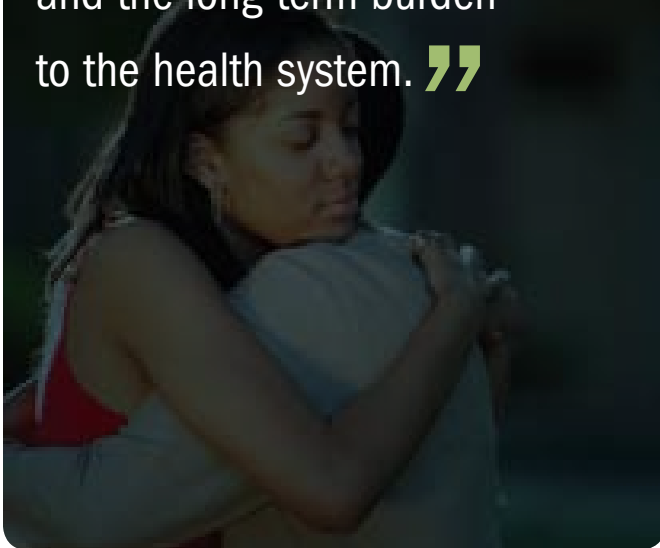
"At the beginning of each training, I inform participants that the material is inherently difficult to think about for people who have been personally affected by depression and suicide," he says. "I remind them of the suffering caused by mental illness for both the client and his or her family. Without exception, I have seen participants in each presentation become emotional; sometimes they even leave for short periods of time, but so far, they have always returned."

Radical Efficiencies and Healthcare

Five medical conditions — heart conditions, cancer, trauma-related disorders, mental disorders and asthma — were ranked highest in terms of direct medical spending in the U.S. in 1996 and 2006, according to the Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality. Mental illness, including suicide, accounts for more than 15 percent of the burden of disease in established market economies. This is more than the disease burden caused by all cancers. Yet, it is only recently that healthcare systems have focused on the mind-body connection. However, the National Council has led the bidirectional care conversation for more than 10 years. We've known that by providing comprehensive healthcare to all in need, we can help lower skyrocketing costs by intervening early in the illness process. In this issue of *National Council Magazine*, we spotlight healthcare "radical efficiencies" — in locating, staffing, and delivering primary care, mental health and addictions treatment services; in the measurement of outcomes; and in health promotion, prevention, and early intervention. We commend the outstanding work already done by pioneering organizations and remain committed to helping further the bidirectional care agenda in a post-healthcare reform world.



The savings come from people seeking help early in their illness, reducing the severity of their condition and the long-term burden to the health system. ”



Results have been just as promising at LifeWays in Jackson, Michigan. The organization offered its first class for free. After it filled in less than 10 days, they quickly scheduled three additional trainings for a fee and booked nearly every seat. In the last eight months they have already delivered Mental Health First Aid to almost 100 people.

“It never ceases to amaze me when someone who took the course stops me and says, ‘I used what I learned in Mental Health First Aid last week,’ says Heather Bridgewater, public relations and marketing manager at LifeWays. “Mental Health First Aid is a tool we can all use to break down the stigma surrounding mental illness and empower people with the skills to help someone when they need it most.”

In Fayetteville, North Carolina, the North Carolina Evidence-Based Practices Center has offered the course to a variety of audiences including county health and social service agencies, police departments, the military, hospitals, private agencies, and even school districts. Robert Wilson says every training so far has been filled to capacity. On account of recent headlines and proximity to Fort

Bragg — home of the U.S. Army’s 82nd Airborne and Special Operations — local interest began soon after the Center advertised Mental Health First Aid training in April 2010. Media coverage was followed by recognition at the Fayetteville City Council meeting, where May 17 was proclaimed as Mental Health First Aid Day in the city.

Kimberly Holm and Leslie Kveene at Woodland Centers, a Community Mental Health Center in Minnesota, say their administration has encouraged them to train as many groups as possible in their rural community. They’ve offered seven courses in 2010 and trained clergy, law enforcement officers, school workers (principals, social workers, and teachers), county social workers, probation officers, tribal social workers, administrative assistants, chemical dependency students, nurses, family members, dental professionals, a doctor, and a college professor. Word of mouth has been the most successful form of marketing. Woodlands is also training all support staff — in billing, medical records, reception, maintenance, transcription — in Mental Health First Aid.

Mental Health First Aid may also be viewed as a “radical efficiency” in promoting mental health literacy, giving participants the capacity to obtain, process, and understand the health information and services needed to make appropriate decisions. The training directly supports the U.S. Department of Health and Human Services’ general health literacy campaign. The National Action Plan to Improve Health Literacy’s guiding principles state that everyone has the right to health information to help them make informed decisions, and that health services should be delivered in ways that are understandable and beneficial to health, longevity, and quality of life.

As we continue to find creative solutions to do more with less, perhaps a little radical thinking about “radical efficiencies” is in order. Mental Health First Aid should be top of mind. The training’s overwhelming success and proven cost savings is a “radical efficiency” that truly fits the bill of a service that is different, better, and cheaper.

Linda Rosenberg is an expert in mental health policy and practice with 30+ years of experience in the design, financing, and management of psychiatric treatment and rehabilitation programs. Under Rosenberg’s leadership since 2004, the National Council for Community Behavioral Healthcare has more than doubled its membership; helped to secure the passage of the federal mental health and addiction parity law; expanded financing for integrated behavioral health/primary care services; was instrumental in bringing behavioral health to the table in federal healthcare reform dialogue and initiatives; and played a key role in introducing the Mental Health First Aid public education program in the United States. Before joining the National Council, Rosenberg served as the senior deputy commissioner for the New York State Office of Mental Health.

Meena Dayak has more than 15 years of experience in marketing and media relations for nonprofit healthcare organizations. She spearheads branding, public relations, social media, member communication, and public education initiatives — including Mental Health First Aid — at the National Council and serves as editor-in-chief of National Council Magazine. Her mission is to help member organizations tell a compelling story so the world will recognize that mental illnesses and addictions are treatable health conditions from which people can recover and lead full lives.

Mental Health First Aid USA

Overview

Mental Health First Aid is a groundbreaking public education program which introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and overviews common treatments. Those who take the 12-hour course to certify as Mental Health First Aiders learn a 5-step action plan encompassing the skills, resources and knowledge to help an individual in crisis connect with appropriate professional, peer, social, and self-help care.

Mental Health First Aid USA is managed and disseminated by the National Council for Community Behavioral Healthcare, the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health — these entities are authorized to offer a 5-day train the trainer program to certify instructors.

Growth in Two Years, 2008 – 2010

- >> **12,000 Mental Health First Aiders across the country.**
- >> 900 instructors trained to deliver program in communities across the country.



MENTAL HEALTH FIRST AIDERS

- *Law enforcement and corrections officers/other first responders*
- *Human resources professionals*
- *Business leaders*
- *Nurses and other primary care workers*
- *School and college workers*
- *Faith community leaders*
- *Mental health/substance use patients and family members*
- *Caring citizens*

>> 2,000+ sites attended Understanding Mental Health webcasts, based on the content of Mental Health First Aid, to mark May is Mental Health Month 2010.

Testimonials

"I found the course to be not only educational, but eye-opening both professionally and personally. Since the course I have adopted a new vocabulary on the topic and am much more aware of and sensitive towards potential issues with my employee population that may need to be addressed."

Cate Nield, Director, Human Resources, Access TCA, Inc. Whitinsville, MA

"Mental Health First Aid — with its new emphasis on recovery — has the power to transform communities, the power to change beliefs, and the ability to connect people in ways they never would have connected otherwise."

Larry Fricks, National Mental Health Consumer Leader



**MENTAL
HEALTH
FIRST AID**

"What struck me most about Mental Health First Aid is the interest it generates among people who don't have a direct connection to the mental health field. It's obvious that this is a program that can move us beyond usual constituencies to truly build a healthy community."

David Johnson, CEO, Bert Nash Center, Lawrence, KS

"As an HR professional who interacts with people everyday I found the Mental Health First Aid training to be extremely helpful — I have already used what I learned on three different occasions. I learned a tremendous amount of information that I can use as an HR professional and as a person."

Lynn Corwin, Assistant Vice President and Director of Human Resources, United Way of Rhode Island

"Police in Rhode Island have turned to a new mental health training initiative to help them respond to crises involving people with serious mental illnesses. ... police began offering Mental Health First Aid training to give officers more response options to help them deescalate incidents and avoid tragic outcomes. 'The new training helps our officers better understand people with mental illnesses so they can respond appropriately without compromising safety,' says Chief Anthony Silva, executive director of the Municipal Police Training Academy in Rhode Island."

International Association of Directors of Law Enforcement Standards and Training Newsletter, July 2010

To learn more, visit www.MentalHealthFirstAid.org, email Info@MentalHealthFirstAid.org, or call 202.684.7457

Consider the Environment: A Public Health Perspective on Integration

Benjamin Druss, MD, MPH, Rosalynn Carter Chair in Mental Health, Emory University

In recent years, there has been a grassroots movement toward improved integration between mental health and general medical services, particularly in public safety net settings. A growing number of mental health and medical providers, often with minimal outside funding or support, have begun to work together to improve access and coordinate care for clients treated across disparate organizations.

The passage of the 2010 Patient Protection and Affordable Care Act accelerates this trend toward integration between mental health and general medical services. Thanks to effective advocacy efforts by the National Council for Community Behavioral Healthcare and other national organizations, mental health is explicitly included throughout this legislation. New resources are becoming available through Medicaid and the Substance Abuse and Mental Health Services Administration to develop medical homes in primary care and specialty settings that address the needs of people with mental disorders. The National Council has been chosen as the national training and technical assistance center to provide support for bidirectional integration activities across these two systems.

Most preventable illness and death in the United States is the result of factors outside the formal health system, including adverse health behaviors, environmental and neighborhood factors, and socioeconomic status. Social determinants also play a central role in the development of and recovery from mental illnesses.

As we move forward in these efforts, it is important to remember that improving integration of mental health and physical health is necessary, but not sufficient, to improve the mental and physical health of the clients they serve. Most preventable illness and death in the United States is the result of factors outside the formal health system, including adverse health behaviors, environmental and neighborhood factors, and socioeconomic status. Social determinants also play a central role in the development of and recovery from mental illnesses.

Community providers are already beginning to implement model programs that combine medical and public health approaches to improving health and mental health. In Keene, New Hampshire, a community mental health center developed a program that links patients to community-based wellness activities such as exercise and dance classes as well as weight-loss and smoking-cessation programs. In Atlanta, Georgia, a Federally Qualified Health Center has

purchased a mobile clinic bus that can deliver integrated mental health and medical services to sites across the county it serves. In New Haven, Connecticut, a community mental health center hosts a weekly farmer's market for staff and clients in its parking lot.

This public health approach represents a return to community providers' historical and philosophical roots. Both the 1963 Community Mental Health Centers Act and the community-oriented primary care movement that gave birth to today's FQHCs called for these new organizations to serve geographically defined catchment areas and to consider the environments and communities in which their patients lived as central determinants of health and illness.

Health reform now offers an opportunity to adopt a broader vision of integration not only between mental health and general healthcare but also between these systems and public health. To achieve this aim, we must look outside the walls of our facilities and more fully engage with the patients we serve in the communities where they live.

Benjamin Druss, MD, MPH, is the Rosalynn Carter Chair in Mental Health at Emory University, where he works to build linkages between mental health, general medical health, and public health. He works closely with the Carter Center

Mental Health Program, where he is a member of the Mental Health Task Force and Journalism Task Force. He has been a member of two Institute of Medicine Committees and has served as an expert consultant to the Substance Abuse and Mental Health Services Administration, the Centers for Disease Control, and the Assistant Secretary for Planning and Evaluation. He has received several national awards for his work.

Mental Health

Medical services



The Victory Is Won, The Crusade Continues

Charles Ingoglia, MSW, Vice President, Public Policy, National Council for Community Behavioral Healthcare

The National Council for Community Behavioral Healthcare has been leading the conversation regarding the integration of behavioral healthcare with primary care for the last ten years. But a funny thing has happened recently – many more people are engaged in the conversation, including federal policy-makers. Here, we summarize the relevant provisions from the Patient Protection and Affordable Care Act related to integration and suggest what these provisions mean for the field and for behavioral healthcare organizations.

Since the passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act in October of 2008, every subsequent piece of federal legislation—including the reauthorization of the Children's Health Insurance Program and the Affordable Care Act—have included parity for behavioral health conditions. The Affordable Care Act went further to require that mental health and substance use treatment services be mandatory services in the Essential Health Benefits offered by private health insurance plans in the exchanges, and in the Medicaid expansion. There is broad recognition that behavioral health services are a fundamental part of the healthcare system.

The Affordable Care Act included authorizing language for SAMHSA's Primary Care-Behavioral Health Integration program, solidifying federal support for this important program that supports the co-location of primary care capacity within behavioral health organizations. This authorization was accomplished by an amendment offered by Senator Jack Reed of Rhode Island, the chief sponsor of the

Community Mental Health Services Improvement Act (S. 1188/ HR 1011).

The Affordable Care Act includes dedicated funding for the expansion of the number of Community Health Centers, and an expansion of the services that they provide, including behavioral health services.

The Affordable Care Act contains a number of delivery system re-design projects – from healthcare homes to Accountable Care Organizations – and behavioral health conditions are explicitly mentioned in both cases. As a result of the National Council's advocacy and the leadership of Senators Stabenow and Bingaman, persons with serious mental illness are mandatory populations for the Medicaid health home State Plan Option and community mental health organizations are listed as eligible medical home providers. These models will test the ability of healthcare providers to work together to manage the overall healthcare expenditures for a defined population. The prevalence data related to behavioral health conditions suggests that these efforts will fail if they do not adequately involve the treatment of underlying behavioral health conditions.

SO WHAT DOES ALL THIS MEAN?

In a nutshell, it means that we've achieved what we have been asking for the last 15 years – for behavioral health to

be recognized as an essential part of the healthcare delivery system. And how does that saying go? "Be careful what you ask for..."

The task before us is to develop relationships with other healthcare providers – hospitals, primary care practitioners, and others – to serve as a high-performing specialty provider that demonstrates results and outcomes.

The National Council will continue to develop and offer educational products – webinars, white papers, and conference offerings to assist you to navigate this changing environment. We are also working with every one of our provider associations to support their efforts as we recognize that all healthcare is local. We are confident that by working together we can thrive in a transformed healthcare system in which bidirectional integration is the expectation, not the exception.

Charles Ingoglia is vice president of public policy for the National Council for Community Behavioral Healthcare. He directs the federal affairs function of the National Council and oversees policy and advocacy outreach to more than 1,800 member organizations across the nation. He also serves as adjunct faculty at the George Washington University Graduate School of Political Management. Prior to joining the National Council, Ingoglia provided policy and program design guidance, including the review of state Medicaid waiver applications and other health and human services regulations, to the Center for Mental Health Services at the Substance Abuse and Mental Health Services Administration.



We've achieved what we have been asking for the last 15 years – for behavioral health to be recognized as an essential part of the healthcare delivery system. The task before us is to develop relationships with other healthcare providers to serve as a high-performing specialty provider that demonstrates results and outcomes.



START

National Council Leads the Way

A Journey in Bidirectional Care

Barbara J. Mauer, MSW, CMC, Managing Consultant, MCPP Healthcare Consulting and Senior Consultant, National Council for Community Behavioral Healthcare



In the fall of 2002, the National Council for Community Behavioral Healthcare started an initiative focused on the integration of mental health and primary health services. From then until 2010, the National Council's priority has been to assist members in being effective partners with Federally Qualified Health Centers and Community Health Centers, as well as other primary care providers in their state and local delivery systems — with a specific concern related to safety net populations. Throughout this journey, the National Council has operated from its core mission — drawing on the best information available from research and demonstration projects, seizing opportunities, and working to ensure that members have the best resources possible.

WHAT PROMPTED US?

The National Council began this integration journey when it identified a profound need to provide information to members and to be sure that mental health and substance use treatment services were part of the healthcare integration change processes that began ramping up in the late 1990s.

In 1995, the John D. and Catherine T. MacArthur Foundation assembled a multidisciplinary group of interested scientists and challenged them to make a difference in primary care management of depression throughout the nation. Their work resulted in the development of the Three Component Model, a specific clinical model for depression management. The 3CM research conducted primarily by Wayne Katon at the University of Washington, as well as the IMPACT trials led by Jürgen Unützer, put integration on the map.

In 2000, the Health Resources and Services Administration initiated expansion of the Community

Health Center system, with major federal funding for new sites, each of which was expected to include mental health, substance use, and dental services as a part of its comprehensive array. HRSA also partnered with the Institute for Healthcare Improvement to develop and staff the Health Disparities Collaboratives for CHCs to improve care for chronic medical conditions such as diabetes and cardiovascular disease.

In 2002, HRSA articulated a goal to eliminate disparities of underserved patients with primary mental health and substance use disorders. It offered competitive grants for existing CHCs to add mental health and substance use access and service capacity and added a Depression Collaborative to the Health Disparities Collaboratives. That year, CHCs delivered nearly 45 million patient visits, including 2 million mental health and substance use visits. In FY 2005, HRSA awarded about 50 new access grants and expanded 60 access grants worth \$16,400,000 — the target for 2006 was for 75 percent of CHCs to provide mental health services and 49 percent to provide substance use disorder services. Since those beginnings, the total number of CHCs has increased, as has the number providing mental health and substance use services.

Also in 2002, the National Program Office for Depression in Primary Care (funded by the Robert Wood Johnson Foundation) developed a clinical framework, or Flexible Blueprint, for best practice. It was based on the care model developed under The Improving Chronic Illness Care Program (also a RWJF-funded project). The Flexible Blueprint comprises six basic components encompassing key provider, health system, community, and patient factors.

This care model is one of the foundational ideas in the patient-centered medical home—an important concept for mental health and substance use or-

INTEGRATION HALL OF FAME

Pioneers and Influential Thinkers

- >> Cherokee Health Systems — Dennis Freeman, Parinda Khatri
- >> Washtenaw County — Kathy Reynolds
- >> National Association of State Mental Health Program Directors — Joe Parks
- >> Participants in the National Council's Integration Learning Collaboratives and Learning Communities

Researchers

- >> Ben Druss
- >> Jürgen Unützer
- >> Steve Bartels
- >> Wayne Katon
- >> Harold Pincus
- >> Alexander Blount
- >> Frank deGruy
- >> Larry Green
- >> Macaran Baird
- >> C.J. Peek— Joe Parks

Organizations

- >> Substance Abuse and Mental Health Services Administration
- >> National Association of State Mental Health Program Directors
- >> National Association of Community Health Centers
- >> Bazelon Center for Mental Health Law
- >> American College of Mental Health Administrators



ganizations to understand. The six components of the model are as follows:

- >> Leadership (also referenced as Organization of Health Care), one of the essential components for initiating and sustaining any program in an organization.
- >> Decision support, the implementation of practice guidelines and protocols.
- >> Delivery system design, the structure created to implement all aspects of decision support.
- >> The clinical information system, the underpinning for maximizing continuity of care.
- >> Self-management support, programs for consumers that encourage empowerment and assist them in dealing with their illness
- >> Community resources, available to consumers and their families to assist in sustaining the effectiveness of treatment.

Within this framework, the Depression in Primary Care program tested a dual focus on clinical and economic support to better manage patients with depression who are seen in primary care practices. The largest of the initiative's three components involved eight research demonstration grants to a variety of healthcare organizations. The goal of these demonstrations was to introduce incentives for identification and treatment of depression at both the system and clinical levels.

The National Council, having started an integration initiative (see Abbreviated Diary, p. 16), was invited to

participate in the annual meetings of the Depression in Primary Care program, which provided opportunities to both learn about the research in integrated care and demonstrate that the National Council was committed to bringing this information into the public sector provider system.

OPPORTUNITIES AND THREATS ALONG THE WAY

HRSA's lead integration consultant, Kirk Strosahl warned in an April 2004 article in *Behavioral Healthcare Tomorrow*:

"...[Community Mental Health Centers] seem almost oblivious to the fact that the majority of mental healthcare is being delivered not in the community mental health clinic, but in the community health clinic. Many CMHCs have reacted in a self-destructive way by viewing integrated care efforts by community health centers as a threat to their turf.... I doubt that this short-sighted approach is going to help much. The future of American healthcare is going to involve integrated primary care."

This perception of CMHCs, unfortunately, is also held by others. Although the actions of National Council members working in CHC partnerships have challenged that view over the years, we still have work to do. In reality, from the beginning of the National Council's integration work, we agreed that the future involved integrated primary care (see the Four Quadrant Model at http://www.thenationalcouncil.org/cs/best_practices_programs)

In the meantime, the mental health system itself was

recognized to be in need of transformation. For instance, the final report in 2003 from the New Freedom Commission established these goals pertaining to mental health:

- >> Educate Americans to understand that mental health is essential to overall health.
- >> Establish mental healthcare that is consumer and family driven.
- >> Eliminate disparities in mental health services.
- >> Make early mental health screening, assessment, and referral common practice.
- >> Deliver excellent mental healthcare.
- >> Accelerate mental health research.
- >> Use technology to access mental healthcare and information.

The 2005 Institute of Medicine report, "Improving the Quality of Health Care for Mental and Substance-Use Conditions," took us further with two overarching recommendations:

- >> Healthcare for physical health, mental health, and substance use problems and illnesses must be delivered with an understanding of the inherent interactions between the mind and brain and the rest of the body.
- >> The aims, rules, and strategies for redesign set forth in the Crossing the Quality Chasm report should be applied throughout mental health and substance use healthcare on a day-to-day operational basis but tailored to reflect the characteristics that distinguish care for these problems and illnesses from general healthcare.

Most of the national focus in the early years of integration was on improving mental health and substance use services in primary care settings, although the Four Quadrant Model clearly laid out the basis for bidirectional integration and attention to the healthcare needs of people being served in the specialty mental health and substance use treatment system.

In 2006, the National Association of State Mental Health Program Directors report "Morbidity and Mortality in the Population with Serious Mental Illness," documented the early death and chronic medical conditions of people with serious mental illnesses. The average age of death for this population is 53 years, and the reasons range from cardiovascular disease and complications of diabetes to other "natu-

“...[Community Mental Health Centers] seem almost oblivious to the fact that the majority of mental healthcare is being delivered not in the community mental health clinic, but in the community health clinic. Many CMHCs have reacted in a self-destructive way by viewing integrated care efforts by community health centers as a threat to their turf.... I doubt that this short-sighted approach is going to help much. The future of American healthcare is going to involve integrated primary care.”

ral causes.” The causes identified for this problem included lack of access to health screening and services, unhealthy lifestyles (eg. smoking), and the impact of antipsychotic medications on physical health. The challenge to the mental health system was reinforced in the 2007 NASMHPD follow-up report, “Measurement of Health Status for People with Serious Mental Illnesses,” which called on the system to implement a recommended set of physical health indicators for each person 18 years of age or older beginning or currently receiving mental health services. These health indicators would also be aggregated and reported for this population as a whole.

The health status of people with serious mental illnesses had not been researched with the same breadth as depression in primary care. In September 2007, the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration convened more than 90 participants for a wellness summit at which the research base was presented and the pledge for wellness was adopted. This part of the journey has barely started; however, new funding and attention to this issue in the Patient Protection and Affordable Care Act will expand the opportunities.

THE NATIONAL COUNCIL'S PRIMARY CARE-MENTAL HEALTH COLLABORATIVE CARE PROJECT

In early 2007, Phase I of the collaborative started with four sites – each a partnership between a CMHC and CHC. Phase IV of the collaborative wrapped up in late summer 2010, and Phase V kicks off in November 2010.

The following are the goals of the collaborative:

- >> Increase the ability of primary care clinics to screen for bipolar, substance use, and suicide risk as a part of conducting depression screening.

Participating Sites in the National Council Primary Care-Mental Health Learning Collaboratives

STATE	SERVICE AREA DENSITY	PRIMARY CARE PATIENTS SERVED ANNUALLY BY CHCS	MENTAL HEALTH SPECIALTY PATIENTS SERVED ANNUALLY BY CMHCS
Phase I			
Behavioral Health Network/Holyoke Health Center, Inc., Massachusetts	Urban	13,053	12,452
Behavioral Health Resources/Primary Health Care, Inc, Iowa	Urban	17,706	4,401
South Central Montana Regional Mental Health Center/Deering Community Health Center /Yellowstone City – County Health Department, Montana	Frontier/Urban	21,144	5,046
Cowlitz County Guidance Association/Cowlitz Family Health Center, Washington	Rural	14,372	2,739
Phase II			
LifeStream Behavioral Center, Inc./Project Health, Inc., d/b/a Thomas E. Langley Medical Center, Florida	Rural/Suburban	12,000	18,175
Porter-Starke Services, Inc./Hilltop Community Health Center, Inc., Indiana	Rural	2,980	6,941
Heritage Behavioral Health Center/Community Health Improvement Center, Illinois	Urban	6,892	5,189
Austin Travis County Mental Health & Mental Retardation/Community Care Services Department, Texas	Urban	45,613	14,514
Community Counseling Services/Horizon Health Care, Inc, South Dakota	Frontier	13,643	2,594
Colorado West Regional Mental Health Inc./Summit Community Care Clinic, Colorado	Rural	2,315	914
North Range Behavioral Health/Sunrise Community Health, Inc., Colorado	Rural	22,000	4,500
Highline West Seattle Mental Health Center/High Point Medical and Dental Clinic/Puget Sound Neighborhood Health Centers, Washington	Urban	4,922	3,791



Phase III			
The North Baltimore Center/People's Community Health Center, Maryland	Urban	12,514	2,219
Meridian Behavioral Healthcare, Inc./Trenton Medical Center, Inc., Florida	Rural	10,037	10,766
Southlake Center for Mental Health/North Shore Health Center, Indiana	Suburban	8,479	4,473
The Mental Health Center Serving Boulder and Broomfield Counties/Clinica Family Health Services, Colorado	Suburban	14,487	6,203
Phase IV			
Community Care Services/ Western Wayne Family Health Center, Michigan	Urban/Suburban	2,442	5,000
Community Support Services, Inc./ Margaret Clark Morgan Integrated Care Clinic, Ohio	Urban	83	6,294
Connecticut Mental Health Center/ The Primary Care Center of Yale New Haven Hospital, Connecticut	Urban	5,036	5,134
David Lawrence Center, Inc./ Collier Health Services, Inc., Florida	Rural	15,000	17,000
Southeast Human Service Center/ Family HealthCare Center, North Dakota	Rural/Urban	10,696	3,569

- >> Increase the capacity of primary care clinics to provide proactive follow-up and management of patients identified with depression in primary care.
- >> Increase the CMHC's provision of psychiatry training and clinical support for primary care, to support a more comprehensive stepped-care model.
- >> Establish processes for ongoing communication regarding collaborative care between primary care and community mental health organizations, including creating protocols for referring people with bipolar disorder and suicide risk from primary care clinics to community mental health organizations to ensure a seamless transition from one to the other, returning stable patients to primary care follow-up as appropriate, and establishing shared methods for medical management of patients at risk for metabolic syndrome who are treated in community mental health settings.
- >> Increase the capacity of both primary care and community mental health organizations to document and track care processes and performance.

The work accomplished in these sites, and the barriers and challenges that they have addressed, has helped us understand the importance of linking the implementation of integration with the emerging medical home movement – setting the stage for

mental health and substance use service providers to think about where and how they will fit within the redesigned healthcare delivery system.

THE DESTINATION

We will have accomplished the National Council's integration goals when we can say that the following statements are true:

- >> Every provider of public mental health and substance use services ensures assessment of health status and has specific protocols in place for medically monitoring all consumers receiving second-generation antipsychotic medications.
- >> Health services ensure that each person served is connected to a health home (which may be located within the mental health and substance use agency) and that specific mechanisms are in place between mental health-substance use providers and primary care providers for coordination of services.
- >> The safety net population in every community has seamless access to mental health-substance use services and physical healthcare. Safety net healthcare providers have strong working partnerships, with roles defined, referral protocols in place, and cross placement of clinical staff that

ensures the presence of integrated care in health homes throughout the community.

- >> Every state has clear policies that describe the mental health-substance use services delivered in behavioral health and CHC settings. CHCs providing briefer services, care management, and consultative services are reimbursed, and the paperwork requirements are lower than those required for serving a population with greater needs, longer duration, and more intensive mental health-substance use settings. These policies provide a template for payers other than Medicaid to support integrated care in health homes.
- >> The federal government has aligned policies among HRSA, SAMHSA, and the Centers for Medicare and Medicaid Services regarding clinical and reimbursement models for mental health and substance use care and primary care integration, and mental health and substance use services are delivered at parity no matter the state or payer.

Accomplishment of these goals will move us toward the system envisioned by the final report of the president's New Freedom Commission on Mental Health and strategically position National Council members as integral to the healthcare delivery system of the future.

An Abbreviated Diary of the National Council's Integration Journey

2003

- >> Behavioral Health/Primary Care Integration background paper, including Principles for Integration and the Four Quadrant Model
- >> Conference track, including presentations from Cherokee Health Systems and the National Association of Community Health Centers
- >> Web resources launched
- >> State Assessment Tool
- >> Agency Assessment Tool
- >> Integration consulting and training services initiated

2004

- >> Conference track, including preconference institute on IHI/HRSA Depression Collaborative
- >> Crosswalk of Evidence-Based Practices to the National Council Four Quadrant Model
- >> Integration listserv launched
- >> Closing the Gap Summit/Seattle (co-sponsored by HRSA and SAMHSA) participant
- >> Integration consulting and training services

2005

- >> Conference track, including sessions focused on models for addressing health disparities of people with serious mental illnesses
- >> Integration consulting and training services

2006

- >> Conference track, including full day workshop on IMPACT
- >> Paper on Finance, Policy and Integration of Services
- >> Book release — Raising the Bar: Moving Toward the Integration of Healthcare
- >> Integration consulting and training services

2007

- >> Primary Care–Mental Health Collaborative Care Project, phase I (January) and phase II (September) launched
- >> Conference track, including multiple sessions focused on the NASMHPD morbidity and mortality report
- >> Making the Case for Collaboration: Improving Care at the Behavioral and Primary Healthcare Interface, paper co-sponsored by the National Council and ACMHA
- >> SAMHSA National Wellness Summit for People with Mental Illnesses participant
- >> Integration consulting and training services

2008

- >> Conference track, including preconference institute: Developing a Federally Qualified Health Center
- >> Integration Learning Community launched
- >> Laura Galbreath joins National Council staff with focus on integrated health and wellness
- >> Primary Care–Mental Health Collaborative Care Project, phase III (August) launched
- >> Integration consulting and training Services

2009

- >> Conference track with boot camp on primary care and behavioral health integration
- >> Kathleen Reynolds joins National Council staff, with focus on integrated health and wellness
- >> Release of paper: Behavioral Health/Primary Care Integration and the Person-Centered Healthcare Home
- >> Online Resource Center for Primary Care and Behavioral Health Collaboration launched
- >> National Council advocacy results in passage of Community Mental Health Services Improvement Act that includes \$7 million to bring primary care into mental health organizations, 13 sites awarded SAMHSA grants
- >> Carter Center Medical Home Summit participant
- >> Primary Care–Mental Health Collaborative Care Project, phase IV (September) launched
- >> Integration consulting and training services

2010

- >> Conference track with focus on wellness, including one-day university: Implementing the Patient-Centered Healthcare Home: Concept to Reality
- >> 43 sites awarded SAMHSA grants as a result of National Council advocacy efforts focused on bringing primary care services into specialty mental health settings
- >> Release of paper, Substance Use Disorders and the Person-Centered Healthcare Home
- >> Webinar series on integration launched
- >> Integration consulting and training services
- >> National Council wins competitive HHS grant to establish the national training and technical assistance center for primary and behavioral healthcare integration, funded jointly by SAMHSA and HRSA

Barbara J. Mauer is a nationally known expert in behavioral health and primary care integration. She has more than 15 years of experience in this field and is a managing consultant for MCPP Healthcare Consulting in Seattle, Washington, and a senior consultant with the National Council for Community Behavioral Healthcare. She offers consulting services to public- and private-sector health and human service organizations on integration as well as strategic planning, quality improvement, and project management. Mauer has authored many papers and presented at national conferences on behavioral health and primary care integration.

IT'S ALL GOOD Patrick Stumer, Thresholds

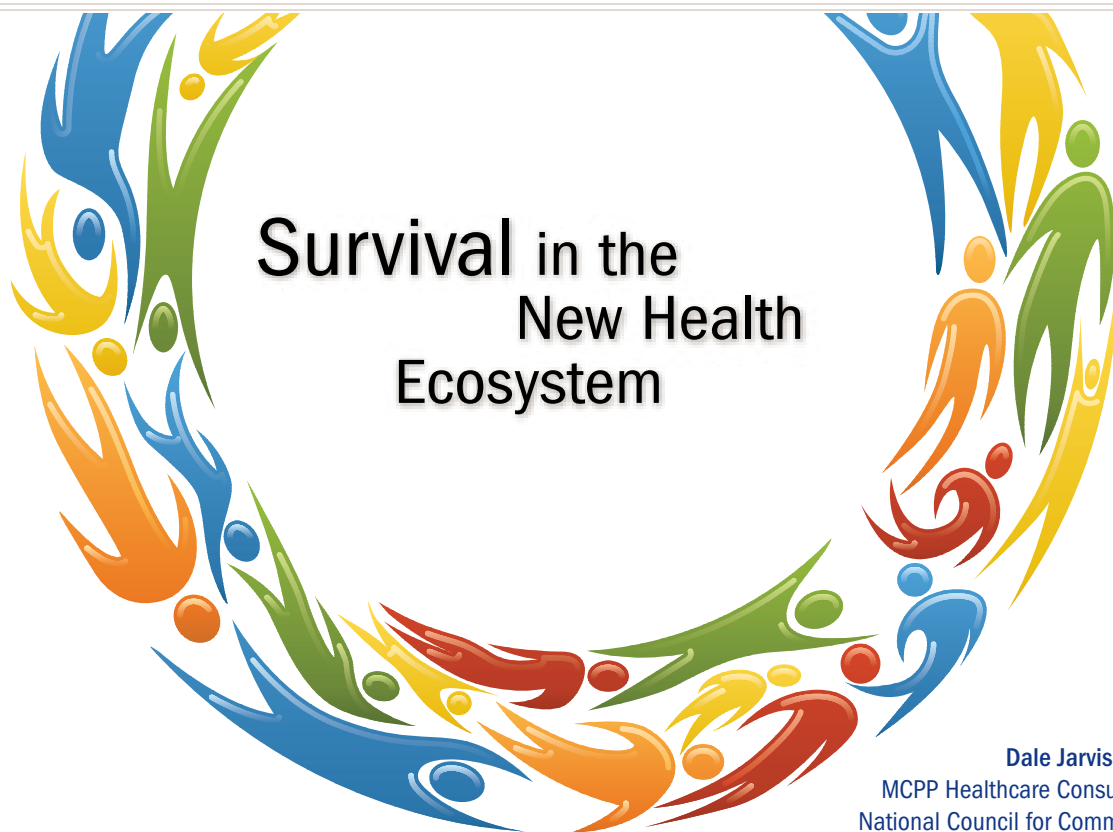
Patrick Stumer was referred to Thresholds in Chicago, Illinois, after he had been discharged from one of many previous hospital stays several years ago. And he's still a member today. What happened in the years in between all the hospital admissions and his entry into Thresholds has enabled him to work to effectively manage his health conditions: high blood pressure and diabetes as well as schizophrenia.

"They're all on the same page at Thresholds," Stumer says. "The nurses helped me with medication management. They explained why I needed to take it on a regular basis and what it was for. We talked about the side effects, and they-checked on me to see if the medicine was working or not." Along with nursing care, Stumer also received psychiatric care. "We worked on self-esteem and problem solving," he explains.

Stumer got help improving his diet and planning healthy meals. "I have to stay away from sugar and salt," he says. But what really helped in the most amazing way, he says, was learning to use physical activity to manage his stress and anxiety. He rides with the biking club and walks with the walking group. Both activities, he says, keep him up and exercising. "It really helps my mental health. Last year on some weekends, our walking group — about three, sometimes four of us — would just go out and walk and talk," says Stumer. It gave him time to sort things out and squeeze in some activity as well.

"Thresholds helped me a lot, especially the groups. I'm feeling so much better now," he says, adding, "I'm staying on an even keel. I used to struggle so much with my medications and trying to stay out of the hospital with flare ups because I'd stopped taking my medication for a while." He now takes his medication consistently because he knows why it's important. "Thresholds helps with both the medical problems and the psychological problems," says Stumer. And it's convenient: "For me, they're only a short bus ride away."





Dale Jarvis, CPA, Managing Consultant,
MCPP Healthcare Consulting and Senior Consultant,
National Council for Community Behavioral Healthcare

The Accountable Care Act is creating major changes in how healthcare services are organized, funded, and delivered in the United States. Because all healthcare is local, state-level changes will occur at different rates across the nation. We will see variation in how Medicaid expansion is supported, healthcare exchanges are developed, and medical homes and accountable care organizations are designed, among several other local variables.

Many of us are scratching our heads and wondering, “What will the health and behavioral healthcare system in my state look like when we get to 2014?” As a resident of Seattle, Washington, I have been most closely watching how healthcare reform is unfolding in my state and thinking about lessons that may be applicable to other states.

Washington state leaders, including Governor Gregoire, Senators Murray and Cantwell, and delivery system executives from Group Health Cooperative and Virginia Mason Medical Center, were instrumental in designing important insurance expansion, payment reform, and service delivery redesign components of the new law. These leaders are also positioning the state to become a national model for healthcare reform. Their proactive efforts have the potential to support the Washington safety net

population of 1.5 million — that is, residents with Medicaid coverage and those under 200 percent of the Federal Poverty Level who are uninsured — if the state’s healthcare reformers initiate specific efforts in conjunction with their federal partners to address the needs of this group.

Of particular importance to the safety net popu-

The new healthcare ecosystem organizes care around the needs of the person, rather than expecting people to organize themselves around the system.

lation, including people with mental health and substance use disorders, is the emergence of the person-centered healthcare home and the accountable care organization.

The term *person-centered healthcare home*, a variant of the patient-centered medical home, illustrates the need to expand the available services in

medical homes to include a focus on the behavioral health, housing, and social and personal supports needed to achieve and maintain health for a whole person, not just a patient. Because most healthcare homes serving members of the safety net will not be the sole provider of all health and social services and supports, they will need to work closely with other community partners such as social service agencies, schools, child care centers, family resource centers, and public health departments.

Accountable care organizations are being designed to serve as the organizing infrastructure to help healthcare homes coordinate care with specialists, hospitals, and other parts of the healthcare delivery system. These organizations will also be helping to manage new payment models, including bundled payments for hospital care and models that incentivize prevention, early intervention, and supports for people with chronic health conditions. For many Americans, especially those with behavioral health disorders, this effort will also require coordination with community partners.

Figure 1 illustrates the components of the new healthcare ecosystem that organizes care around the needs of the person, rather than expecting people to organize themselves around the system.

I anticipate that behavioral health providers, as members of the healthcare community, will be found in two parts of the diagram (see Figure 1): embedded in healthcare homes supporting the delivery of primary care and as specialty providers of high-quality behavioral health services to people enrolled in an accountable care organization. This comprehensive approach has the potential to be a new and significant stabilizing force for the safety net population, including people with behavioral health disorders, while helping better manage the growth in healthcare costs for this complex population.

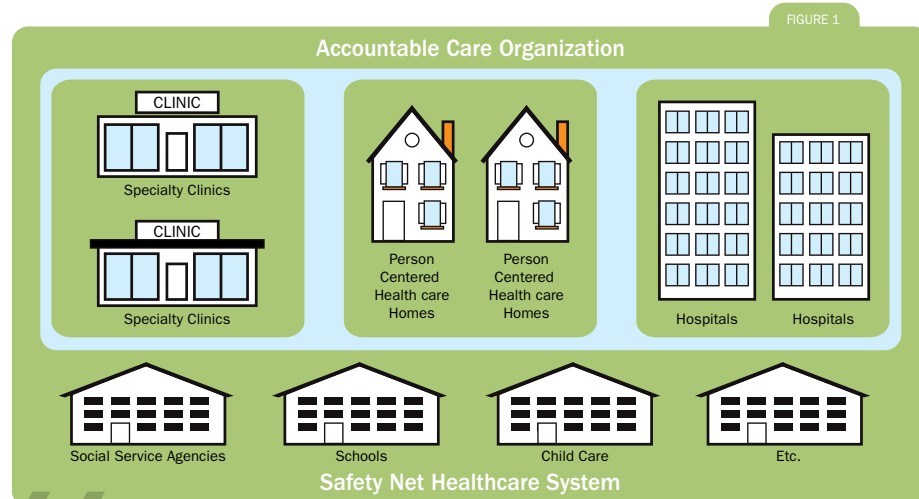
Designing a new system will not be easy. Healthcare homes and accountable care organizations will quickly learn, for example, that if they have a patient with major depression and diabetes, they will not be able to help him or her manage the diabetes until the depression is under control. Add to this scenario the facts that the patient is the head of household with children, is recently unemployed, is experiencing domestic violence, and is on the brink of homelessness. It is even more unlikely that the patient will be able to manage the diabetes unless he or she receives a full set of services and supports to achieve safety, housing stability, and treatment for depression.

This scenario, in which one person has multiple co-occurring health, housing, and job challenges, is common for people and families in the safety net. It will be particularly important for state and federal health planners to assist the safety net system of Federally Qualified Health Centers, community behavioral health providers, public health departments, and social service agencies as they design new safety net healthcare systems to better serve this population.

ORGANIZING A SAFETY NET HEALTHCARE SYSTEM

The Patient Protection and Affordable Care Act of 2010 includes more than 100 grants, demonstration projects, and other funding opportunities that have been designed to accelerate efforts to improve quality and manage the growth of healthcare expenditures.

Washington is among several states that are well positioned to work with federal and local partners to leverage a number of these initiatives to design a demonstration safety net healthcare system. This organizing effort could include the expansion or development of FQHCs that are more closely integrated with behavioral health, social services, public health,



“ Behavioral health providers will be embedded in healthcare homes supporting the delivery of primary care and as specialty providers of high-quality behavioral health services to people enrolled in an accountable care organization. ”

and other key partners, supported by a safety net accountable care organization.

The following initiatives could support this effort.

» **Accountable Care Organization Pilots (Washington State Initiative):** Washington is in the process of organizing a pilot of two types of accountable care organizations that will be supported with technical assistance provided by Group Health Cooperative. The state could sponsor the development of an additional safety net accountable care organization pilot.

» **Community Health Centers and the National Health Service Corps Fund (PPACA, title X, section 10503):** The PPACA provides for expanded and sustained national investment in Community Health Centers by more than doubling center grants between FY2011 and FY2015. It also provides a substantial increase in funding for National Health Service Corps – supported providers. The state could work with local partners to apply for funding targeted to support this demonstration project.

» **Colocating Primary and Specialty Care in Community-Based Mental Health Settings (PPACA, title V, section 5604):** Fifty million dollars have been appropriated to improve care for adults with mental illness who have co-

occurring primary care conditions and chronic diseases through colocation of primary and specialty care services in community-based mental and behavioral health settings. Several Washington community mental health center/community health center teams are already in the queue based on an application process that occurred in 2009. If one or more of these centers were to be funded, they could potentially participate in the demonstration.

WHAT ABOUT YOUR STATE?

This set of ideas represents one scenario for building a demonstration safety net healthcare system. All of these ideas are based on work already underway in Washington State. What healthcare reform wheels have begun to turn in your state? Is the community behavioral healthcare system at the design table? The train is probably still in the station in your state, but chances are, it's leaving soon.

Dale Jarvis is a managing consultant for MCPP Healthcare Consulting and Senior Consultant, National Council for Community Behavioral Healthcare. He specializes in payment and reimbursement system redesign, financial modeling, and business systems design for healthcare purchasers and providers. For more than 20 years, as a financial manager and consultant, he has helped healthcare systems identify their strengths and weaknesses, become more efficient, and provide high-quality care to their clients while maintaining financial viability.

Substance Use Treatment: New Links in the Chain

Henrick “Rick” Harwood, Director of Research and Program Applications,
National Association of State Alcohol and Drug Abuse Directors

The needs, opportunities, and challenges for linkage and integration of substance use disorder services with primary care as well as mental health services are virtually limitless. Currently, the SUD system incorporates a substantial amount of linkage, and integration is clearly on the rise.

Substance use, primary care and mental health services fill critical needs, and the evidence for integration or at least linkage of these services is growing stronger, with several validated models of service delivery available. However, best practices in terms of organization and delivery have not been clearly defined. Equally important, financial models have not yet been refined and widely implemented. Integration and linkage of services are costly, and although research shows a subsequent financial payback from integration, insurance plans and the government have been slow to provide funding. Healthcare reform presents an opportunity to advance the linkage agenda, although progress needs to be a developmental process, allowing for experimentation, evaluation, and revision.

Because SUD is a chronic condition, care coordination and linkage are at the core of treatment. The Substance Abuse and Mental Health Services Administration has produced an extensive series of technical assistance publications and treatment improvement protocols, most of which address linkage, coordination, or integration between SUD care and the many health and social systems with which SUD patients are involved. Subjects covered prominently feature mental health and primary care, criminal and juvenile justice, child and family services, housing, public and private health insurance, access for vulnerable populations and in rural and frontier areas, and information systems that weave them all together.

State SUD and mental health agencies, with the assistance of SAMHSA, are increasingly taking the initiative to achieve better linkage, coordination, and integration – and several programs are notable:

- >> Medication-assisted treatment for SUD.
- >> Care for co-occurring SUD and mental disorders.
- >> Screening, brief interventions, and referral to treatment, or SBIRT.
- >> Infectious disease (and other health conditions) screening and referral.

Medication-assisted treatment is increasingly promising. Currently, two opiate-dependence medications and five alcohol-dependence medications have FDA approval. Each of the prescribed medications is reimbursed by Medicaid, as all MAT manufacturers have signed rebate agreements with the Centers for Medicare and Medicaid Services. Since 2003, about 19,000 physicians, physician’s assistants, and nurse practitioners – the vast majority in primary care – have been waived to prescribe buprenorphine for

“Because substance use disorders are a chronic condition, care coordination and linkage are at the core of treatment. Healthcare reform presents an opportunity to advance the linkage agenda, although progress needs to be a developmental process, allowing for experimentation, evaluation, and revision.”

opiate dependence. By 2008, more opiate patients were getting buprenorphine than methadone, effectively doubling the most effective treatment modality for opiate dependence. In Missouri, the state substance abuse agency now requires all of its contracted SUD providers to have MAT capability, whether at the clinic or by linkage. Massachusetts is now funding counseling and case management at primary care practices that provide MAT.

The SUD field has been working to address co-occurring SUD and mental disorders, with varying degrees of success. Integration is a key element of the recommended approach. The Four Quadrant Model, embraced by the National Association of State Alcohol and Drug Abuse Directors and NASMHPD in 1998, is central to plans of many states to organize and deliver services for patients with co-occurring disorders. Under this model, SUD and all mental health providers should screen and assess for SUD and mental disorders, be capable of treating patients with defined co-occurring disorder patterns, and actively refer other patients to appropriate care.

SAMHSA has awarded 19 states “Co-occurring State Incentive Grants,” which has resulted in a wealth of products such as assessment protocols, program standards, implementation manuals, and training curricula. These products and technical assistance can be accessed through the SAMHSA Co-Occurring Center for Excellence. Several states have set the goal for their entire network of funded providers to be “co-occurring capable,” that is, able to serve or link co-occurring clients to the right type of care.

SBIRT through primary care providers is in a growth mode. A series of rigorous studies dating back to the early 1990s provided evidence of effectiveness as well as cost effectiveness. In 2003, SAMHSA began funding large-scale SBIRT demonstrations in 13 states and two Native American tribal entities. SBIRT reimbursement has been instated through initiatives such as the Wisconsin Initiative to Promote Healthy Lifestyles. Wisconsin subsequently decided to cover SBIRT under Medicaid, and numerous private health insurance plans in Wisconsin also cover it. The Federal Employees Health Benefits Program added coverage for SBIRT in 2010.

Infectious diseases, including HIV; hepatitis B, C, and D; tuberculosis; and sexually transmitted diseases, have long been recognized as disproportionately prevalent among people with SUD. SUD providers are often the first healthcare contact that SUD patients have accessed in some time. Integration of SUD and primary care or at least active linkage is strongly recommended by SAMHSA. Surveys find that on-site screening for infectious diseases is offered by about a quarter of stand-alone SUD and mental health providers but by a majority of providers that are affiliated with a hospital or community health center.

Integration and coordination of SUD, mental healthcare, and primary care will be important to improve delivery of MAT, co-occurring care, SBIRT, and infectious disease screening and treatment. Healthcare reform can play a role in the promotion of integration and linkage by providing improved insurance coverage for low-income populations and increased emphasis on, and support for, substance abuse prevention.

Rick Harwood has served as director of research and program applications at the National Association of State Alcohol and Drug Abuse Directors since July 2008. He has more than 30 years experience examining the economic costs of health disorders and doing economic analysis of the effectiveness and financing of healthcare, with a concentration in behavioral health. Previously, he worked at The Lewin Group, which he joined in March 1992. Previously, he served as assistant deputy director for treatment and workplace policy and as senior policy analyst in the Office of National Drug Control Policy, Executive Office of the President.

BETA TESTERS WANTED ACHC'S BEHAVIORAL HEALTH PROGRAM

The Accreditation Commission for Health Care, Inc. (ACHC) has recently developed standards for Behavioral Health providers. ACHC is seeking providers that will participate as beta test sites for validation of this program.

The standards that will be tested cover services offered to persons challenged with mental health, intellectual/developmental disabilities, and/or substance abuse issues. This unique opportunity will allow providers to verify the quality of their services against national standards, provide feedback for fine tuning of our accreditation process, and, with successful completion of the process, achieve national accreditation for behavioral health.

If interested, contact Britt Welch, Behavioral Health Clinical Manager, at 919-785-1214, ext. 233 or at bwelch@achc.org.



Reform Means Planning for Healthcare System Wellness

Laura Galbreath, MPA, Director, Health Integration and Wellness Promotion and Jeff Capobianco, Consultant, Health Integration and Wellness Promotion — National Council for Community Behavioral Healthcare

In this issue of the National Council Magazine our focus is on whole health and wellness. Wellness is not simply an absence of illness, it is an active process of becoming aware, planning for, and carrying out healthy choices that bring about positive change. Understanding and maintaining wellness is critical in every one of our lives — and in the lives of the people we serve who are recovering from mental illnesses and substance use disorders.

As members of the behavioral health community, we must engage in the active process of becoming aware, planning for, and carrying on the hard work of healthcare system reform. This kind of “healthcare system wellness” is our responsibility. Federal healthcare reform legislation is a big step in the right direction. However, maintaining wellness is an ongoing process. In considering the wellness of our healthcare system there are several dimensions we as providers and consumers of healthcare services should be attending to. These dimensions of healthcare system wellness include funding, health information technology, service provision, quality improvement and research. Some examples of the planning and activities we can engage follow.

FUNDING

- >> Reform the payment system to stop the promotion of paying for procedures and replacing it with payment based on the quality care.
- >> Aggressive reform of billing practices that stymie providers from making the necessary changes to create seamless healthcare services. Including funding for coordination of care, case management, transportation and allowing providers in every state to bill for more than one service in a day in the same clinic.

HEALTH INFORMATION TECHNOLOGY

- >> The development of patient registries for the uniform collection of clinical and administrative data. Registries will allow for better monitoring and continuity of care while helping to make the business case for behavioral and primary care services integration.



>> Making sure that our electronic health records are compliant with Health Level Seven (HL7) international interoperability standards. Required by the US Department of Health and Human Services, these standards will enable electronic medical records to exchange, manage and share information between providers. (See www.hl7.org for more information)

SERVICE PROVISION

- >> Adoption of the healthcare home approach to care. This approach requires a bi-directional care provision which challenges the traditional thinking about how providers work with one another. Specialty mental health and primary care providers must reach out to one another and work in a coordinated fashion to provide disease management services for people with severe mental illness and/or substance use conditions.
- >> The implementation of wellness programming as a Medical Home standard of care for all people diagnosed with a severe mental illness and/or substance use condition.
- >> The expansion of peer-led wellness programming as an effective way to promote healthy living and care coordination.
- >> Improving the surveillance capacity at the state and local levels. This includes the ability to provide early identification of mental and substance use disorders as well as the morbidity and mortality tied to these conditions.

QUALITY IMPROVEMENT

- >> The training of staff in the use of lean techniques for quality improvement. These approaches build on the Plan-Do-Study-Act model to rapid cycle improvement for services monitoring and enhancement.
- >> The continued standardization of screening and treatment processes through the use of evidence-based practices and validated measures.
- >> With the development of sophisticated electronic medical records healthcare organizations have more access to data than ever before. Learning how to use data to monitor and create positive change in our organizations is required if we are going to succeed in this new age of healthcare.

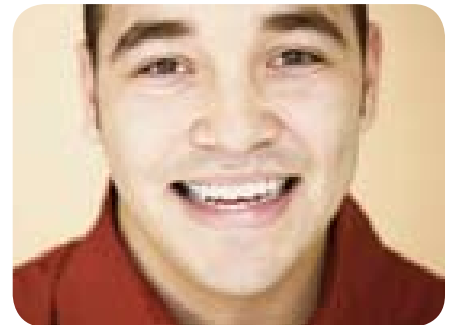
RESEARCH

- >> Every year billions of tax dollars are spent on research that is directly related to the services we provide to consumers and their families every day. It is only through engaging the research community in a discussion about how to better work together that practice can become informed by research and research by practice.

The behavioral health community has come together to help make Healthcare Reform a reality. Maintaining these gains while continuing to improve the behavioral healthcare system requires we become engaged in the activities inherent to wellness, namely awareness building, planning and the continued hard work that comes from creating high quality services.

Laura Galbreath is the deputy director of the National Council's Training and Technical Assistance Center for Primary and Behavioral Health Integration and focuses on expanding opportunities for community mental health and addictions services organizations to meet the primary health needs of the people they serve. Galbreath has extensive experience in health policy analysis, community organizing, and project management. Before coming to the National Council, she served as the senior director of healthcare reform at Mental Health America.

Jeff Capobianco, MA, PhD (Candidate) is a research investigator at the University of Michigan School of Social Work. His areas of research include quality improvement, with a special focus on lean six-sigma, family psychoeducation, and primary and behavioral healthcare services integration. He has extensive experience as a clinician, administrator, and researcher. At the state level he has led integrated health and family psychoeducation implementation learning communities. Most recently he served as the director of research and new program development for the Washtenaw Community Health Organization, a four-county behavioral health managed care organization.



“However, maintaining wellness is an ongoing process. In considering the wellness of our healthcare system there are several dimensions we as providers and consumers of healthcare services should be attending to.

Who Pays for Integrated Care?

Kathleen Reynolds, MSW, ACSW, Vice President, Health Integration and Wellness Promotion, National Council for Community Behavioral Healthcare

The financial reform that is part of healthcare reform law will not be fully implemented until 2014. Integrated behavioral health and primary care services are being provided now, however, and need to be billed. Organizations across the country, including the National Council for Community Behavioral Healthcare, are slowly but surely addressing these reimbursement issues.

Although Medicaid is unique in each state, the following four interim billing solutions can make your integrated health program financially viable right now.

>> PARTNER WITH AN FQHC

FQHCs generally are reimbursed for behavioral health services on an encounter basis. An encounter can be 10 minutes or 2 hours – but the FQHC is reimbursed at the same rate. By contracting with an FQHC and providing services at its site, you can provide additional services to more people and the FQHC can bill at its encounter rates. This approach brings more reimbursable services to more people needing behavioral healthcare in your community.

Another partnership option is for the FQHC to initiate a “change of scope” to add the mental health site to the FQHC’s network of sites. Including this site in the network will allow FQHC staff to come to the mental health site and get reimbursed for providing primary care services to mental health consumers. Usually a 90-day process, a change of scope makes providing primary care services in mental health sites a reality in communities across the country.

>> BECOME AN FQHC

Over the next four years, the Bureau of Primary Health Care/Health Resources and Services Administration will be developing or expanding new access points across the country. In August 2010, the U.S. Department of Health and Human Services announced the availability of up to \$250 million in grants for New Access Points for the delivery of primary health care services for underserved and vulnerable populations under the Health Center Program. The funds, made available by the Affordable Care Act, will be

awarded by the Health Resources and Services Administration).

A new access point is a new full-time service delivery site that provides comprehensive primary and preventive health care services. New access points improve the health status and decrease health disparities of the medically underserved populations to be served.

Many Community Mental Health Centers in underserved areas have already been successful in adding FQHC status to their business portfolio. This option is recommended only if there is no existing FQHC in your community or if the community is underserved by an existing FQHC. It is a huge undertaking to become an FQHC; however, if you decide to go this route, consider joining the National Council Learning Community on Becoming an FQHC, launching in May 2011 (contact Thea Browning at TheaB@thenationalcouncil.org) and visit www.hrsa.gov website for new Access Point applications.

>> GET HBAI CODES REIMBURSABLE IN YOUR STATE

In summer 2010, the National Council contacted each state’s Medicaid office to inquire about the status of the 96000 series of HBAI codes. These important codes allow for behavioral health specialists to bill on the same day a person sees a physician for services ancillary to a primary care diagnosis. The

Four Interim Billing Solutions

1. Partner with a Federally Qualified Health Center.
2. Become an FQHC yourself.
3. Work to get Health and Behavior Assessment and Intervention codes reimbursed in your state.
4. Complete comprehensive billing worksheets to ensure that everything that is currently billable is being billed.

results of the National Council’s survey, including limitations on who can bill the codes, and details for each state can be found at http://www.thenationalcouncil.org/cs/strategies_opportunities.

>> COMPLETE COMPREHENSIVE BILLING WORKSHEETS

Inaccurate billing information is widespread. For example, a common misconception is that two services in one day are not billable. The National Association of Community Health Centers, however, completed a recent survey and found that 28 states do allow such billing. It is important to take time to carefully review the Medicaid rules and regulations on integrated health codes in your state. Sample state-by-state integrated care billing worksheets for Medicare and Medicaid are being completed by the National Council Learning Communities and National Council. Several state billing grids have been finalized and are posted on the National Council’s Resource Center for Primary and Behavioral Health Collaboration website at http://www.thenationalcouncil.org/cs/strategies_opportunities.

*Kathleen Reynolds has more than 30 years of experience in the mental health and substance abuse field. Reynolds was the director of the Washtenaw Community Health Organization, a nationally recognized leader in the integration of behavioral health and primary care services. She coauthored a book on implementing integrated care, *Raising the Bar: Moving Toward the Integration of Health Care*.*



Pledge for Wellness

A National Call to Action for Wellness of People with Mental Health Problems



The United States Government has spearheaded the **SAMHSA 10x10 Wellness Campaign**, launched in 2010, to promote the importance of addressing all parts of a person's life in hopes of increasing life expectancy for

persons with mental health problems by 10 years over the next 10 years. More than 2,000 organizations and individuals have expressed their commitment to promoting wellness and reducing the disproportionate impact of preventable morbidity and mortality on people with mental health problems by signing the Pledge for Wellness, and the Campaign is guided by a multidisciplinary Steering Committee representing consumers, providers, and researchers.

The early mortality rates of people with mental health problems — with decades of life lost — have recently received much-needed attention. This disparity in life expectancy is unacceptable. People with serious mental health problems deserve to live long and healthy lives like other Americans. As the National Association of State Mental Health Program Directors Medical Director's Council recently reported, the "increased morbidity and mortality are largely due to treatable medical conditions caused by modifiable risk factors, such as smoking, obesity, substance abuse, and inadequate access to medical care."

Pledge for Wellness

WE ENVISION

A future in which people with mental health problems pursue optimal health, happiness, recovery, and a full and satisfying life in the community via access to a range of effective services, supports, and resources.

WE PLEDGE

To promote wellness for people with mental health problems by taking action to prevent and reduce early mortality by 10 years over the next 10 year time period.

Sign the Pledge for Wellness at www.promoteacceptance.samhsa.gov/10by10/pledge.aspx

If You Don't Measure It, You Won't Manage It

Jeff Capobianco, Consultant, Health Integration and Wellness Promotion, National Council for Community Behavioral Healthcare



Recent findings show that focusing only on patient-level changes without measuring system-level changes can inhibit progress toward integration.

The integration of primary care and behavioral healthcare services requires system-, clinic-, and patient-level changes that are not easily made unless proper attention is paid to choosing relevant measures. The old adage “That which is measured improves” speaks to the fact that when organizations focus on measuring integration, integration begins to happen.

A review of the literature reveals a wide variety of integration measures from which to choose. Unfortunately, few resources actually explain which integration measure is the best to choose and why. From the perspective of a clinic administrator or clinician, a good measure is broadly applicable and adds value in understanding program performance while mediating the significant resource allocation required to execute it. One approach to controlling the cost related to developing and implementing a new measure is to review the measures your agency already collects for state and accreditation reporting. An often overlooked set of measures can be

found in current and past short-term quality improvement projects and strategic planning documents. These measures can be leveraged to describe your integration efforts with minimal changes to your data collection infrastructure.

Because healthcare services integration requires significant system-level collaboration (which includes the integration of two or more agencies within the context of a specific community), identifying system-level measures of change is paramount. Recent findings show that focusing only on patient-level changes without measuring system-level changes can inhibit progress toward integration. A good place to start when beginning integration is to choose a model for integration that best describes your efforts (such as the National Council Four Quadrant Model) as a framework for your strategic planning documents that you create with your partner(s). Progress toward completing the integrated healthcare strategic plan objectives and goals is a good measure of your integration efforts. Examples of system-level measures include measures of collaboration, cost sharing, and the number of cross-agency partnership agreements.

Another level of integration occurs at the clinic level. Clinic-level measures roll up into the system-level measures and often depend on the system-level measures being in place (eg. to successfully refer a patient to a partner clinic, both agencies should have a clear collaboration agreement on the most efficient and effective protocol). Measures detailing the number of patients referred to a com-

munity partner agency for care, rehospitalization rates, numbers of patients seen, and cost of care are all examples of clinic-level measures. At the level of clinical care provision, measures describing the specific kind of care provided include those specific to screening and disease management. Patient-level measures include the perception of care provided. Wellness self-management achievements and patients’ perception of their health are also important measures to capture.

A final measure worth considering for inclusion in your integrated health effort is one Paul A. Nutting describes as “adaptive reserve.” Adaptive reserve includes measures of your organization’s adoption of learning organization or participatory leadership approaches to system change.

Regardless of the measures you choose to monitor and describe your integrated health efforts, it is always helpful to reach out to others who have already started the journey toward integration. You can do this through the National Council Integrated Health Resource Center website at www.TheNationalCouncil.org/ResourceCenter

Jeff Capobianco, MA, PhD (Candidate) is a research investigator at the University of Michigan School of Social Work. His areas of research include quality improvement, with a special focus on lean six-sigma, family psychoeducation, and primary and behavioral healthcare services integration. He has extensive experience as a clinician, administrator, and researcher. At the state level he has led integrated health and family psychoeducation implementation learning communities. Most recently he served as the director of research and new program development for the Washtenaw Community Health Organization, a four-county behavioral health managed care organization.

NO WHEELCHAIR FOR JOYCE

Joyce Boyd, Independence Center



Recovery & Wellness

When first approached to become a member of the Independence Center in St. Louis, Missouri, Joyce Boyd was skeptical. For starters, she was struggling with her weight. “I was also diabetic, on oxygen, and I used a cane,” she explains, “but I thought, well, I’ll give it a try.” Little by little, Boyd noticed subtle changes. Eventually, she got rid of the cane and the oxygen tank. She steadfastly works on her diabetes. “The support and the push of the staff and the other members help me,” she says. It turned out that the camaraderie of being a member and having access to physical health and wellness services were just the prescription Boyd needed to manage her physical health problems as well as her schizophrenia. “I’m a firm believer now in how exercise and a healthy diet can really help your mental health,” Boyd says emphatically. “Workouts especially — they help calm the voices.”

Mike Keller, executive director of the Independence Center, says that Boyd has made a great deal of progress. “The clubhouse atmosphere can be life saving and life changing,”

he says. Jenia Kincade, the wellness program coordinator, explains, “Everything here is based on relationships,” which include members mentoring other members and a rigorously trained staff that help members approach healthy living in a practical, real-world way. “We train our staff to be wellness coaches to help members learn how to grocery shop,” Jenia says. They focus on prevention and healthy lifestyles. Members receive screenings for cholesterol and diabetes and learn how to prevent a catastrophic health crisis.

Boyd says that before she joined the center, her father worried that if she kept going in the same direction, she would spend the rest of a very short life in a wheelchair. Now, Boyd is able to work out with enthusiasm. “I like that I can go to the gym and I don’t have to wear those tights,” she laughs. She also takes stretching classes and yoga.

Boyd’s previous diet was abysmal. “I used to have this thing about soda. I couldn’t go 4 hours without a Big Gulp,” she explains. Boyd started weaning herself off regular sodas and going instead for diet drinks before she went off sodas altogether. She used her newfound knowledge to make healthy substitutions in her diet and to cook her meals — no more fried chicken and ice cream. “The staff told us to write down everything we ate to see where we went wrong,” she explains. However, Boyd took it a step further by writing down her moods when she ate. “If I ate 20 cookies, it was usually when I was having an emotional problem,” she says. Boyd is ecstatic about craving carrots instead of calorie-laden, sugary foods. “I can’t believe it,” she says of her 180-degree turn around. “If you feel physically good, chances are you’ll feel mentally good.”



Learn Together: The Power of Collaboration

Kathleen Reynolds, MSW, ACSW, Vice President, Health Integration and Wellness Promotion, National Council for Community Behavioral Healthcare

For more than five years, the National Council for Community Behavioral Healthcare has been offering group learning experiences for member agencies and their primary care partners. The initial Primary Care-Mental Health Learning Collaboratives initiative (Phase I) developed by the National Council drew heavily from the Institute for Healthcare Improvement's Learning Collaborative model. In the Learning Collaboratives model, groups of three to six pairs of sites agree to participate in a year-long process focused on implementing standard screening and follow-up interventions for treating depression and bipolar disorder in primary care. With support from Jürgen Unutzer, MD, from the University of Washington, many sites implemented the IMPACT model of depression care in primary care settings.

Learning Collaboratives emphasize the collection of routine Patient Health Questionnaire 9 scores and the use of data to make decisions around treatment changes and increase levels of care. This high-intensity Learning Collaboratives initiative continues, with Phase V beginning in the fall of 2011.

In 2009, the National Council expanded this model of learning to more sites through the development of the Learning Community concept. Learning Communities are similar to Learning Collaboratives; however, they include up to 30 pairs of behavioral health and primary care partners per community. Each learning community begins with an onsite learning congress, where the group learns together about integrated health concepts and models. Work plans are established, and monthly coaching calls assist sites in meeting established benchmarks. Quarterly webinars on topics of interest to all the participants continue the group learning process. All Learning Communities are also supported by a web-based education site with a discussion board, resource section, member profiles, and a wiki. This joint, peer-based learning process helps reduce the length of time it takes to implement integrated health and provides support to ensure that the implementation process is successful.

State-based integrated health Learning Communities are currently available in California, Colorado, Illinois, Maine, Ohio, and Texas. In addition, Mental Health Corporation of America and the National Council sponsor Learning Communities for sites across the nation. Three National Council Learning Community participants discuss their experiences and lessons learned.

AROOSTOOK MENTAL HEALTH SERVICES AND PINES HEALTH SERVICES INTEGRATED HEALTH CARE

Mental Health Corporations of America Learning Community

Lorraine Chamberlain, LCSW, Director of Outpatient Operations and Emergency Services, Aroostook Mental Health Services

In Maine on the Canadian border, Aroostook Mental Health Services, a comprehensive Community Mental Health Center, and Pines Health Services — a Federally Qualified Health Center since 2007, have partnered to deliver integrated health services in their rural community, which covers approximately 3,000 square miles.

AMHC and Pines have identified nine key points for consideration when seeking to develop integrated health services:

1. Support the integration team and provide strong executive leadership.
2. Ensure that leadership communicates a strong integrated service vision.
3. Encourage healthcare providers to communicate effectively using "warm hand-offs," a single medical record, and structured "provider memos" to support referrals and integrated treatment planning.
4. Hold monthly performance and utilization review meetings to ensure that the service is meeting patient and provider needs.
5. Use effective and efficient assessment and outcomes measurement tools.
6. Be flexible when identifying the service delivery models.
7. Resolve medical record, office space, provider certification, team communication, and billing issues to optimize service delivery.
8. Manage the "culture" change; don't let the culture manage you. Make integrated care a priority for your organization.
9. Participate in a learning community to share findings and learn new techniques to improve service delivery.



This joint, peer-based learning process helps reduce the length of time it takes to implement integrated health and provides support to ensure that the implementation process is successful.



EL PASO FIRST HEALTH PLANS AND EL PASO MENTAL HEALTH AND MENTAL RETARDATION

Texas Learning Community

Janel Luján, LMSW, Case Management Coordinator, El Paso First Health Plans, Inc.

El Paso First Health Plans and El Paso Mental Health and Mental Retardation have partnered to create a co-case management model that integrates medical and mental healthcare for children, adolescents, and adults. The purpose of this collaboration is to bridge the gap between medical and mental health systems of care while establishing best practices that guide appropriate resource utilization. The current population consists of children and adults with comorbid behavioral health and medical care concerns. Licensed social workers with master's degrees, professional counselors, and registered nurses from each respective agency use a clinical assessment tool that explores the participants' biological, social, and psychological needs (i.e., the Biopsychosocial model)

The two agencies exchange data on critical elements like emergency room visits, ER inpatient hospitalization, inpatient psychiatric hospitalization, primary care physician office visit, specialist office visit, and pharmacy. The data collected are recorded in a web-based portal to analyze resource utilization and costs. The portal is a tool uniquely created for this collaboration.

The multidisciplinary team meets on a monthly basis to review current treatment plans, identify unmet needs, and make recommendations for follow-up contact. All recommendations are documented on the clinical assessment tool. A consulting medical physician and psychiatrist from each agency provide treatment recommendations on an as-needed basis. Joint home visits are made when needed to engage consumers in services.

COMMUNITY SUPPORT SERVICES, INC./ MARGARET CLARK MORGAN INTEGRATED CARE CLINIC, OHIO

Phase IV Learning Collaborative

Kim Shontz, Director of Outpatient Services, Community Support Services, Inc.

On November 11, 2008, the Margaret Clark Morgan Integrated Care Clinic opened its doors after more than a year of planning and collaboration with community partners that included local universities, medical providers, the Margaret Clark Morgan Foundation, and the BEST Center. The Community Support Services model of integrated care is one of collaboration. The clinic is fully operated by Community Support Services with contract providers. The clinic includes an on-site pharmacy and laboratory, operated by local providers. In the first year of operation, clinic staff successfully identified and treated health conditions that were previously undiagnosed.

The clinic is currently entering its third year of operation and offers 26 hours of primary care services provided by a nurse practitioner and a family practice physician. The clinic gives care to nearly 500 mental health consumers and recently received a 3-year accreditation from the Accreditation Association for Ambulatory Health Care.

In 2009, the clinic began to work with the National Council as part of a primary care collaborative project that offered expertise and collaboration with other integrated care clinics. This effort has allowed staff to learn from each other's programs and to discover diverse models of integrated care. Clinic staff is also working with the National Council to assist others in pursuing implementation of integrated care clinics.

*Kathleen Reynolds has more than 30 years of experience in the mental health and substance abuse field. Reynolds was the director of the Washtenaw Community Health Organization, a nationally recognized leader in the integration of behavioral health and primary care services. She coauthored a book on implementing integrated care, *Raising the Bar: Moving Toward the Integration of Health Care*.*

Integration Evaluation Specialists

Outcome evaluations for the integration of behavioral health services with primary care using standardized and customized assessment instruments.

- Behavioral and Physical Health Outcome Assessments
 - Process Assessments
 - Model Fidelity Assessments
- Patient Utilization and No Show Rate Assessments
 - Provider Satisfaction Assessments
 - Client Satisfaction Assessments

Call for free consultation / sample products



Gary Bess Associates

800 546 3863

www.garybess.com

Behavioral and Primary Health Integration: State Snapshots



ALABAMA

Champions in More than Football

Molly Brooms, Director, Office of Mental Illness Community Programs, Alabama Department of Mental Health

The Alabama Department of Mental Health, in concert with state-level partners, received Transformation Transfer Initiative grants in 2008 and 2010 to address the early mortality of people with serious mental illness. The grants were awarded on a competitive basis by the National Association of State Mental Health Program Directors using funding from the Substance Abuse and Mental Health Services Administration. State partners include the National Alliance for Mental Illness–Alabama, Wings (statewide consumer organization), Alabama Family Ties (organization for families of children with severe emotional disturbance), the Alabama Medicaid Agency, the Alabama Department of Public Health, the Alabama Hospital Association, the Academy of Pediatrics, the Academy of Family Physicians, the Alabama Primary Health Care Association (a statewide group representing Federally Qualified Health Centers), and the Alabama Council of Community Mental Health Boards. All the activities discussed here were planned and implemented with the participation and support of the partners.



Consistently identified topics

included effective lines of communication, development of personal relationships that support effective referrals, cross-training, colocation, and billing issues.



The 2008 grant supported 10 regional roundtables in which local representatives of each state partners convened to identify opportunities and challenges to improving collaboration among primary care and mental health providers. Consistently identified topics included effective lines of communication, development of personal relationships that support effective referrals, cross-training, colocation, and billing issues. This grant also partially supported an adult psychiatric institute and a child and adolescent psychiatric institute, which focused on primary care issues and the participation of primary care physicians.

The 2010 grant has three main elements. First, two expert panels comprising primary care physicians and psychiatrists were convened to address issues of specific concern to medical practitioners. The results of a survey of psychiatrists and primary care physicians were shared with the panels.

Second, six grants were awarded to local partnerships involving Community Mental Health Centers and FQHCs to develop written plans to improve collaboration. With technical assistance from NASMHPD, three national experts — Joseph Parks, Benjamin Druss, and Kathy Reynolds — met with the local partners to provide information on best practices and to address questions and concerns arising from local discussions. The development of these plans is expected to position the local partnerships to apply for grants from SAMHSA supporting integration of primary and mental healthcare.

Third, the child and adolescent psychiatric institute focused on integration of primary and mental healthcare, with a special emphasis on Alabama Medicaid Agency plans to develop medical home networks in the upcoming year.

Numerous opportunities have been created to build on the relationships initiated or enhanced with the grant support:

>> The Alabama Medicaid Agency now covers telepsychiatry as part of its Physician's Program.



- >> The Alabama Medicaid Agency issued a policy advisory regarding ways in which FQHCs and CMHCs could collaborate and bill mental health services.
- >> The Alabama Department of Public Health has offered patient education materials and expertise to mental health centers to support wellness initiatives.
- >> The Alabama Department of Public Health, Medicaid Agency, Department of Mental Health, and child welfare and corrections agencies are meeting to address the myriad of issues presented by implementation of healthcare reform and parity.
- >> The Alabama Medicaid Agency is including the Department of Mental Health as a partner in the development of its medical home concept.
- >> The Alabama Primary Health Care Association has included a mental health track in two of its annual conferences.

MARYLAND

Whole Health Plans Embark in the Sailing Capital

Herbert S. Cromwell, Executive Director, Community Behavioral Health Association of Maryland

Community mental health programs in Maryland have tried for some time to incorporate whole-person wellness programming into their service array. The 2006 National Association of State Mental Health Program Directors report on the shortened life expectancy of people with mental illnesses spurred the members of the Community Behavioral Health Association of Maryland into more concerted action.

CBH is the professional association for Maryland's network of community providers that serve the 110,000 children and adults who use the state's public mental health system. Member providers operate outpatient clinics; rehabilitation programs; and a variety of housing, vocational, crisis, and related services that support recovery and community participation.

TASK FORCE FINDINGS

Soon after the release of the NASMHPD report in 2006, CBH formed a Task Force on Integrated Care to strengthen its ability to respond to the somatic challenges of the people our agencies serve. The first step was to document the scope of comorbidity. The task force surveyed its member agencies to assess the following:

- >> What are the most common health problems experienced by people served by CBH agencies?
- >> What are the modifiable risk factors that affect current health status?
- >> What problems do consumers and member agencies experience in accessing appropriate medical services?
- >> What consumer vulnerabilities affect securing medical care?
- >> What reimbursement or resource issues limit CBH agencies in securing appropriate care?
- >> Have CBH agencies implemented best or promising practices to address the medical needs of consumers?

The task force findings mirrored those of the NASMHPD report:

- >> A majority of programs identified diabetes, infectious diseases, cardiovascular disease, and oral health as common healthcare problems among their service recipients.

- >> A majority identified smoking, alcohol and drug abuse, obesity, and poor nutrition to be widespread.
- >> Several programs cited difficulty in finding somatic providers willing to see users of the public mental health system, an absence of specialty care, and consumer reluctance to seek care as common problems in securing appropriate medical services.

HEALTHCHOICE

Most people served by the public mental health system are eligible for Medicaid. As such, they access somatic care through Medicaid's managed care program HealthChoice or via fee-for-service Medicaid providers. When HealthChoice was established in the mid-1990s, Maryland policymakers did not want to turn community mental health services and financial risk over to for-profit managed care companies that were ill-prepared to deliver the specialized services and supports needed by most users of the public system. As a result, mental health was carved out of HealthChoice, and it remains so today.

HealthChoice managed care organizations are supposed to be the "medical home" for Medicaid recipients, but the complex psychiatric conditions of public system consumers often compromise access to care and continuity of care. Because community mental health programs generally have longstanding relationships with the people they serve, they often become consumers' real medical homes. As in most states, however, community mental health programs in Maryland are not funded to deliver somatic care or to provide medical case management to facilitate access to such care.

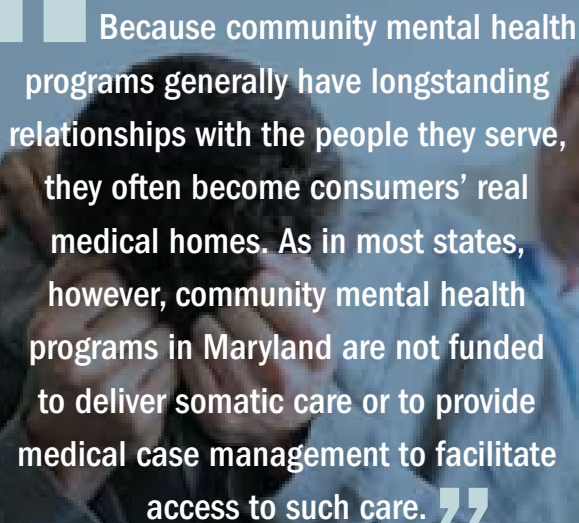
ACTIONS TO DATE

CBH members believe that public mental health system recipients would be able to access primary and specialty medical care more easily and effectively if somatic care professionals were embedded within community mental health programs; therefore, much of our work has focused on assisting our agencies to do just that. Actions and accomplishments since the task force's first meeting in January 2007 include the following:

- >> CBH helped win passage of state legislation to include community mental health programs among the "community health resources" eligible for integrated care

grants made by a new state Commission on Community Health Resources.

- >> So far, three CBH member agencies have won integrated care grants from the commission. Johns Hopkins Bayview Community Psychiatry program received one of the first grants and used the funds for a research-based Access to Wellness project, an “augmented primary care” effort encompassing health assessment and wellness management utilizing a nurse practitioner and a somatic case manager. In June 2010, Mosaic Community Services and People Encouraging People won commission grants to support the hiring of a somatic nurse practitioner; Mosaic’s nurse practitioner works at the agency site and PEP’s nurse practitioner works with assertive community treatment teams.
- >> The University of Maryland Community Psychiatry program received a state mental health authority grant to hire a family practice nurse practitioner to assist consumers with access to care and care coordination and to provide education on a variety of individual health-related issues such as diet, exercise, and use of medical equipment.
- >> The Task Force on Integrated Care became a full committee of the CBH Board, chaired by the CEO of St. Luke’s House, a member agency with a long history of innovation.
- >> The Committee on Integrated Care held an integrated care forum for interested stakeholders in January 2009 featuring initiatives by CBH members. Presentations included changing clinical practice in outpatient settings by the University of Maryland Community Psychiatry program and a Healthy Lifestyles wellness initiative by Way Station.
- >> The Committee on Integrated Care continues to facilitate exchange of best practice-oriented resources, strategies, forms, and other tools among CBH members. Information has been shared on care for older adults by Arundel Lodge and Volunteers of America; operating a medical day program by Mosaic; wellness and the illness management and recovery evidence-based practice by Pathways; and somatic screening and case management by St. Luke’s House.
- >> The committee held a webinar in June 2010 on progress to date of Hopkins Bayview’s Access to Wellness program led by Anita Everett, MD.
- >> CBH members have played key roles in the work of the “aging-in-place” workgroup of Maryland’s mental health transformation project; preliminary policy recommendations aim to incorporate nursing services within residential rehabilitation settings to help maintain community tenure for people whose somatic care needs put them at risk of nursing home or state psychiatric hospital placement.
- >> With advocacy support from CBH, the state health department’s Maryland Quit Now smoking cessation program has devoted portions of recent trainings to tobacco use by people with severe and persistent mental illnesses.
- >> Seven CBH members have supported consumer participation in Achieve, a Hopkins-led weight-loss intervention research study.
- >> CBH succeeded in including behavioral health in 2009 state legislation offering incentives to healthcare providers to implement electronic health record



“Because community mental health programs generally have longstanding relationships with the people they serve, they often become consumers’ real medical homes. As in most states, however, community mental health programs in Maryland are not funded to deliver somatic care or to provide medical case management to facilitate access to such care.”

systems; it continues to advocate for full behavioral health inclusion in ongoing state health information exchange efforts.

PRELIMINARY RESULTS

Although it is too early to report concrete clinical outcomes, agencies conducting integrated care projects are positive about their experiences so far. For instance, the University of Maryland Community Psychiatry program reported that since January 2010, 80 referrals were made to the nurse practitioner for the following reasons: refusal to see a primary care physician (2.5%), coordination of care (11.4%), education to manage a chronic condition (20.3%), focused problem or a specific acute issue (38%), and no connection to a primary care physician (27.8%). The nurse practitioner took the following actions for 41 of the 80 patients: ordered imaging tests (4.9%), ordered labs (12.2%), started the patient on medication (51.2%), referred the patient to the emergency room (9.8%), and other (22%).

The CBH Committee on Integrated Care is also charged with bringing about policy and programmatic change for Marylanders with co-occurring mental illnesses and substance use disorders. Individual CBH member agencies have organized integrated dual-disorder treatment teams and taken related steps to integrate mental health and addiction care, but this undertaking has largely been on their own initiative with private grant funds. The state has different administrative agencies with separate budgets and regulations for mental health and addictions (as well as for developmental disabilities). Unlike Maryland’s role as national leader in supported employment, the state has yet to make a commitment to evidence-based practice in dual disorder treatment.

Our work to date has not resulted in whole-person care integration in Maryland, the public mental health system, or any individual agency. Many more financial and regulatory barriers have to be surmounted, more best practices have to be learned, and more leaders within and beyond CBH have to make care integration a higher priority. However, we have made a start, and as with many other advances, the provider community is leading the charge.

NOTHING I CAN'T SURVIVE Cheryl Sharp, On Our Own Maryland



Cheryl Sharp, Wellness Recovery Action Plan (WRAP) outreach coordinator with On Our Own Maryland, a statewide mental health consumer education and advocacy group, had been hospitalized nine times by the time she was 24 years old. Sharp had wrestled with mental illness and addiction since her teens, and eventually, other health problems cropped up. “I continued to struggle. I wanted to die. Life was just too overwhelming,” she says. Her mental illness coexisted with fibromyalgia and chronic fatigue. Many days, she was absolutely paralyzed. “I took care of my children. But I’d be in bed most of the time. I’d do what my children needed, and then go back to bed again,” she explains.

Over the years, living in North Carolina and always seeking answers and knowledge, Sharp eventually found her way into alternative treatment. For the first time ever, her mental and physical health were dealt with in a way that worked for her. “Deep tissue massage therapy was very helpful,” she says. “I started it when I was pregnant. Human touch is something we never get enough of, and massage therapy was a safe way to get comfortable in my own body.”

Sharp finds physical activity refreshing and centering. “I’m an avid sailor,” she says. She is not a lazy, sunny day sailor; Sharp races. She loves working on the boat (and her arms prove it). She walks the dog and stays active with her children — a 25-year-old and 12-year-old triplets — and her 19-month-old grandchild. “It’s little steps along the way and learning how to build exercise into your day,” she says. Sharp grew up on a traditional Southern diet. “I like my steak once in a while,” she admits, “but we also eat chicken and fish. We’re cook-at-home people. I don’t deprive myself, but I pay attention to what goes into my body, and how much of it.”

Mental illness can be debilitating, and complicated by the stress and the stigma. It fed into the fibromyalgia and the chronic fatigue,” Sharp explains. “And then you go to a doctor, and he says it’s all in your head. I would say, ‘Tell my legs that it’s not real.’” Healthcare professionals typically are unable to grasp the level of trauma a person with mental illness has experienced and how that affects their physical health — or how physical illnesses bring on depression. “If you don’t know how to talk to your doctor, you can’t be proactive in your own wellness and recovery,” she says. This approach to healthcare is a large part of what Sharp does now — empowering patients with mental illness to take charge of their own care.

“There’s nothing I can’t survive, and there’s nothing I can’t achieve that’s within my abilities,” says Sharp. “I’m learning how to dream again and set a course. My eyes are always on the horizon of where I want to go and that allows me to be right in the moment and see what’s right in front of me.”



MICHIGAN

Great Examples from the Great Lakes State

Michael Vizena, Executive Director, Michigan Association of Community Mental Health Boards

During the past decade, Michigan's 46 county-based Community Mental Health boards have become increasingly focused on the need to better coordinate and integrate the physical and behavioral healthcare services for people with serious mental illnesses, developmental disabilities, and substance use disorders. Building on the strengths of existing community partnerships and available community resources, the CMH boards are developing a variety of local models to improve health outcomes for people with chronic health and behavioral disorders.

In Muskegon County, CMH Services of Muskegon County has placed integration of behavioral health with primary care at the forefront of its strategic planning efforts. Recognizing that almost 40 percent of its active caseloads used physicians from one of two local Federally Qualified Health Centers as the primary care physician, Muskegon CMH worked over several years to build trust and a collaborative working relationship with those centers. It established credibility with the FQHCs through regular communication and dedicated staff to respond immediately to concerns or problems with CMH clients served in these settings. Muskegon CMH offers weekly psychiatric consultation to the primary care site, and a full-time clinician with mental health and substance use disorder expertise is now placed at one of the centers.

As a result of this collaborative work, the FQHCs now accept referrals for people with serious mental illness who have been stabilized at the CMH for 6 months. This relationship allows clients to receive physical and behavioral health services through a single provider — their primary care physician — and improves access at Muskegon CMH for people with more complex psychiatric needs.

Summit Pointe, the mental health authority in Calhoun County, has created a primary care practice (Summit Healthcare Group) within its network of behavioral health services. The primary care services create a one-stop, holistic solution for 200 clients. The practice also accepts referrals from the general community; in doing so, the practice diversifies revenue sources and reduces the stigma related to support for those with serious mental illness and substance use disorders.

In addition to a primary care physician, the SHCG employs peer support specialists to provide integration, education, mentoring, and advocacy support services. The peers have been trained in the Stanford Disease Self-Management Program (called PATH in Michigan) and help clients develop self-management skills in wellness and management of chronic health conditions. Working with the Flinn Foundation, SHCG has started an evaluation of this new service initiative. Although the data are preliminary, early assessment suggests that improvements in treatment attendance and adherence are leading to better physical and behavioral outcomes for participants.

In Macomb County, Macomb County CMH Services has collaborated with a local hospital's family practice residency program to improve access and coordination of physical healthcare for its consumers. The hospital's mobile outreach

clinic visits Macomb County CMH's outpatient sites monthly to provide health services and share clinical information to better coordinate clients' physical and behavioral treatment. CMH has also initiated a pilot health registry project to electronically track clients' health status, using the physical healthcare parameters identified by SAMHSA. The project uses information generated by the mobile outreach clinic population to refine the reporting tool and assess capability to input and transfer data through its electronic medical record system. Working with three of its county's medical health plans, CMH is also identifying shared consumers who are high users of emergency and inpatient services, both for physical and behavioral services, to develop a collaborative effort to improve coordination of care and reduce utilization of high-intensity, high-cost services.

Building on the strengths of existing community partnerships and available community resources, the Community Mental Health boards are developing a variety of local models to improve health outcomes for people with chronic health and behavioral disorders.

In Washtenaw County, the Washtenaw Community Health Organization has partnered with five local primary care clinics to provide on-site outpatient clinicians dually trained in mental health and addictions treatment. A consulting psychiatrist is also available to work with primary care physicians at these clinics to assist in cases in which additional expertise is needed to manage complex issues related to psychotropic medication. In addition to improving physical and mental health outcomes, the Washtenaw CHO and its partners have sustained this integrated partnership with a variety of funding sources, including Medicaid reimbursement, capitated health plan support, and third-party billable services.



MISSOURI

“Show Me” the Integration

William Kyles, MA, MPA, President and CEO, Comprehensive Mental Health Services, Inc., and Board Chair, National Council for Community Behavioral Healthcare; **Kimberly Connor, PhD**, Assistant Professor of Counseling, Lincoln University, CMHC/FQHC

Missouri is a national leader in searching for ways to prevent people with serious mental illness from dying at an early age. Health and wellness strategies for persons with mental illness include Community Mental Health Center and Federal Qualified Health Center collaborations, hospital partnerships, enhanced use of health technology, disease management and wellness programs, and healthcare homes. The approaches are not part of a single strategy but represent a progression of strategies that have come together over time.

Although much of the push to improve integrated care has occurred since 2005, CMHCs began partnering with hospital systems in the 1990s. Some of the largest safety net health systems in Missouri have had partnerships with CMHCs (e.g., BJC Healthcare, Truman Medical Centers, Ozark Medical Center, Freeman Health/Ozark Center, and Cox Health Systems/Burrell Behavioral Health). These affiliations strengthened both CMHCs' focus on physical health and health systems' focus on behavioral health.

Missouri's history of the treatment and care of people with mental illness has been affected not only by best practices or trends of the time but also by significant research contributions, political support, and proactive leadership. The Missouri Medicaid Reform Commission acknowledged that reform was essential and would require a system transformation. It recommended an emphasis on prevention along with early intervention and support for approaches that strengthened connections between FQHCs and CMHCs. In 2006, FQHCs and CMHCs came together to obtain political support for a collaborative initiative that included the Missouri Coalition

of Community Mental Health Centers and the Missouri Primary Care Association. This initiative was embraced in a bipartisan way in the general assembly and was included in the Medicaid commission report.

FQHCs and CMHCs are now working together to improve integrated care in more than 13 locations in Missouri. Two FQHCs – People Health Center/Hopewell and Swope Health System – have developed CMHCs as part of the FQHCs. One CMHC – Crider Health Center – started out as a CMHC and became an FQHC. Some of these initiatives received state funding as pilot sites, some were supported by grants from the Missouri Foundation for Health or the Greater Kansas City Health Foundation, and others operated with no additional funding.

Major goals of integration included improving access to care, providing clinical care, and fostering collaborative efforts of the systems of care. Underlying these efforts were the themes of seeing the person as a whole, providing preventative care, and considering a person's physical health as essential to mental health recovery. FQHCs and CMHCs working as independent agencies were failing to provide effective and comprehensive care to clients. Therefore, the Missouri Foundation for Health in 2007 provided a technical assistance grant to help the Missouri Coalition of CMHCs and the Missouri Primary Care Association implement program integration.

The “Morbidity and Mortality in People with Serious Mental Illness” report was published in October 2006, and Joseph Parks, MD, the Missouri Department of Mental Health medical director, was a contributor. The study found that people with serious mental illness die at a much younger age than their counterparts in the general population. “People with mental illness are dying at worse than Third World rates,” according to Parks. The higher morbidity and mortality rates were found to be largely due to preventable diseases such as cardiovascular disease, diabetes, respiratory disease, and infectious diseases. Risk factors for such diseases include smoking; alcohol consumption; poor nutrition; obesity; lack of exercise; unsafe sexual behavior; intravenous drug use; and residence in group care facilities or homeless shelters, where exposure to certain infectious diseases is increased. Other important articles include Measurement of Health Status for People with Serious Mental Health Illness (October 2008) and Smoking Policy and Treatment (October 2006), to both of which Parks contributed. Parks has not just been a leading researcher but also a moving force in developing strategies in Missouri that have resulted in necessary system changes.

In 2007, Keith Schafer became the director of the Missouri Department of Mental Health. His vision included several key concepts that continue to be essential in behavioral health: integrating medical and behavioral services, focusing care coordination on consumers' behavioral and medical conditions for better health outcomes, using data analytics for consumer risk prediction and program decision making, and developing and supporting strong local mental health service systems accountable for a full continuum of care.

When the Missouri Medicaid Reform Commission held hearings in 2005, the commission's leader proposed this question: **“We know Community Mental Health Centers are effective in managing mental illness, but are they effective in managing overall health?”** This challenge was not taken by the providers as a threat, but as an opportunity.

“ You don’t have to have a physical health expert, but someone who can advocate for their clients. [What people need is] fundamental intensive care coordination starting on the ground level.”

Keith Schafer, Director, Missouri Department of Mental Health

Missouri had a successful chronic care program that was transformed into a healthcare home program. The state implemented a pilot healthcare home program targeted at patients with chronic conditions. The Missouri Healthnet leadership identified CMHCs as organizations that could be healthcare homes. The program evidence strongly suggested that CMHCs could both improve outcomes and generate significant cost savings. This cost savings was reported in *Psychiatric Annals: Mental Health Community Case Management and Its Effects on Healthcare Expenditure*, August 2010. “A key decision was for [Missouri] Healthnet to designate CMHCs as Healthcare Homes,” stated Parks. Another key was that Missouri Healthnet did not “put all of its eggs into one basket and has utilized multiple technology data vendors to analyze data. This allowed Missouri Healthnet to maintain control of encounter data that many states lose when they capitate services,” according to Parks.

In 2007, Missouri CMHCs began to improve local care management and local care coordination: The Missouri Coalition trained more than 1,000 case managers to improve healthcare coordination. The case managers of today are well trained in using health technology tools and assisting consumers in accessing medical care. Treatment plans commonly feature health and wellness interventions.

According to Schafer, “You don’t have to have a physical health expert, but someone who can advocate for their clients. [What people need is] fundamental intensive care coordination starting on the ground level.” The CMHCs have continued to augment this process by benchmarking performance in completing disease management tasks and prescreening for diabetes.

CMHCs contracted with a health technology support organization (Care Management Technologies) to focus on preventing, screening, diagnosing, and treating metabolic syndrome or diabetes, hypertension, and dyslipidemia as well as on monitoring and managing weight gain and smoking cessation. Each CMHC hired health nurses to support the case management programs. The nurses receive quarterly reports on patients taking multiple psychotropic medications and who have not filled their prescriptions as well as frequently review the charts of patients with comorbid chronic medical conditions (e.g., chronic obstructive pulmonary disease, asthma, diabetes, and cardiovascular disease). This initiative has had bipartisan support of key political leaders.

CMHCs’ enhanced care coordination has been supported by both of the state executive and legislative branches. When the Missouri Medicaid Reform Commission held hearings in 2005, the commission’s leader proposed this question: “We know CMHCs are effective in managing mental illness, but are they effective in managing overall health?” This challenge was not taken by the providers as a threat, but as an opportunity.

In 2008, all psychosocial rehabilitation programs expanded the content of their programming to include health and wellness activities and health education. The state has implemented illness management and recovery services, and “clubhouse” programs have shifted focus toward fitness, diet management, and smoking cessation. Independence Center, a psychosocial rehab program in St. Louis, has become a regional training center for wellness activities.

All of these key factors have fallen into place to position CMHCs as healthcare homes for the future. “We believe it has the greatest chance to improve quality of life and to improve chances of persons to live longer,” says Schafer. The Missouri Department of Mental Health has named these series of programs DMH Net. Missouri is already looking toward the future and planning the next steps. It should not be surprising that Missouri is considering moving to a healthcare home state plan amendment targeting people with mental illness. The CMHCs are taking a close look at National Committee for Quality Assurance certification for healthcare homes. Continued success will require ongoing efforts by the CMHC leadership, Missouri Department of Mental Health leadership, and political leaders in Missouri.

CMHC/FQHC COLLABORATIONS IN MISSOURI

- Family Guidance Center/Northwest Health
- Swope Health/Swope Behavioral Health
- Swope Health/Comprehensive Health
- Swope Health/Rediscover
- Pathways CBH/Katy Trail Health Center
- Pathways CBH/Community Health Center
- Mark Twain Counseling/Northeast Missouri HC
- Family Counseling Center/Missouri Highlands
- Burrell BH/Family Health Center
- Ozark Center/Access Family Care
- BJC Behavioral Health/Grace Hill HC
- Hopewell Center/Peoples Health Center
- Crider Health Center/Crider Health Center

WALKING, THINKING... AND LIVING **Karl Riggins, Margaret Clark Morgan Integrated Care Clinic**



Karl Riggins' ongoing severe depression was worsened by grief after his mother died. "I was ready to give up," he says. "I didn't care about anything." That was before Riggins arrived at Community Support Services, Inc., at the Margaret Clark Morgan Integrated Care Clinic in Akron, Ohio. "I didn't know I was very sick," he explains, "but I'm so glad I came here and found out."

Riggins was referred to physicians and had badly needed tests done. The tests revealed that he had diabetes, high cholesterol, and high blood pressure. He was a walking cardiac time bomb. The staff helped Riggins focus on eating right and staying physically active. "It doesn't take my mind off my mother, but it makes me stronger," he says. "It's keeping me okay."

"Karl became extremely isolated after his mother died," explains Terri Shavers, Riggins' case manager. She accompanies him to doctors' appointments, and she takes him grocery shopping and explains how to read labels. "I had no idea of calories or all the sugar in my drinks," says Riggins, astounded that his love for Kool-Aid, bacon, and fried food was close to landing him in a diabetic coma. "Now, I'm eating better — and I feel better," he says, adding that healthy foods taste even better. "It was like I went into another world. I'd never eaten some of these things," he explains. He swaps out fried foods for baked and says seasonings make all the difference in the world. "A friend of mind made turkey breast with some delicious seasonings. He made it taste like a pork chop!" says Riggins. "So I'm learning how to use spices to add flavor." And water is his new drink of choice.

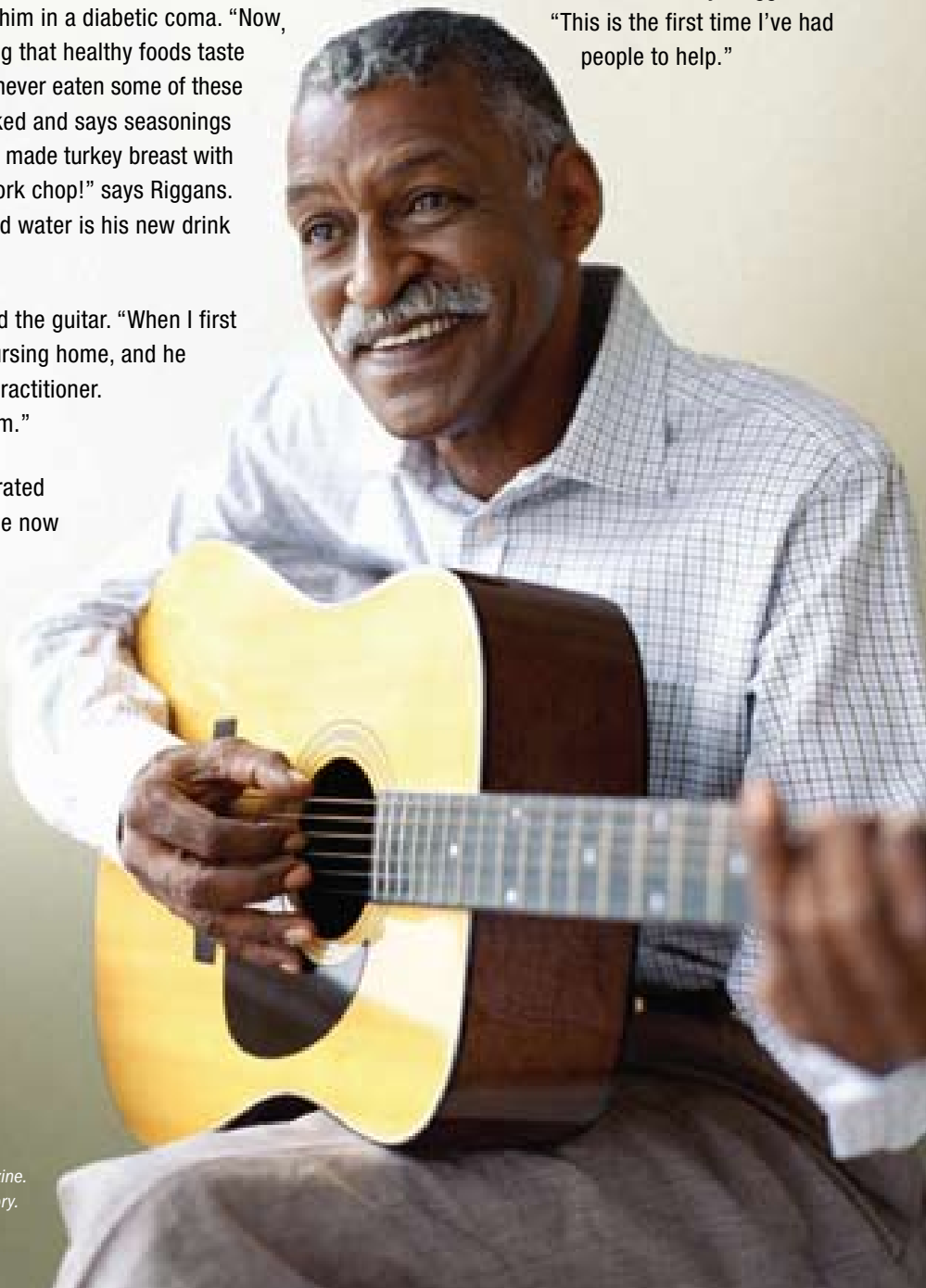
No longer isolated, Riggins enjoys playing drums and the guitar. "When I first met Karl he was in a sad state. His mom was in a nursing home, and he needed physical," explains Kathleen Scott, a nurse practitioner. "He was as strong as he could have been for his mom."

After Riggins' mom died, his physical health deteriorated rapidly. "He was inwardly grieving," says Kathleen. He now motivates his friends to adopt healthier lifestyles.

Riggins has also taken an interest in feeling stronger and more resilient. "I do a lot of thinking," he explains. "It helps to walk and think about things. I think about everything I did that day. My legs get tired, but I still walk."


Riggins also learned to check his blood pressure and monitor his blood sugar. "When I take my blood pressure and it's high, I go for a walk and it goes lower — I learned about that," says Riggins, adding that the more he learns, the more it motivates him to stay healthy. "I didn't have a medical home or a doctor before," says Riggins.

"This is the first time I've had people to help."



In the Comfort of Their Own [Healthcare] Homes

Aileen Wehren, Vice President of Systems Administration, Porter-Starke Services, Inc.; Beth Wrobel, CEO, HealthLinc, Inc.



The primary care setting has recently been the subject of much discussion about the integration of primary and behavioral healthcare. The data on integration appear to be compelling, improving health outcomes and decreasing costs. However, the focus on integrating behavioral care into the primary care environment omits one important group and has the unintended effect of creating the assumption that this integration will meet the needs of all clients. Behavioral health service delivery in the primary care setting does reach many people who otherwise would not receive behavioral health intervention.

It also provides a level of expertise regarding diagnosis and intervention for problems not generally seen in the medical setting, resulting in increased knowledge and skill in detection and treatment of behavioral health problems within the medical community.

The group that is unlikely to benefit as much as the people studied and included in integration efforts so far are those with serious mental illness. We know that people with serious mental illness die an average of 25 years before their peers without these illnesses. We also know that most die from preventable causes. Often, symptoms of the mental illness interfere with the ability to seek out and benefit from medical care. In addition, poverty, estrangement from family, and isolation from a social community exacerbate health conditions.

Our experience indicates that provision of medical care within the context of the behavioral health service delivery system results in better care, including adherence to medical recommendations and lifestyle change



“...the pressing healthcare needs of these people are more likely to be met in an expedient manner by building on the principal connection that they do have with the healthcare system, which is through specialty, rather than primary, care.”

— actions that can prevent illness from occurring or becoming worse. Alakeson, Frank, and Katz make the same case in their discussion of the need for specialty medical homes for this population. They state, “We argue that the pressing healthcare needs of these people are more likely to be met in an expedient manner by building on the principal connection that they do have with the healthcare system, which is through specialty, rather than primary, care.”

Porter-Starke Services, Inc., a Community Mental Health Center, and HealthLinc, Inc., a Federally Qualified Health Center (both located in Indiana), have partnered to deliver integrated care at the HealthLinc site for several years. We discovered that the mental health center’s clients with serious mental illness did not seek care from the FQHC and that the care they did receive was likely to be fragmented. Not only did many of these clients not receive the medical care that they needed, but they also did not receive the level of support needed to effectively use the care or to make needed lifestyle changes for improved physical and mental health.

Providing the level of support needed and coordinating that care with the staff with whom clients felt comfortable required that we meld the strengths of the two organizations and deliver the care in the environment in which clients felt most comfortable, that is, the CMHC. HealthLinc set up a limited access health clinic at Porter-Starke staffed with a nurse practitioner, and Porter-Starke selected clients with medical issues and provided a case manager who assisted clients with obtaining the necessary medical follow-up (e.g., labs) and instructed and coached them on lifestyle changes. The case manager spent an average of 4–5 hours per week with each of the five clients providing these services. Funding for the medical service was through HealthLinc, whereas funding for the supportive service from Porter-Starke was through Medicaid.

Initially, we faced many barriers to improved health outcomes, including Indiana’s carve-out of behavioral health and assignment to community primary care doctors, thus limiting the clients who could be seen by HealthLinc; lack of extensive training in integrated care for the direct care staff from both agencies; interference of psychiatric symptoms with client participation; balancing of assertive case management with client autonomy and independence; lack of participation

incentives for clients; and the need to provide supplemental resources, such as a dietician. We successfully overcame most of these barriers.

The result was improvement in health outcomes and mental health status for four of the five clients. We measured both medical indicators (cholesterol levels, triglyceride levels, blood levels indicative of diabetes, weight, and waist size), indicators of emotional well-being (depression, anxiety, and substance abuse), and lifestyle indicators (smoking and exercise levels). Three clients have had significant improvement in lab values, one has lost significant weight and is engaged in an exercise program, one quit smoking and another decreased smoking, and all but one demonstrated improvement in the measures of emotional well-being.

What we learned is that in a busy medical office, including an FQHC, people with serious mental illness can get lost and not have their healthcare needs met in a manner that is likely to result in the lifestyle changes that will improve medical status. The typical approach of behavioral health consultants is to provide a total of three to five brief interventions — not a successful approach with people who need sustained and personal support to begin to make necessary changes. Delivering medical care in a familiar environment in the CMHC with CMHC-employed case managers who know the clients and can spend ample time with them results in improvement.

CMHCs are a necessary component for the successful delivery of integrated care. Neither CMHCs nor FQHCs alone can improve the health, both behavioral and medical, of everyone. Each entity has a niche in this effort.

Aileen Wehren received her EdD from Rutgers University in 1981. She has worked in community behavioral health for the past 23 years. Areas of focus include revenue cycle management, process improvement, risk management, and managed care contracting. At Porter-Starke Services she works with the local FQHC to develop effective integrated care for patients at the FQHC and for seriously mentally ill adults in the CMHC setting.

Beth Wrobel has been the CEO of HealthLinc (formerly Hilltop Community Health Center) for 9 years. She has moved the organization from a free medical clinic, serving adults, to a Federally Qualified Health Center, providing a healthcare home to all life cycles — prenatal to seniors — with an integrated medical, dental and behavioral health services at 4 different locations. She has presented at many conferences both at the national and state level. Wrobel holds a bachelors degree in mechanical engineering from Valparaiso University. She is also a graduate of the Johnson and Johnson UCLA Health Care Executive Program.



Where Patient Outcomes Drive Payer Outcomes

Dennis Freeman, CEO and Bob Franko, Vice President, Marketing — Cherokee Health Systems

During the Watergate investigation, The Washington Post's Bob Woodward received the following sage advice from his inside source, Deep Throat, "I have to do this my way. You tell me what you know, and I'll confirm. I'll keep you in the right direction if I can, but that's all. Just... follow the money" (All the President's Men, 1976). This axiom also tends to ring true in today's healthcare system; we can all cite numerous cases when we've felt forced into changing course, broadening our scope, or shifting our missions in the quest to "follow the money." In fact, in many cases, it has simply been a matter of survival.

Integrating primary care and behavioral health services is a policy-shifting idea that has found much interest throughout the country. At Cherokee Health Systems, we like to describe our integrated, or blended, approach as a one-door entry point. People don't walk into the mental health door or primary care door. They come to Cherokee and actively participate in our integrated practice model. It's true that we don't even talk about integration, it is simply our way of providing quality care. Most people don't talk about oxygen and nitrogen, they just breathe.

Like scenic U.S. Route 441, which bisects the Great Smoky Mountains through North Carolina into Tennessee, our road to integration has been winding, sometimes treacherous, and filled with periods of long climbs and quick descents. We imagine that as people travel that route they sometimes may get a bit carsick and wonder why they started the journey at all — that is, until they catch a view of the vista through a break in the trees. Those moments are the payoff.

Cherokee started its journey more than 30 years ago. Our roots are as a Community Mental Health Center, where, like many centers in rural settings, we found access to primary care difficult at best. Our solution at that time was to hire medical practitioners and begin the process of integrating care; it didn't take long to recognize the immediate benefits of such an approach. This method of healthcare delivery spread throughout our various sites. People who visit us are often surprised to hear that it was only recently, in 2002, that we added the Federally Qualified Health Center designation and found new ways to fund our delivery model. That's because we didn't follow the money at the onset — there wasn't much to follow. We moved ahead with integration because it was the right approach.

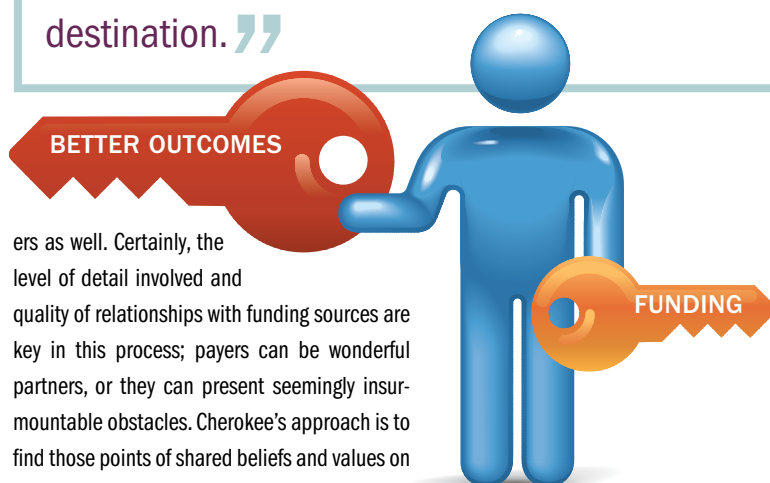
Today, it seems as though there are two entry points into the decision of integrating care. One is marked "funding," and the other is marked "better outcomes." Those doors don't always lead to the same destination. Readers may be familiar with "Sutton's law." Willie Sutton was a bank robber throughout the 1920s and 1930s; when nabbed, a judge asked him, why he robbed banks. "Because that's where the money is," Sutton allegedly replied. Sutton's law, in this case, doesn't always lead to the best outcomes for providers and patients. It tends to cloud the vision, overlook details, and create mirages that can never be reached. Such is often the case in healthcare when we feel forced to follow the money. However, we all understand that in today's healthcare environment and in the face of reform, the time is certainly ripe to discuss integrated care.

When consulting with our partners and friends around the country on the process of integration, we always recall our roots and journey toward integration. We discuss it as a process, not a destination. Unfortunately, many organizations exploring integrated care feel pulled along like Bob Woodward was by Deep Throat: "You tell me what you know, and I'll confirm. I'll keep you in the right direction if I can. . . ."

Our approach is to be active in the planning and development of the project; explore the reasons behind integrating care; and take an inventory of the resources in place, the partners involved, and the operational and administrative environment. Ours is a population-based approach that is guided by achieving the best outcomes for the patients, which when achieved are always the best outcomes for pay-

“

Today, it seems as though there are two entry points into the decision of integrating care. One is marked "funding," and the other is marked "better outcomes." Those doors don't always lead to the same destination. ”



ers as well. Certainly, the level of detail involved and quality of relationships with funding sources are key in this process; payers can be wonderful partners, or they can present seemingly insurmountable obstacles. Cherokee's approach is to find those points of shared beliefs and values on which to frame contract discussions. Our model

works, and we nurture and guard it with respect and a fair degree of tenacity. We advocate strongly for it with our funding partners. We like our college football in the South, and in our case, we like to be the offensive coordinator and move the ball. We don't like to play defense.

The good news is that healthcare reform is here. The bad news is that healthcare reform is here. Integrated care is healthcare reform, and if it is delivered based on the right values for the right reasons, following the money won't be a problem. Cherokee Health Systems is a ready resource for our National Council colleagues looking for real-world assistance in delivering integrated care. We are willing to share the advantages we have found as a hybrid safety net provider, merging the mission of community mental health with commitments of an FQHC. Integration is about reforming our practices to better serve our patients and our communities.

Dennis Freeman, PhD, has been CEO of Cherokee Health Systems for over 32 years and has been pioneered an integrated primary behavioral health care practice. Today, Cherokee Health Systems provides fully integrated care in each of its 21 sites across East Tennessee. Freeman is an active advocate for the implementation of integrated care throughout the safety net system and consults frequently with national leaders on public health policy. He is the first recipient of the University of Tennessee department of psychology's Distinguished Alumni Award in 2010.

Bob Franko, MBA, is the vice president of marketing and technical assistance at Cherokee Health Systems. Bob has worked in mental health for more than 20 years, and in community mental health for the last 15 years. He was a project leader of an integrated care collaboration between a CMHC and FQHC in Valparaiso, Indiana. Bob received both his undergraduate and graduate degrees from Purdue University.



Where One Plus One Equals Three

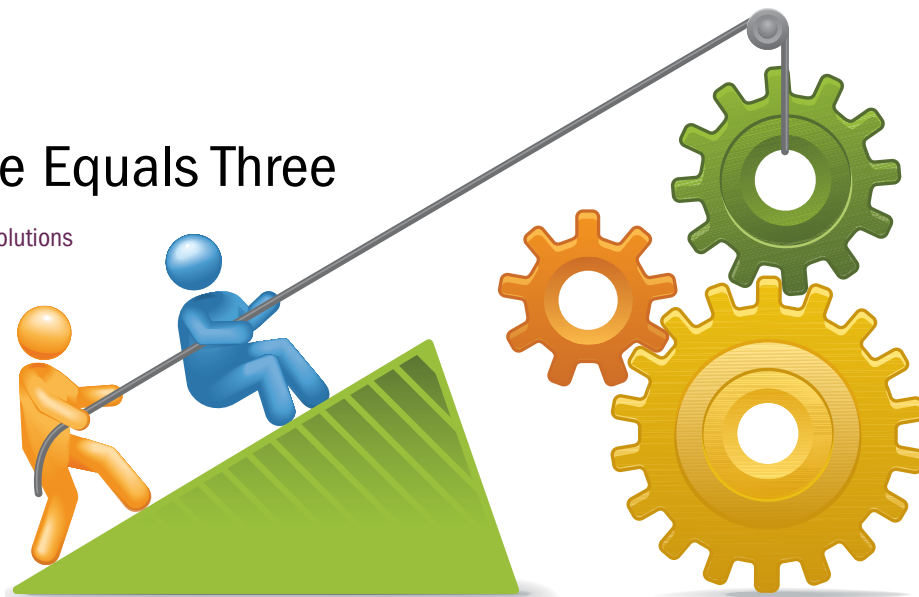
John Van Camp, CEO, Southwest Counseling Solutions

Southwest Counseling Solutions has served the southwest Detroit community for 34 years. Services include outpatient mental health treatment and psychosocial programming for adults with serious and persistent mental illness and for children with a serious emotional disturbance; substance abuse treatment; and housing, employment, and training for adults with SPMI. The agency also provides a continuum of prevention services for children and families.

Staff of Southwest Counseling Solutions saw that their patient population had needs that transcended mental health and looked for a local organization that would help provide medical care. For many years, fear of working with people with serious mental illness proved to be a barrier in finding a partner.

Southwest began to investigate the option of starting its own medical clinic, but clients suggested another option. They told the staff at Southwest that they received excellent care from a nearby faith-based free medical clinic — Covenant Community Care. Covenant was launched in 2000 as a free-standing and independent, grassroots, community- and faith-based primary care provider. Its mission of providing affordable and quality healthcare to the people who needed it most had an impact on Southwest's clients. "They respect us and treat us with dignity," the clients told Southwest. The seeds were planted for dialogue between the two organizations.

As discussions progressed, the primary question centered on the most effective way to integrate medical and mental health services. Southwest had been researching the option to start its own medical clinic and was familiar with the Federally Qualified Health Center model, which provides enhanced reimbursement for Medicaid patients as well as annual grant revenue to support the operational needs of a clinic. Independently, Covenant had also been exploring FQHC status as a path to sustain-



ability and quality of care. It soon became clear that each organization needed the strengths offered by the other for the FQHC model to work.

The FQHC funding model made it possible for Covenant to open a second site within Southwest's facility and for Southwest counselors to have a presence within Covenant clinics. In December 2006, a New Access Point application was submitted to request FQHC status for Covenant Community Care, with Southwest Counseling Solutions as the primary mental health provider. The government approved the request in 2007, and since then, the ability of each organization to provide high-quality, integrated care has continued to grow.

The goal of the Southwest/Covenant partnership is to coordinate services at one care location for the patient in an integrated treatment plan. Providing mental health services at a primary care site reduces stigma, increases the likelihood that people will access behavioral healthcare, and improves patient outcomes. In addition, the medical provider can call on the mental health team to identify and treat mental health conditions that are intertwined with pressing medical problems. Issues such as comprehension and medication adherence can be addressed far more readily and easily, as can other barriers to care.

One way in which the partnership has enhanced the integration of medical and mental health services is by providing the opportunity for brief (15-minute)

interventions that can be embedded within the medical visit or treated as standalone follow-up sessions. These interventions enable providers to address many issues that might go untreated outside of an integrated model. The result of this initiative is better treatment planning; more support for providers as they rely on one another as available resources for treatment; and less defensive disengagement on the part of providers, who now have a way to respond to the problems presented to them.

In addition to collaborative diagnosis and treatment, the partnership makes it possible to provide education and preventive care to each organization's clients. Recent examples include H1N1 educational outreach to the Southwest patient base by Covenant's medical team and joint efforts to create a paradigm of wellness that includes medical and behavioral health within the context of lifestyle modification (exercise, nutrition, smoking cessation, etc.).

STAFFING AND FINANCING

Southwest employs licensed behavioral health specialists who are dedicated to serving at Covenant. Covenant employs one physician and one nurse practitioner who are both specialists in dealing with people with severe and persistent mental illnesses. In addition, Covenant employs one part-time behavioral health director (D.Psych).

Total revenue is based on a combination of self-pay fees (which are related to a person's ability to pay) and the flat Medicaid encounter rate for qualifying

encounters. Within the FQHC model, Covenant bills for the services and then pays a uniform contract rate to Southwest.

CHALLENGES

Combining the cultures and missions of two organizations is ultimately rewarding but is not without its challenges. Listed below are some of the primary challenges Southwest has faced during the process of forming and managing its partnership with Covenant:

>> Exchange of information: The documentation needs of each organization, which are based on legal and professional standards, are significantly different. Initially, Southwest thought that its electronic health record system could be adopted by Covenant to streamline the exchange of information. Covenant's documentation needs (both core medical records and FQHC reporting), however, required the purchase of a separate EHR system, which has slowed the process of making information accessible across organizations.

>> Building trust: Change of any kind creates uncertainty and, often, fear in the hearts and minds of the people who will be affected. Two fears that had to be faced during the initial phases of the Southwest/Covenant partnership were Covenant's concern that Southwest's size would overwhelm Covenant's voice in the decision-making process and Southwest's concern that Covenant's faith-based mission might be at odds with mental health standards of neutrality for providers. These fears have become a significant asset to the partnership, however. Covenant has had considerable opportunities to expand the scope of its services in the region as a result of its status as an FQHC (made possible in large part through the partnership with Southwest), and Southwest patients who want to incorporate faith into their healing process have also reaped a great benefit from Covenant's ability to speak to such issues. We were able to realize the benefits because of each organization's commitment to clear communication at three distinct levels — executive/board, clinical leadership, and operational staff. Representatives from each of the three areas were involved in ongoing conversations to address concerns and to cultivate a foundation of trust that has made it possible for the partnership to grow and flourish.

>> Staff workload: The work required to provide the level of integrated care described is significant, and

“One plus one equals three. The long-term impact of this partnership has been so much more robust than would have ever been possible if each organization had attempted to expand services alone. Each organization has learned from the other and from the process, and this has helped us both grow and provide quality care for clients.”

it has often taxed the capacity of staff members who are doing the hard work of case management.

>> Managing expectations: Southwest entered the partnership with Covenant anticipating certain levels of mental health patient referrals and related revenue. Although Covenant has made great strides in implementing programs such as mental health screenings and the brief-intervention process, the growth anticipated in Southwest's patient base has been slower than expected.

>> Structural barriers: In some situations, external factors have prevented the level of collaboration and integration that both organizations desire. For example, obtaining approval from state mental health organizations that would allow mental health patients to be seen by their primary care physician for routine medication management involves a process of reallocating patients that has been challenging. Authorizations for behavioral healthcare are typically cumbersome, and coding of encounters can be complex.

WHAT WE HAVE LEARNED

One plus one equals three. The long-term impact of this partnership has been so much more robust than would have ever been possible if each organization had attempted to expand services alone. Each organization has learned from the other and from the process, and this has helped us both grow and provide quality care for clients. A short list of what has been learned includes the following:

>> Facility planning: As a result of working together during the past 3 years, the organizations have learned a great deal about configuring physical space to promote effective integration of care. This knowledge is being incorporated into the plans for a new site: a 50,000-square-foot former cigar factory that will be renovated into a full-fledged wellness center.

>> Boundaries for care: Coming into the partner-

ship, each organization had distinct approaches to caring for clients that reflected a continuum of engagement with the client as a person and different organizational cultures. Each organization has learned a great deal from the other about setting and maintaining appropriate boundaries as well as about caring for the whole person and engaging with each client as a person (in contrast with the role of client).

>> Multilayer communication: As stated previously, both organizations made a commitment at the beginning to communicate at every level of each organization. Setting aside blocks of time for retreat days as well as other meetings for planning and outlining treatment protocols has been vital to the partnership. This commitment is an investment of time, ultimately, money, and it has yielded exponential benefits.

In looking at the big picture, in an age in which organizations are often encouraged to do whatever it takes to look out for their own self-interest to retain profits or market share, the experience of the Southwest/Covenant partnership reveals that doing the exact opposite brings the biggest rewards. Each organization was willing to risk its individual success to participate in a bigger story — the result has been success for the organizations, for the partnership, and for the community.

John Van Camp has been with Southwest Solutions since its beginning in 1973. He started as an administrative assistant and became head of the organization in 1981. John expanded the vision of Southwest Solutions. He believed that reintegrating the mentally ill and homeless into the community also required providing quality affordable housing and support services, and actively participating in neighborhood revitalization and economic development. He was named Ernst & Young's "Entrepreneur of the Year" for 2007. In 2009, John was one of six individuals in the country to be named a "Behavioral Healthcare Champion." His leadership has been acclaimed by the Mental Health Corporation of America and Crain's Detroit Business, who named Southwest Solutions "Best Managed Nonprofit" in 2005.



Where Interaction Shapes Integration

Inman White, Executive Director and Rick Roberts, Director, Integrated Health — Community Healthcore

Some years ago, people with serious mental illness in Longview, Texas were simply not able to access routine healthcare. The board of trustees of Community Healthcore, a local Community Mental Health Center serving approximately 8,000 individuals, saw an opportunity to make a difference by creating a Federally Qualified Health Center.

Committing the organization's resources through multiyear processes, we established the East Texas Border Health Center as one of the first FQHCs in our area. Access to healthcare was the issue that created the center; however, the integration of care has become the issue that defines it.

Integration of services between the two organizations began with the colocation of mental health

services within the East Texas Border Health Center. Integration was limited, however, and over time, as both organizations grew, the need for additional space resulted in the separation of mental and physical health services. Since then, interaction between the two entities occurred through referrals.

About a year ago, we again began looking at the need for services in a single location for people with both primary and behavioral health issues. About 40 adults and 20 adolescents and children who were stable with medication-only services from behavioral health but who needed a medical home were referred to primary services. Staff were cross-trained and primary care providers shadowed behavioral health providers to learn more and improve the referral process.

Community Healthcore and two area FQHC partners — the East Texas Border Health and Wellness Pointe — worked to establish improved primary and mental healthcare services for the local communities through a Hogg Foundation initiative. Integration was advanced by ongoing discussions about Community Healthcore colocating with East Texas Border Health and about plans for expansion of primary care services in Community Healthcore's mental health clinics through Wellness Pointe.

Partnering with East Border Texas Health to provide psychiatric services in Harrison County and improve collaborative efforts between primary and psychiatric care has helped reduce duplication of services and costs. We are also working on a learning project with the Mental Health Corporations of America that includes review of electronic medical record systems to provide real-time information on patients seen in both settings.

The partnership with Wellness Pointe has focused on bringing primary healthcare into the mental health clinics in Longview. Initial efforts have included a learning project with MHCA that targets bringing primary care services into the mental health clinic one day a week. The focus is on integrating services across practices and providers.

Vertical integration has defined our most recent integration efforts as we sought to place behavioral health services in primary care practices and primary care services in behavioral health settings.

We have faced some difficulties in our partnerships, including communication, sharing of patient information, lack of integrated information technology systems, and care coordination. Other barriers we've had to overcome include reimbursement, staffing and workforce, billing and coding, space, practice culture, viability, and charting and record keeping. However, sites have been identified, and processes are being put in place to colocate once again.

“Access to healthcare was the issue that created the center; however, the integration of care has become the issue that defines it.”





Community Healthcore and East Texas Border Health participated in an incubator grant offered by the Texas Department of State Health Services to identify processes and barriers to determine infrastructure abilities. Outcomes included a memorandum of understanding signed by the boards of both organizations to further integration efforts. It was the intent of the East Texas Border Health to partner with Community Healthcore and increase access to primary care and behavioral health services for our clients. This partnership effort required time and commitment of key staff and decision makers of each organization. Efforts to meet the Department of State Health Services program goals included developing an Integrating Mental Health and Primary Care Services Partnership Infrastructure Checklist to measure progress and facilitate a "lessons learned" document. The focus of that document included addressing governance issues, service provision, systems and processes conflicts and solutions, and fiscal resources.

In our journey to first establish an FQHC and then integrate care between behavioral and primary care systems, we've learned some important lessons:

- >> We benefit much from being a part of a learning community on integration issues. Although not available when our project started, the MHCA learning community has moved us along faster than our individual effort.
- >> Orient everyone to your philosophy of treatment. Recruit, train, and promote for integration. This step is easily overlooked in the fast pace of running a clinic; however, everyone involved, from the secretary at the front desk to board members, must be continually trained on the value of meeting the total health needs of an individual.
- >> Develop board approval agreements that outline details of the relationship between the organizations involved and the conditions under which both agree to provide services. Consider the legal, risk management, and scope of practice issues formally. It is an important step that goes beyond the traditional handshake between providers. It is the structure that extends continuity, particularly when there is turnover in leadership.

And finally, we learned never to give up on a dream. Pressing forward despite the difficulties has produced results. Establishing a primary medical home for people with mental illness who have typically relied on the emergency departments of local hospitals will make a big difference in the lives of the people we serve.

Inman White has been the Executive Director of Community Healthcore since 1995. He was formerly Assistant Deputy Commissioner of Mental Health/Mental Retardation in Austin. He has also served as the MHMR representative to the Early Childhood Intervention Council and Chairman of the Texas Council Community MHMR Centers Executive Director's Consortium. He is on the Policy Subcommittee and Integration Workgroup of the Health and Human Services Commission. He is a board member of East Texas Border Health, the Federally Qualified Health Center he was instrumental in founding.

Rick Roberts is the director of the \$21.3 million Integrated Health Division of Community Healthcore. He leads a 240-person workforce and oversees all financial, business development, productivity and administrative affairs. He has also served as director, development and expansion director, intervention and support operations, director, systems compliance, and director of children's services. He has provided psychological/counseling services in a clinic settings and managed a general hospital's psychiatric unit.

Do you need capital to buy, build or renovate a facility, update your IT systems, or refinance existing debt?

CHFF CAN HELP!

We are a non-profit loan fund that provides capital to non-profit behavioral healthcare organizations nationwide.

- ❑ Aggressive interest rates
- ❑ Flexible terms and structures
- ❑ Gap and subordinate financing
- ❑ Loans from \$150,000
- ❑ Participation with other lenders
- ❑ Strategic financial planning services

The Community Health Facilities Fund is pleased to have provided financial advisory services and/or direct loans to the following organizations in 2009:

Ability Beyond Disability
Bethel, CT

Alternatives Unlimited
Whitinsville, MA

Cache Employment and Training Center
Logan, UT

Community Housing Associates
Baltimore, MD



For more information contact,

Chris Conley | **Dean Adams**

203-273-4200 | 812-273-5198

cconley@chffloan.org | dadams@chffloan.org

www.chffloan.org ♦ info@chffloan.org

Community Health Facilities Fund
6 Landmark Square, 4th Floor, Stamford, CT 06901

Ending Separate Histories: Innovation in Integration

Benjamin F. Miller, PsyD, Associate Director of Primary Care and Outreach, Depression Center, and **Larry A. Green, MD**, Epperson-Zorn Chair for Innovation in Family Medicine — University of Colorado-Denver

Mental health and physical health system have a history rife with separation and fragmentation. However, scientific evidence won't allow us to proceed as though the brain and behavior are separable from the body. Treating one condition at a time, whether it is a "mental health condition" or a "physical health condition," without taking into account their inseparability, results in poorer outcomes and higher costs. But integration of care leads to what seems to be a promising "value proposition."

This is an exciting time in healthcare. We are in the midst of significant health insurance reform and health services expansion for a population that has previously been uncovered. Efforts are afoot to cross the chasm from the current system to a system that will meet the needs of the communities we serve. One area begging for innovation is that of mental health and primary care integration. Three initiatives from the Department of Family Medicine at the University of Colorado-Denver illustrate this crucial part of healthcare redesign: Advancing Care Together, or ACT; Collaborative National Network Examining Comparative Effectiveness Trials, or CoNNECT; and Promoting Resources for Integrated Care and Recovery, or PRICARe.

ACT is an action-oriented collaboration across primary care, mental health, and substance use focused on demonstration projects across Colorado. It is organized as a set of diverse comparative case studies linked to support both project-specific and cross-project learning. ACT will study proposed approaches from primary care practices and mental health centers to learn what can be accomplished now in real-world settings to integrate the care of people of all ages who have both mental and physical health problems. ACT aspires to compare these innovations to one another to better understand what works and what doesn't.

The first project of the Collaborative Care Research Network, CoNNECT, combines efforts of two existing practice-based research networks. One network, CCRN (Collaborative Care Research Network; www.aafp.org/nrm/ccrn) is focused on practices orga-

nized to provide onsite and integrated collaborative mental healthcare to patients with emotional and behavioral problems. The other network, DARTNet (Distributed Ambulatory Research and Therapeutics Network), uses structured, electronic exploration of electronic health records across organizations to enable the study of patients with multiple medical morbidities that include depression and other mental health problems. The resulting structure — the intersection between DARTNet and CCRN — is CoNNECT, which aims to use the methods of comparative effectiveness research to answer many questions that have been raised about the intersection of mental health and primary care. The union of these capacities constitutes an innovation in the research infrastructure of practice-based research networks that aligns with urgently needed comparative effectiveness knowledge.

PRICARe is a 3-year Colorado Access project funded by The Colorado Health Foundation to integrate primary care into two Mental Health Center of Denver clinical sites. In collaboration with the Department of Family Medicine, the program has placed a full-time family physician into two Community Mental Health Centers to offer primary care services.

With the expansion in knowledge and insurance coverage, now is an opportune time for innovation. Integrating care that has often been divided should be one of the top priorities of any effort intended to address the healthcare needs of the whole person. The Department of Family Medicine is committed to contributing to integrated care for the whole person and welcomes ideas for collaboration.

Benjamin Miller, PsyD, is the associate director of research and primary care outreach for the University of Colorado, Denver, Depression Center. He is also an assistant professor in the Department of Family Medicine at the University of Colorado, Denver, School of Medicine, where he is responsible for integrating mental health across all three of the department's core mission areas: clinical, education, and research. Miller is a co-principal investigator and co-creator of the National Research Network's Collaborative Care Research Network.

Larry Green, MD, is professor of family medicine and the Epperson-Zorn Chair for Innovation in Family Medicine at the University of Colorado, Denver. Aside from being a faculty member, Green has served in various roles, including practicing physician, residency program director, developer of practice-based research networks, and department chair. He is a member of the National Committee on Vital and Health Statistics and co-chair of the steering committee for Preparing the Personal Physician for Practice. He is chair of the board of directors of the American Board of Family Medicine and a member of the Institute of Medicine.

Treating one condition at a time, whether it is a "mental health condition" or a "physical health condition," without taking into account their inseparability, results in poorer outcomes and higher costs.



MIRROR, MIRROR... Allison Gaiter, Thresholds

"The way you look at yourself in the mirror... you feel like you're the ugliest person in the world. To me, I was the ugly duckling," says Allison Gaiter, who was in dire crisis when she came to Thresholds in Chicago, Illinois. She was battling major depression. "I was crying 7 days a week," she says, and she didn't care if she lived or died. Her diabetes and blood pressure were out of control, and she had trouble sleeping. Gaiter was waking up at 2 am and eating fried chicken. She then fell asleep in group therapy during the day. It was a vicious cycle. Too much was going on, medically and mentally, for her to stop.

At Thresholds, not only did Gaiter work on her mental health issues, but she also began to realize the benefits of exercise and learning

to read food labels and ingredients. She's lost more than 100 pounds and is still counting down. "Cooking was always my passion," she says, but she was cooking all the wrong foods. Gaiter desperately wanted to work to manage her depression and her medical conditions. She just needed some help and guidance to pull it all together.

The nurses from the Integrated Healthcare Program explained her medications and worked with Gaiter to adjust them so she would sleep better at night and be able to function during the day. They continue to monitor her weight and blood pressure. Gaiter's diabetes is under control, and she needs less medication. She is losing the weight slowly, to keep it off for good. "My calves are pretty strong now. People tell me, 'you have pretty legs,' " she laughs. She got to see a dentist and sports a lovely smile. Gaiter learned about food and how it provided the vitamins she needs to be healthy. "Thresholds has one of the best exercise groups," she says. "Every Friday, we get to swim or use the gym equipment and lift weights."

Some days are still difficult, but Gaiter's improved nutrition and exercise sheds a different light on her situation. "I put one foot in front of the other," she says. "I read books on depression and attend groups." Gaiter is very spiritual and involved in her church: "When I get depressed, I close my eyes and say to myself over and over 'Look at what life has done for you' until something else pops in my head other than a suicidal thought," she says. She can hold her precious grandchildren without trembling and enjoy conversations with her children.

Gaiter recently started a walking group with other Thresholds members. "I want to help others find their sunshine," she adds. "My thing is — I feel deep in my heart, my mother gave me birth, but Thresholds gave me life." Gaiter pauses and says, "I don't need other people to say 'I'm proud of you,' because I can look in the mirror now... and feel proud of myself."





Novartis shares The National Council's commitment to Wellness!

Novartis is proud to be the innovative force that's bringing new hope and optimism to our world in so many ways.



41st National Mental Health and Addictions Conference & Expo

May 2-4, 2011, San Diego, CA



San Diego: There's no better place to be!

www.TheNationalCouncil.org/Conference 202.684.7457

Progress Notes from SAMHSA Integration Grantees

In 2009, the Substance Abuse and Mental Health Services Administration selected 13 community programs across the country to receive funding for up to four years with an award amount per grantee of \$500,000 annually for Primary and Behavioral Health Care Integration programs to address the needs of people with serious mental illnesses. These programs are aimed at improving the physical health of people with serious mental illnesses by supporting communities to coordinate and integrate primary care services into publicly funded community mental health and other community-based behavioral health settings.

Five of the 13 initial grantees share their progress to date with National Council Magazine.

Care Plus NJ: Bringing Two Cultures Together

Kathy Bianco, APRN-BC, Vice President, Clinical Services; **Chris Doerr, APRN-BC**, Associate Vice President, Clinical Services; and **Shelby Rosso, LSW**, Associate Vice President, Corporate Development, — Care Plus NJ, Inc., NJ

Care Plus NJ, a behavioral healthcare organization based in New Jersey, has more than 30 years of history providing community-based services for adults with serious and persistent mental illness who also struggle with a multitude of comorbid medical conditions. For many years, CPNJ's staff had been tracking the increasing number of medical conditions along with the treatment needs of our clients. The organization has long advocated for access to medical care, providing care management to facilitate coordinated services when available. When SAMHSA issued a request for proposals in 2009 for integrated behavioral and primary care, the data surrounding the needs of this population for unified care were available and articulated in our proposal.

Funding received through SAMHSA afforded CPNJ the ability to hire primary care staff to enhance our current multidisciplinary behavioral healthcare recovery team. We've hired a family nurse practitioner, nurse case manager, consultant diabetes educator, and consultant nutritionist. Our collaborating primary care physician, who specializes as a pulmonologist, works closely with the staff.

Primary care services are provided onsite within the mental health center, thus optimizing opportunities for collaboration. It is an everyday occurrence to see primary care and behavioral health staff meeting together with a client or family member. When inpatient medical care is required, the team notifies the collaborating physician, who is often able, through inpatient privileges, to direct this portion of care. When inpatient psychiatric care is required, the nurse case manager is credentialed at our county psychiatric hospital and is able to ensure immediate collaboration and participate in discharge planning.

Bringing two different cultures together in the workplace has at times required the team members to take a step back and remind themselves for whom they are working. Each time, the answer is the client, once again allowing the process to move forward. In addition, refining communication and changing processes as needed are necessary at all levels of the organization. These goals have been and will continue to be a focus moving into year 2.

The most obvious effect of the program thus far is the ease of access to medical care for our clients. Referral processes, which used to take days, can now be scheduled within our electronic medical record system. Treatment is often started the same day, eliminating the need for emergency room visits for such care. For example, upper-respiratory infections that could fester during a delay are immediately treated. Coordination of care with specialists has improved as well.

Anecdotal reports from clients indicate that they have much greater accessibility to care and high satisfaction with the system. It is easy to imagine the impact of severe auditory hallucinations or panic-level anxiety on clients seeking or participating in care. However, clients have reported that the ability to see a single provider has increased their comfort level in seeking services. In addition, clients who had put off screenings because of the lack of understanding of their importance or unease about the procedures are able to be accompanied by staff. This improves treatment and follow-up and decreases anxiety. The inherent struggles of people with serious and persistent mental illness in navigating the healthcare system have been greatly reduced. Care provided within our medical home has been reported to be significantly easier to obtain and health interventions more readily understood.

Sustainability remains a critical outcome of this project. We have experienced some challenges in this regard because in New Jersey, an integrated care model requires licensing by both the Division of Mental Health Services and the Department of Health and Senior Services. We are the first community (i.e., non-hospital) entity to request such designation in the state. CPNJ has been licensed for behavioral health services by DMHS for more than 30 years. We have in the past run discrete programs licensed by DHSS; however, merging two programs — essentially, a licensed program within a licensed program — has challenged the regulatory system. In addition, combining the programs has required renovation of program space to provide separate areas for the two services.



CENTER FOR FAMILIES & CHILDREN

Center for Families and Children: Serving the Uninsured

Shawna Lewis, LISW-S, Project Director, Integrated Health Care Project, Center for Families and Children, OH

The Center for Families and Children is a community mental health provider known for its dedicated staff and high-quality services. As one of the largest providers in Northeast Ohio, CFC serves nearly 4,300 adults with severe mental illness and 500 children with serious emotional disorders each year. Services include mental health assessment, community psychiatric supportive treatment, counseling, and pharmacological management (including onsite pharmacy services). CFC has also been providing educational and wellness activities through a peer support group (CFC Club) for several years. The integration of primary care services onsite was an established goal for CFC and a natural progression.

CFC focused the SAMHSA grant opportunity on the roughly 40 percent of our adult clients who are without any insurance, including Medicaid and Medicare, and are unable to pay for services. These clients are especially at risk because of the complicating effects of their mental illness coupled with the conditions of their poverty status and the lack of community-based primary care for the indigent. In addition to the myriad physical health complications that people with serious mental illnesses face, the capacity of many clients to travel and follow through on scheduled appointments is limited.

The Integrated Health Clinic at CFC was opened on February 1, 2010. In partnership with the Cleveland Clinic, we operate two part-time primary health clinics, housed within two of our behavioral health sites. The SAMHSA grant has allowed us the opportunity to staff the IHC with primary care and administrative staff so that we can provide free services to our uninsured clients.

Our part-time medical director and full-time nurse practitioner and medical assistant are contracted employees of the Cleveland Clinic. Our full-time patient navigator (i.e., healthcare case manager), administrative support, and project director are employed by CFC and provide the critical day-to-day support to both patients and behavioral health staff to coordinate services.

Patients receive health screenings, annual exams, gynecological care, laboratory tests, and management of chronic diseases. All medications are provided to pa-

tients free of charge and are primarily obtained through pharmaceutical companies' patient assistance programs. When medications are not available through such programs, they are purchased with grant funds through local pharmacies.

Specialty care, including dental, vision, mammography, and podiatry, is made available offsite through various programs and providers. Tertiary care, including general surgery, ophthalmology, endocrinology, and gynecology, is provided by the Cleveland Clinic. All offsite care is funded through nongrant financial assistance specific to the programs and providers.

Also as part of grant-funded activities, we offer wellness opportunities to all CFC behavioral health clients (insured and uninsured). Monthly wellness educational workshops, with topics such as yoga, mood and food, and stress management, are offered through CFC Club. Clients can also meet individually with a fitness or nutrition coach to support a healthier lifestyle.

Upon enrollment to the IHC, several health and mental health outcomes are tracked as part of the grant requirements. CFC monitors weight, body mass index, blood pressure, lipid profile, and blood glucose on an ongoing basis for every patient. Patients are assessed for their use of alcohol, tobacco, and other drugs using with ASSIST every 6 months and on an ongoing clinical basis. National outcome measures are taken every 6 months to formally determine the progress of mental health outcomes.

"The CFC routinely provides CBC, TSH, and syphilis screens as well as a complete metabolic panel for each new client. The clinic performs other screens as clinically warranted." We measure client satisfaction through surveys and ask for feedback especially related to wellness to guide our program offerings.

We plan to continue providing these services beyond the grant term and are currently determining the model of service that will allow us to offer care to our insured and uninsured behavioral health clients.

CODAC

CODAC: Following the Healthcare Home Model

Dona Rivera-Gulko, MS, CRC, CCM, Vice President, and **Kristine Welter**, Director of Development and Marketing, Adult Network Services, CODAC Behavioral Health Services, Inc., AZ

I like the fact that I can get everything done in one place. Having medical and mental health services together will help to keep all the doctors in the same loop, so I can get the help I need.”

Even though we are at only the first step of our journey into integrated healthcare, such statements reflect the importance of continuing to develop our programs.

A collaborative effort by CODAC Behavioral Health Services, Inc., and El Rio Community Health Center, Whole Health is our integrated system of care designed to improve the physical health status of 1,300 adults with serious mental illness in Southern Arizona. It has been one year since receiving news of our Substance Abuse and Mental Health Services Administration grant award and six months since Whole Health opened its doors to members with serious mental illness.

Using the person-centered healthcare home model, Whole Health delivers fully integrated mental health, medical, and wellness services under one roof. The program emphasizes prevention and offers individualized wellness plans, workshops, and fitness regimens.

The Whole Health program serves 295 clients. As anticipated, the clients have several health concerns that their integrated treatment team is now monitoring and treating. Those problems include obesity (39 percent), co-occurring substance use disorders (32 percent), tobacco use (29 percent), diabetes (6 percent), hypertension (6 percent), and high cholesterol (3 percent).

In the recovery world, it is often said that acceptance is the first step. But here, knowledge must come before acceptance. “Many of our members don’t actually know what health problems they really have,” says Holly Monka, the nurse practitioner. “Now they have the facts and a team of compassionate professionals to help them get healthier in mind and body.”

At Whole Health, the clinical team is experienced in working with people with serious mental illnesses. The team includes a behavioral health medical professional, two therapists, three care coordinators, two wellness support specialists, a family nurse practitioner, a registered nurse, a certified medical assistant, and a medical office specialist. In addition, to best serve members, the program provides mental health and primary care at one of CODAC’s treatment sites, where people with serious mental illnesses have traditionally received care.

Although each partner organization maintains its own electronic health records, the entire team is able to view records on each others’ EHR systems to get a full picture of a member’s medical history and present conditions. Moreover, “Because we share the same space, I can pop my head into the nurse’s office to confer about something I’m seeing in a member — and vice versa. It’s really helpful,” says John Delgadillo, a care coordinator.

Outcomes specific to chronic illnesses are tracked by care coordinators through the EHR system. Additionally, impact consultants evaluate national outcomes measures collected at intake, repeated at 6- and 12-month intervals, and when the member is discharged from the program.

Both CODAC and El Rio have been in Southern Arizona for 40 years. Whole Health expands upon an established partnership between the two organizations that, together, provide healthcare to more than 90,000 low-income people each year. The two organizations were strong candidates for this SAMHSA grant because

- >> El Rio is one of Arizona’s largest Federally Qualified Health Centers,
- >> They have reputations for successfully managing SAMHSA and Health Resources and Services Administration grants, and
- >> CODAC—as a managed behavioral health organization—has provided integrated mental health and substance use disorder treatment and prevention services for more than 15 years.

Starting an integrated program takes time and money. Under our grant, SAMHSA and the Center for Mental Health Services provide \$500,000 annually. Infrastructure accounts for about 23 percent of the budget, and wellness activities make up 15 percent. It has taken time for the program to be built from the ground up. After the infrastructure and implementation plans were developed, staff recruitment took about 4 months. Onsite laboratory services began in June 2010, and telepharmacy was started in September 2010.

“We are extremely fortunate to be one of the original SAMHSA grantees, at the forefront of this new way of caring for people with serious mental illness — care for the whole person,” says CODAC President W. Mark Clark. “National healthcare reform and mental health parity legislation have set the stage for sustainability of programs like Whole Health, which we believe will prove to be better for the whole health of our members, their families, and our communities.”



Shawnee

Shawnee: Improving Outcomes with Primary Care

Cynthia Holstein, Project Director, Shawnee Mental Health Center, OH

Shawnee Mental Health Center serves people who live in three of the most impoverished counties in Appalachia, Ohio: Adams, Lawrence, and Scioto. Our consumers present with serious medical needs such as uncontrolled diabetes, hypertension, chronic obstructive pulmonary disease, heart disease, and cancer. More than 40 percent have no primary care provider and seek services through local emergency rooms.

In 2007, we were fortunate to receive funding from the Health Foundation of Greater Cincinnati to begin integrating primary and behavioral healthcare. This funding put us in a position to submit a competitive proposal when the SAMHSA request for proposals was announced. At that time, the following items were in place at our agency:

- >> Three exam rooms equipped to provide primary care (one in each county)
- >> Primary care assessment forms and data collection tools (all paper based)
- >> Contracts with two managed Medicaid companies
- >> A family nurse practitioner who provided basic primary care services
- >> A contract with a primary care physician to supervise the nurse and provide consultation
- >> An agreement with an external billing company to process our primary care billing
- >> A Medicaid provider number for physical health services
- >> Electronic medical record capabilities for mental health services.

Since receiving the SAMHSA grant, we have added two more exam rooms and hired three licensed practical nurses as nurse care managers (one for each county) and three part-time wellness coaches (one for each county). Our supervising physician is now onsite one-half day each week, and he provides direct services in addition to consultation and supervision. We plan to hire an additional full-time nurse practitioner when our primary care caseload increases.

We are billing and being reimbursed for our primary care services by Medicaid, Medicare, and various private insurance companies. SAMHSA funds enabled us to receive training in billing and coding, and we now handle all of our primary care billing in-house instead of contracting with an external billing company.

Our services include basic primary care, an immunization clinic for at-risk consumers, smoking cessation services, peer wellness services (e.g., fitness, nutrition, support, wellness planning), and benefits assistance through the Ohio Benefits Bank. We are recruiting for a contract nutritionist to develop meal plans for consumers and are in the process of developing an after-hours "hotline" system for primary care services. This system is being designed to prevent unnecessary emergency room visits. We are e-prescribing within our primary care department with Allscripts, a free, web-based prescribing system and using a registry tracking system that we developed within our electronic medical records system.

Preliminary outcomes suggest that our primary care services are having a positive impact on lowering blood pressure and hemoglobin A1c levels and helping people with severe mental illness stop smoking and lose weight. After further analysis of year 1 data, we will distribute our outcomes to our stakeholders and use these data to make modifications to the program, if necessary.

Keeping these services available for our community is one of our organization's priorities. Activities include reviewing reimbursement rates, claims denials, and other financing practices to help us determine the appropriate service mix and number of encounters needed to sustain the services. We are pursuing involvement with our state's expedited SSI/SSDI and Medicaid program to help people in need rapidly access resources. We are actively advocating at the state level for recognition of the services provided by wellness coaches and nurse care managers so that we can receive reimbursement for their activities (which already occurs in several other states).

Finally, we are exploring the feasibility of becoming a Federally Qualified Health Center and establishing a pharmacy. We believe that the possibilities are endless and that the SAMHSA grant is allowing us to pursue more and enhanced primary care services for the people we serve.

SouthEast

Southeast: Building On a Strong Infrastructure

Sue Green, Grants Manager, and **Jayn A. Devney**, COO, Southeast, Inc., and **Phyllis Panzano**, President, Decision Support Services, Inc., OH

Southeast's longstanding interest in transforming its business model from behavioral healthcare to integrated care, the strong commitment for doing so from leadership and management, and the organization's preliminary investment and experiences incorporating primary care services into the operation provided a solid platform for seeking funding from the Substance Abuse and Mental Health Services Administration for an integrated healthcare grant.

Southeast, Inc., a behavioral health center with sites in five Ohio counties, is building on a strong foundation of management and leadership support and existing primary healthcare services to develop an integrated care model to address disparities in morbidity and mortality experienced by people with serious mental illness. Existing services included a small primary care clinic, a full-service pharmacy, and an emerging best practice model of wellness management and recovery. In addition to primary care services, Southeast has a strong program-planning process that includes clinicians, human resources, fiscal staff, and project evaluators who work together to create a fundable — and feasible — project.

Southeast has long been aware of the health needs of the populations we serve. In 2009, the organization provided behavioral healthcare and homeless services to nearly 12,000 clients. Clients with serious mental illnesses have an increased incidence of chronic conditions, including those affected by modifiable health risks such as diabetes, hypertension, obesity, chronic obstructive pulmonary disease, cardiovascular disease, chronic pain, and substance use (especially high rates of smoking). An Ohio study found that patients in Ohio's state psychiatric hospitals died an average of 32 years earlier than the general population, largely as a result of these chronic conditions. The adults with serious mental illnesses served by Southeast have limited economic means, lack access to primary care, and think of mental health care as being similar to an acute medical care model.

To respond to these needs, Southeast expanded from a primary care clinic staffed by 0.4 FTE providers to a full-time clinic staffed by 1.4 FTE providers. SAMHSA funding allowed Southeast to hire a nurse care manager and bring

onsite laboratory services back into the organization. Issues of integration include identifying client pathways into treatment and how to coordinate care among disparate providers in a large organization. We are adapting our electronic health record to incorporate physical health data. In addition, we are evaluating the capacity of our current billing and EHR software for primary care and are actively investigating alternative systems.

Project outcomes assess the ability of people to manage and prevent chronic health conditions. We operate on the premise that if clients adopt a wellness approach to healthcare, they will be able to better manage or prevent the chronic conditions that contribute to the increased morbidity and mortality of people living with psychiatric disorders. Client-level healthcare outcomes being tracked include hemoglobin A1c levels, lipid levels, weight and body mass index, blood pressure, and tobacco use.

The project was initiated in a context that favors long-term success, and all grant activities have been implemented with an eye to the future and sustainability. Medical records and fiscal staff are working to increase third-party billings for primary care. In fact, Southeast is adapting its billing systems to capture more billings and increase revenues. Consistent with this aim, we hypothesize that an integrated approach to completing disability determination paperwork will lead to more rapid determinations for disability and increased access to Medicaid and Medicare benefits.

As revenues increase, we plan to hire more providers and expand services beyond the initial grant funding. Most important, Southeast's longstanding belief that the future for behavioral healthcare lies in its integration with primary care motivates us to seek new funding opportunities, such as those offered under the Federally Qualified Health Center New Access Point available as a result of the healthcare reform act.

RIPPLES IN THE POND Lisa Coley, Community Partnership of Southern Arizona



"Between the fibromyalgia and the arthritis, I was barely able to walk," says Lisa Coley, a student at the University of Arizona and a participant in the university's Recovery thru Integration, Support, and Empowerment (RISE) Camp Wellness. She was also suffering from multiple personality disorder, posttraumatic stress disorder, depression, and agoraphobia. "I'd been through therapies before," Coley explains, "and my physical health always bothered me. I thought, I can't be mentally fit if I'm not physically fit." So when Coley's doctor recommended her for the program and she was accepted, she jumped right in. "This camp gave me the incentive to work on my physical health, to affect my mental health," she explains.

Coley can go to the grocery store now or out in public, alone. The first time she left the house alone, she panicked a little. "But then I thought to myself, you can do this," and she just kept going, she says. "I knew if I panicked, I could leave. But I didn't." Coley not only managed to pick up her groceries, but even paid a visit to the thrift store next door. "I had lost weight and needed new clothes. I ended up staying for an hour and a half," she laughs.

There was a time when Coley's mobility was so limited she could barely lift one leg. Yet, by the time she graduated from camp she was walking a fast-paced jaunt on the treadmill. She bought a bike so that she could ride every night. "You really have to give credit to the peer health mentors," says Coley. "They know what they're doing, and they're open to new suggestions. They motivate us, but they don't push us to overdo it."

Coley fully embraced the nutrition classes and started avoiding fats and other unhealthy foods. "It was easier to cook with fresh foods than I expected it to be," she says. "I went through my fridge and wiped out all the bad stuff." As a result, she's lost weight, and inches. "I eat more fresh foods and vegetables and skip the sugary stuff and fried foods. It helps my mood and my energy levels to eat right. Fibromyalgia can really wipe you out," Coley says. With the changes she has made, she feels refreshed in the mornings. In addition, her thyroid balanced out and her cholesterol levels went down.

Coley eagerly volunteers at the center. "I come to the classes to motivate the other students, and I also offer free haircuts [she is a trained beautician]," she says. It wasn't long before Coley joined the advisory council. She's working on putting together a swim club at one of the local YMCAs. "Before, I was worried about having a heart attack," says Coley, "But I didn't really care. This camp gave me the incentive to think about me — to care if I live or die."

Camp Wellness, a contract program of the Community Partnership of Southern Arizona, began in December 2009 and is the first step in a whole health initiative by the CPSA, which administers public behavioral health services in Pima County. The program targets CPSA members with serious mental illness, enhancing their knowledge and skills and helping them integrate healthy choices into their lives. The partnership receives funding from the Arizona Department of Health Services/Division of Behavioral Health Services, the Arizona Health Care Cost Containment System, and the Substance Abuse and Mental Health Services Administration.

From Case Managers to Health Navigators

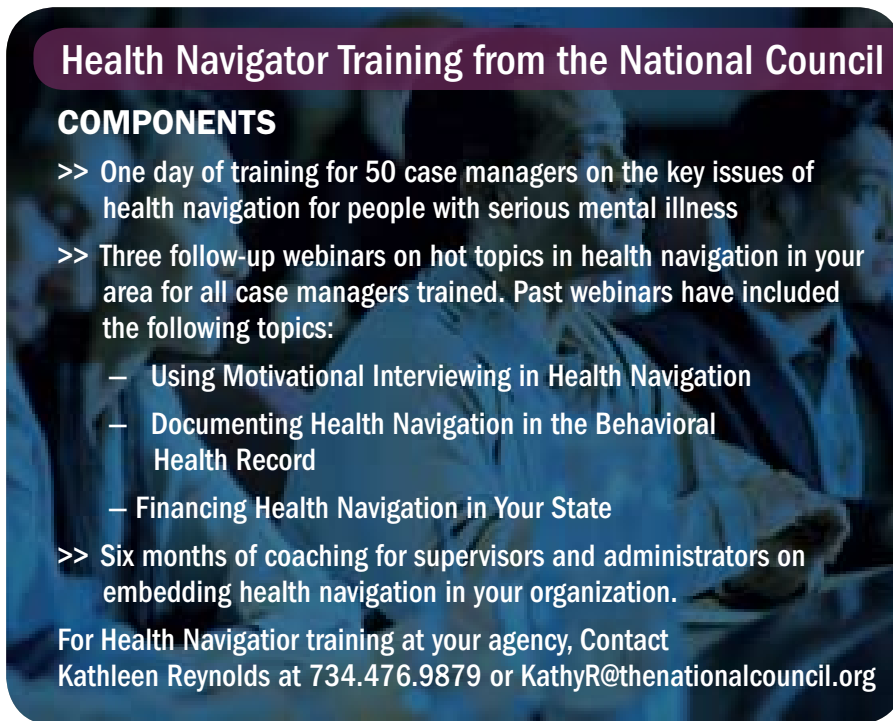
Kathleen Reynolds, MSW, ACSW, Vice President, Health Integration and Wellness Promotion, National Council for Community Behavioral Healthcare

As the healthcare reform act is implemented and medical homes become a reality for people with serious and persistent mental illness, how will the role of the traditional case manager evolve? Community Mental Health Centers across the country are training case managers to become health navigators. Health navigation expands the traditional case manager role from helping consumers with severe and persistent mental illnesses establish a life in recovery to a broader role of assisting them to learn to manage chronic physical illness.

The mental health field has spent more than 40 years perfecting the skills necessary to assist people in learning to manage their chronic mental illness. Those same skills — helping consumers accept and overcome the challenges of mental illness, navigate the system, and learn or relearn life skills — are transferrable to chronic physical health conditions such as diabetes, heart disease, and chronic obstructive pulmonary disease. In fact, behavioral health case management has the exact skill set needed to assist primary care in moving from addressing issues of chronic illness by treating acute episodes to adopting a preventive, recovery-oriented approach to physical health problems.

How do we do this? Centerstone, a nonprofit provider of community-based behavioral healthcare in Indiana, and the Office of Behavioral Health in Delaware County, Pennsylvania, have taken the first steps in the process by providing training and support for existing case managers to become health navigators. Working cooperatively with the National Council for Community Behavioral Healthcare, both organizations have trained 150 case managers in key issues related to health navigation. The issues include addressing physical health needs in the behavioral health assessment and in treatment planning, assisting case managers with preparing consumers for upcoming primary care appointments, and collecting health outcomes alongside behavioral outcomes in day-to-day work.

Bob Siegmann, vice president for healthcare integration at Centerstone, says, "This training was



Health Navigator Training from the National Council

COMPONENTS

- >> One day of training for 50 case managers on the key issues of health navigation for people with serious mental illness
- >> Three follow-up webinars on hot topics in health navigation in your area for all case managers trained. Past webinars have included the following topics:
 - Using Motivational Interviewing in Health Navigation
 - Documenting Health Navigation in the Behavioral Health Record
 - Financing Health Navigation in Your State
- >> Six months of coaching for supervisors and administrators on embedding health navigation in your organization.

For Health Navigator training at your agency, Contact Kathleen Reynolds at 734.476.9879 or KathyR@thenationalcouncil.org

very valuable for our case managers. They now understand that they can play a pivotal role in the physical health of their clients. Physical health challenges tend to shorten client lives much more than their mental illness. The full-day training followed by three webinars was an ideal instruction method for keeping the case managers involved as they further developed their skills."

The training in Pennsylvania was led by Jonna DiStefano and the HealthChoices HealthConnections team from the Office of Behavioral Health. The HCHC program has been operating for more than 2 years. Health navigator training gave case managers from HCHC the tools to more easily facilitate access to care for their clients. DiStefano says, "This was excellent training for our HCHC case managers. They

benefited from the information presented. There were good interactions, and the training was done in a pleasant and understandable manner, with a lot of room for attendee feedback. Our new navigators are looking forward to additional training facilitated by the National Council."

Kathleen Reynolds has more than 30 years of experience in the mental health and substance abuse field. She currently is vice president of Health Integration and Wellness Promotion for the National Council. Previously, Reynolds was the director of the Washtenaw Community Health Organization, a nationally recognized leader in the integration of behavioral health and primary care services. She also coauthored a book on implementing integrated care, Raising the Bar: Moving Toward the Integration of Health Care, a Manual for Providers. book is in its second edition and is used widely to implement integration between the public behavioral health system and primary care providers.

In fact, behavioral health case management has the exact skill set needed to assist primary care in moving from addressing issues of chronic illness by treating acute episodes to adopting a preventive, recovery-oriented approach to physical health problems.

Staff training persists despite cuts; many agencies turn to online formats

These days in many community mental health agencies, a client no-show for an appointment no longer leaves a clinician grasping for alternatives to staring at the wall. The clinician is likely to use the newfound time to complete mandated training activity, simply by going online to access the educational material.

Community mental health agencies now have a number of alternatives to sending staff members off-site for training and incurring the transportation costs and productivity losses associated with employees leaving their work site for an extended period. A number of companies offer online learning systems covering most or all of the training areas affecting behavioral health organizations, and agencies are reporting that staff members are becoming increasingly comfortable with less face-to-face interaction with a trainer.

"Some are hesitant at first, but once they participate they get sold on it," Tasha Walsh, a vice president in the Eastern Division operation of Providence Service Corporation, a national company managing more than 100 community mental health offices across the country, told *MHW*. "Clinicians appreciate the flexibility, because in direct care they always have to juggle a client schedule."

The National Council for Community Behavioral Healthcare responded to the emergence of online training opportunities in recent years by cementing an exclusive partnership with the company Essential Learning, which offers customized e-learning for mental health, addiction and other human-service

agencies. As part of that arrangement, the National Council hosts a small-agency version of Essential Learning's Learning Management System, tailored to the needs of member organizations with 60 or fewer employees and helping reduce their overall training costs.

"In online training, if a clinician is waiting for a client, they can start on a course," Essential Learning CEO Sue Erskine told *MHW*. "Also, some agencies let their employees take the training classes at home."

'These types of training are not going away; they don't get cut when governments cut agencies' budgets.'

Sue Erskine

Specific training needs

Staff training needs in behavioral health organizations are far-ranging, involving an array of state and national regulatory requirements, professional accreditation standards and other mandates. They have represented something of a fixed cost for agencies, in that the requirements don't tend to be lifted when an agency's government funding gets reduced. If anything, the continued push to evidence-based practice will only intensify the need for consistently updated training schedules in

Bottom Line...

Some mental health agencies are seeing a variety of benefits in moving more toward online training, from cost, productivity and staff satisfaction standpoints.

behavioral health agencies.

"These types of training are not going away; they don't get cut when governments cut agencies' budgets," Erskine said.

Providence Service Corporation's Walsh said that while state training requirements differ greatly among the many offices in its decentralized operation, the company has been able to organize common training needs for everyone into an all-staff orientation. Covered topics include ethics, the Health Insurance Portability and Accountability Act (HIPAA), cultural awareness and environmental safety, she said.

Likewise, the director of education and training at community mental health agency COMTREA, Inc. in Missouri lists ethics training at the top when asked to cite the hot-button subjects in staff training these days. Overall, San Mueller says training remains an important priority in the organization's administration. "We feel it's important for our staff that evidence-based principles are used in the therapy that we do," Mueller told *MHW*.

Mueller said her agency has used the Learning Management System from Essential Learning for about three years.



WELLNESS, It's More Than Being Well!

Peggy Swarbrick, PHD, OTR, CPRP, Training Director, CSP-NJ Institute for Wellness and Recovery

The term wellness is not new in society, although it is considered a relatively new framework as it relates to mental health recovery. Wellness is now being viewed as an important construct as it relates to personal recovery and mental health systems transformation. We use the term broadly but often tend to focus on the physical dimension. Programs and state authorities view wellness narrowly, in terms of physical health. Although physical health is important, it is critical to understand the wellness framework as a bigger concept, so that services and programs can be organized, and outcomes measured, more effectively.

The following is a brief history of the term wellness followed by a wellness framework. Consider this framework a guideline, whether you are managing your life, seeking and using services, delivering services, or helping to manage and oversee a wellness-oriented service system.

Wellness is an inspiring and powerful word in the English language. However, it is one of the least un-

derstood and therefore most open to interpretation and personal definition. Wellness is not a popular or exotic fad but rather a philosophy of living that can help people live a more satisfying, productive, and happy life. Wellness offers a person a philosophy that supports healthy lifestyle habits that have positive effects on quality of life.

For centuries, philosophies of good living, health, and well-being have evolved within societies. Since early times, the ancient Greeks went to temples to remove themselves from the stress and pulls of life. They focused on diet, relaxation, and self-examination, which were believed to help restore energy and vitality, as well as a sense of wholeness, harmony, and balance. Individuals were viewed holistically. Music, arts, exercise, healthy nutrition, play, and imagery were seen to promote healing and health.

Art, philosophy, humor, and spirituality were seen as lifestyle practices to replace

- >> Stress with harmony.
- >> Anger with peace.

- >> Despair with hope.
- >> Isolation with community.

In 1961, Halbert Dunn started lecturing and writing articles about an idea he called "high-level wellness." Dunn stressed the importance of mind/body/spirit connections, the need for satisfactions and valued purposes, and a view of health as dramatically more than nonillness. He defined high-level wellness as "An integrated method of functioning of which the individual is capable within the environment." In this definition, there is no optimal level of wellness, but rather recognition that wellness is a direction in the progress toward an ever higher potential of functioning.

Wellness is not the absence of disease, illness, and stress but the presence of

- >> Purpose in life.
- >> Active involvement in satisfying work and play.
- >> Joyful relationships.
- >> A healthy body and living environment.
- >> The presence of happiness.

The WE in Wellness: What Consumers Really Need

As a teenager, Lauren Spiro was hospitalized for over a year with a diagnosis of chronic schizophrenia. As an adult, she has worked to reform mental health treatment and educate stakeholders in the mental health system and broader community on the many diverse paths to wellness. She is an eloquent advocate for medical procedures and public policies that are directed by empowered consumers of mental health services. For more than 30 years, Spiro has worked in a variety of behavioral healthcare settings in positions ranging from direct service provider to senior manager. Currently, she is the director of public policy at the National Coalition of Mental Health Consumer/ Survivor Organizations. Spiro is a consultant and educator on the recovery process, peer support, systems transformation, and cultural competency.

Lauren Spiro shares her perspectives on wellness with National Council Magazine

WHAT WE REALLY NEED IS ...

- >> for people to understand that wellness is more than the absence of illness, that it's about having purpose in life
- >> an end to band-aid approaches and a serious attempt to understand why people may not be well
- >> faith in recovery, belief in ourselves
- >> to understand why we feel the way we do
- >> encouragement of expression, not conformity
- >> to have a safe place where we can express our feelings
- >> to be listened to — on a human level
- >> to have a range of recovery options, including non-pharmaceutical alternatives, to choose from
- >> to be able to make meaningful choices
- >> to get help in dealing with the public stigma against and mistrust of persons with mental illness
- >> to participate in shared decision-making with providers regarding our recovery options
- >> to be at the policy development table, to have a voice
- >> to know we are not alone, to heal with others



WELLNESS IN MENTAL HEALTH

Wellness approaches for mental health practice have been proposed in recent years. Wellness is a conscious, deliberate process that requires a person to become aware of and make choices for a more satisfying lifestyle. A wellness lifestyle includes a self-defined balance of health habits such as adequate sleep and rest, productivity, exercise, participation in meaningful activity, nutrition, productivity, social contact, and supportive relationships.

It is important to note “self-defined” because everyone has individual needs and preferences, and the balance of activity, social contact, and sleep varies from person to person. Wellness is the process of creating and adapting patterns of behavior that lead to improved health in the wellness dimensions.

EIGHT WELLNESS DIMENSIONS

The following model includes eight dimensions of wellness — physical, spiritual, social, intellectual, emotional/mental, occupational, environmental, and financial — and attempts to outline a framework for mental health recovery.

Physical

- >> Recognizing the need for physical activity, diet, and nutrition while discouraging the use of tobacco, drugs, and excessive alcohol consumption.
- >> Paying attention to physical and physiological signs of stress.
- >> Balancing the physical dimension by creating a self-defined daily routine that includes adequate sleep and rest, walking or exercise, appropriate levels of activity and productivity, and involvement in creative or structured activity that counteracts negative stress responses.
- >> Learning to assume personal responsibility and care for minor illnesses, and knowing when professional medical attention is needed.

Spiritual

- >> A broad concept that represents one's personal beliefs and values; having meaning and purpose, and developing a sense of balance and peace. The spiritual dimension recognizes our search for meaning and purpose in human existence. It includes the development of a deep appreciation for the depth and expanse of life and natural forces that exist in the universe.
- >> For many people, healing and health are enhanced by exploring, respecting, and incorporating person-

“The development of personal strengths (potentials) in the context of a balanced life may be the key to well-being.” Aristotle

al values and beliefs and awareness of a being or force that transcends the material world and gives a sense of connectedness to the universe.

- >> For many people, the spiritual dimension is closely related to cultural, religious, and spiritual traditions.

Social

- >> The social dimension encourages contributing to the environment and community and emphasizes the interdependence between ourselves, others, and nature.
- >> The ability to communicate our needs and ideas with people who support and care about us.
- >> Personal relationships, important friendships, and connection with people, pets, and the community.
- >> Like all other dimensions, people's social connectedness and social wellness vary greatly. Some people have a few relationships; others have many. Some people have most of their relationships in one area of their lives; others have broader relationships.
- >> For many people, relationships involve a sense of reciprocity and equality.

Intellectual

- >> Recognize creative abilities and find ways to expand our knowledge and skills while discovering the potential for sharing those gifts with others. Lifelong learning, application of knowledge learned, and sharing knowledge.
- >> The intellectual dimension can be activated through a wide array of activities. Many people find it useful to set aside time regularly to pursue personal interests, such as reading books, magazines, and newspapers and engaging in other means of keeping abreast of current issues and ideas.

Emotional/Mental

- >> The capacity to recognize our feelings; involves the ability to express feelings, adjust to emotional challenges, cope with life's stressors.
- >> The ability to assess our strengths, limitations, and areas we want to develop further.
- >> Tolerance, and the awareness of and acceptance of a wide range of feelings in ourselves and others.
- >> The ability to live and work independently while realizing the importance of seeking and appreciating

the support and assistance of others.

- >> The ability to take on challenges and recognize conflict as being potentially healthy.

Occupational

- >> The opportunity to participate in activities that are meaningful and rewarding and that provide meaning and purpose.
- >> Activities that reflect personal values, interests, and beliefs.
- >> Personal satisfaction and enrichment in one's life is derived from participation in work and volunteer activity as well as other activities and tasks.

Environmental

- >> The environment includes our living, learning, and working spaces and the larger communities where we participate as citizens.
- >> Good health can be fostered by occupying pleasant, stimulating environments that support our well-being. Additionally, good health can be enhanced by places and spaces that promote learning and contemplation and elicit the relaxation response.
- >> Being able to be and feel physically safe, in safe and clean surroundings, and access clean air, food, and water.

Financial

- >> Objective indicators may include measures such as income, debt, savings, and aspects of financial capability such as having knowledge of financial products and services, planning ahead, and staying on budget.
- >> Subjective perceptions may include a feeling of satisfaction with one's current and future financial situation.

Margaret (Peggy) Swarbrick is the CSP-NJ Institute for Wellness and Recovery Training Director and a post doctoral fellow in the Psychiatric Rehabilitation Program at University of Medicine and Dentistry of New Jersey - School of Health Related Professions. She has been involved in the mental health field since 1977 personally and professionally since 1986. Swarbrick has lectured nationally and internationally on recovery and wellness and consumer-operated services and completed doctoral work at New York University, in the Occupational Therapy Program. Peggy has published on the wellness and recovery model, consumer operated services, a commentary on a cognitive behavioral treatment for persons diagnosed with mental illness who experience PTSD, and peer delivered wellness and recovery programs.



Peers Lead by Example

Meghan Caughey, MA, MFA, Peer Wellness Coordinator, Benton County Health Services

The report “Measuring Premature Mortality Among Oregonians” reveals that people in Oregon who were treated for mental illness and substance abuse have an average age of death of 45.1 years, with up to 38 years of life lost. That’s outrageous and we cannot simply accept it as the status quo! The Peer Wellness Program at Benton County, Oregon seeks to reverse this shocking trend.

The Peer Wellness Program serves adult clients of the Benton County, Oregon, Health Department, a Federally Qualified Health Center and is part of the center’s health promotion initiatives. The program blends the services of the primary care clinic with mental health services, including peer-delivered services. This “sideways” versus “top-down” approach is vital to the well-being and recovery of people with serious and often chronic mental health conditions who may also have co-occurring physical health and substance use issues.

As part of a team working to create a person-centered medical home, we have designed training programs to help people become certified peer specialists. In addition, we will soon be implementing a new Peer Wellness Coach Program to offer direct help to clients who have serious physical issues in addition to mental health needs.

Our initial funding included a state block grant derived from a federal block grant. We are now moving to a level of sustainability by starting to bill peer services to Medicaid. In 2007, the Center for Medicaid Services issued a ruling that if states had a process for certifying peer-delivered service workers, then those certified peer specialists could bill Medicaid for appropriate services.

At Benton County, we began by creating a peer-designed curriculum that used some of the tried-and-true approaches of other peer training programs around

“

We cannot push or lead someone into motivation. We can, with understanding, create conditions that potentially excite motivation.”

Patricia Deegan, Consultant and Creator, CommonGround

the country, but distinguished itself with a strong wellness orientation. Students in our peer specialist training program attend a weekly student-led “process group” in addition to completing 44 hours in the classroom. The process group is important because students are able to bond with one another and practice group facilitation and leadership skills. An essential part of the program design includes building a paid workforce of trained peers who can use their abilities and talents to help clients using our services.

An example of our wellness orientation is the use of mindfulness techniques among the peer practitioners. Mindfulness techniques are medically proven to have cardiovascular benefits. In the first stages of training, students learn to use mindfulness techniques and are encouraged to apply the lessons to their own lives. Later, students learn to use the techniques with their peer clients. In addition, students are encouraged to try new leadership roles, both in leading “mindfulness segments” and in creating and leading “movement segments” in which the entire group engages in fun, often playful, creative movement around a chosen theme. The use of movement in training helps inculcate the value of nonsedentary, active role modeling.

The training coursework has a strong emphasis on creating wellness for ourselves, supporting it in our peers, and engaging in wellness-oriented policy change. We believe in strong “wellness-informed” care.

The new Peer Wellness Coach Training emphasizes working with clients and provides in-depth knowledge about chronic diseases, such as diabetes and metabolic syndrome, as well as exercise, nutrition, motivational interviewing, advanced tobacco cessation support, and other components of wellness-oriented lifestyles.

The Peer Wellness Program includes the LOTUS (Lifestyles Overcoming Trouble Utilizing Support) Wellness Support Group. In this weekly group, facilitated by two certified peer specialists, mindfulness techniques are practiced and participants take part in “check-in” time, during which they can get support from the group on their individualized goals, which are part of their own person-driven wellness action plans. The Peer Wellness Program also offers peer-led support groups for people who have both mental health and substance use issues (called Dual Diagnosis Anonymous) and for veterans.

Peer specialists meet with clients on a one-to-one basis both at the health department and in the community. They also use phone check-ins to support clients, for example, to remind them to take medications and to complement efforts in helping reduce isolation.

The Peer Wellness Program has developed several assessment and outcome measurement tools and is starting to use integrated electronic medical records as a way of gathering outcome data to track clients’ physical and emotional recovery. Outcome tools include a Wellness Survey for clients and a Workforce Weekly Survey that tracks levels of recovery, job satisfaction, and coping with stress among the peer specialists.

It has been an evolving process for the peer specialists to become accepted and used by some of the licensed clinical staff. We have learned that it is helpful for the peer specialists to participate in the adult mental health team meetings and staff meetings. In these settings, the clinicians and the peer specialists have gotten to know and trust one another in greater depth and have learned how to coordinate their services, further developing the team approach to care. The peer specialists also attend their own clinical supervision and consultations with a licensed provider.

For the peer specialists, the creation of a “culture of wellness” among the mental health community is personal. Too many of our peers have become sick and died before their time. The paradigm shift of creating the culture of wellness informs the direction of our work in our community and reaches across our state to the national level. We are on the forefront of creating change. Much work needs to be done, and the Benton County Peer Wellness Program is fully engaged in taking it on.

Meghan Caughey is the Peer Wellness Coordinator for Benton County Health Services in Corvallis, Oregon. She is in charge of designing and implementing wellness oriented peer support services for the community. She oversees and supervises the peer workforce, designs and conducts trainings, and provides direct clinical service to clients. She is involved in state policy concerning peer services, mental health and health integration. As a national speaker on wellness and recovery as well as art, Caughey has presented to physicians, researchers, administrators, and program directors. She has led several workshops on wellness model, peer delivered services, art and transformation.



“This September 17, 2010, marked my 3-year anniversary of being the Peer Wellness Coordinator at Benton County Health Services, where I have designed and implemented the Peer Wellness Program. It is the first time in my life that I have had a full-time job. Even my psychiatrist had told me I could not work. After years of struggling, including more than 100 hospitalizations, seclusion rooms, and restraints, I am now able to successfully do work that I love. I think that this might be a source of hope for many who do not think that a life as disrupted by mental health issues as my own could ever turn around.”

Personal Trainers Keep “Recoverers” In-SHAPE

Kenneth Jue, MSSA, Senior Executive and In-SHAPE Founder, Monadnock Family Services

At Monadnock Family Services, we launched In-SHAPE in 2003 in response to the premature deaths of many of our clients with serious mental illness. We witnessed them suffering from comorbid health conditions and co-occurring substance use issues accompanied by poor healthcare access, unhealthy lifestyles and diets, social exclusion and discrimination, and sedentary existences.

In-SHAPE was embraced by local, state, and national foundations. The Robert Wood Johnson Foundation and the New Hampshire Endowment for Health became our lead funding partners. We formed partnerships with nonprofit and for-profit fitness and dance centers, nutrition partners through our local Keene State College and county extension services, medical clinics and hospitals, and two peer-run support organizations.

This fitness and healthy eating program aims to increase the life expectancy and eliminate the gap for people with a serious and persistent mental illness. We work from a health paradigm and employ certified personal trainers as program health mentors to guide our program participants to healthy lifestyles. Nutrition and healthy eating, access to integrated healthcare services, and all physical activities are carried out in integrated community settings. We base our program on full social inclusion, recovery principles of self-direction and self-management, individual empowerment, community engagement, integration of health and mental healthcare, partnerships, and social innovation.

In-SHAPE is currently being implemented across New Hampshire by all of the state's 10 Community Mental Health Centers under grants from the National Institute of Mental Health and the Centers for Disease Control and Prevention. The grants were awarded to Dartmouth's Centers for Aging and Healthy Living to study the implementation process and effectiveness of the programs. Additionally, the program is being replicated in Boston under another NIMH research grant. Mental health agencies in Flint, Michigan, and Providence, Rhode Island, have also implemented the program. The state Medicaid agencies in Michigan and New Hampshire are now providing partial but significant reimbursement for aspects of the program.

There is a “Ron” in every agency where In-SHAPE

We work from a health paradigm and employ certified personal trainers as program health mentors to guide our program participants to healthy lifestyles. Nutrition and healthy eating, access to integrated healthcare services, and all physical activities are carried out in integrated community settings.

has been implemented. The programs fill up quickly and have significant wait lists. Monadnock has 150 participants enrolled with a wait list of 50 people. The Dartmouth research data has not yet been published; however, for every person who benefits from the program there is another who struggles to participate and to demonstrate progress in healthy lifestyles goals. As we know all too well, most of us struggle with our own fitness and health aims and efforts without having the added complication of a serious mental illness. Although getting fit is not rocket science, we also realize that it is not a slam dunk.

We have established a learning collaborative among the different In-SHAPE programs. We have significantly altered some program components, such as expanding nutrition and healthy eating. We are incorporating a more deliberate smoking cessation effort. Plus, we are striving to make the integration of health and mental healthcare work smoothly and effectively.

Finding the right community partners is not always easy and varies from community to community. Community engagement requires a certain skill set and knowledge base about how community systems

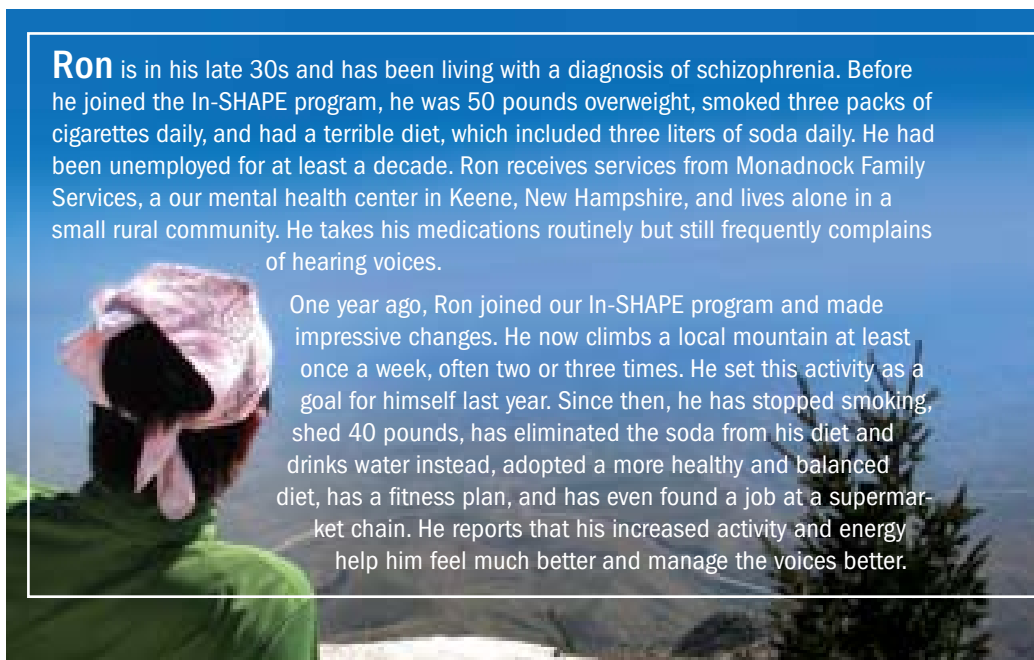
work. The use of potential tools, such as “social capital” and partnerships, requires forethought and sound planning. Of course, the economic environment has only made everything more challenging.

The gains that so many of our program participants have made generate a feeling of hope for them, the other participants, and for us. Innovation based on a value set that challenges the status quo of the societal view toward and acceptance of people with a mental illness has inherent value and can lead to the reduction of discrimination and build social inclusion and meaningful citizenship for the participants.

Kenneth Jue is the creator and founder of the award-winning In-SHAPE program, which is being replicated and researched in four states and the senior executive of Monadnock Family Services. From 1998 to 2009, he was the chief executive officer of the In-SHAPE program. He has worked in mental health for 38 years in Colorado and New Hampshire and also in corrections and substance use. He has presented at numerous professional conferences; and consulted with businesses, governments, and organizations around the world. Jue serves on the boards of directors of many community nonprofit agencies and New Hampshire advocacy organizations and has held local public elected office.

Ron is in his late 30s and has been living with a diagnosis of schizophrenia. Before he joined the In-SHAPE program, he was 50 pounds overweight, smoked three packs of cigarettes daily, and had a terrible diet, which included three liters of soda daily. He had been unemployed for at least a decade. Ron receives services from Monadnock Family Services, a our mental health center in Keene, New Hampshire, and lives alone in a small rural community. He takes his medications routinely but still frequently complains of hearing voices.

One year ago, Ron joined our In-SHAPE program and made impressive changes. He now climbs a local mountain at least once a week, often two or three times. He set this activity as a goal for himself last year. Since then, he has stopped smoking, shed 40 pounds, has eliminated the soda from his diet and drinks water instead, adopted a more healthy and balanced diet, has a fitness plan, and has even found a job at a supermarket chain. He reports that his increased activity and energy help him feel much better and manage the voices better.



ADVERTORIAL



Focus on Fitness and Recreation Building a Stronger Foundation for Recovery

Duane Reynolds, LSW, LADC, BCCR, Associate Director, Vinland National Center

Successful chemical dependency treatment and sustained recovery involve a multiplicity of factors. Some of the most elusive and difficult elements of chemical dependency treatment and subsequent recovery maintenance are the interpersonal skills required for building meaningful relationships and finding sober lifetime leisure activities. For people in recovery from alcohol and drug abuse, the development and participation in leisure activities is essential for maintaining long-term sobriety. For this reason, it is critical to incorporate fitness and leisure activities in the treatment setting to spark a client's life-long interest in sober activities.

Importance of Fitness in Treatment Setting

Exercise contributes to noticeable improvements in self-esteem and increased dedication to recovery. Setting and achieving short-term fitness goals helps individuals realize they can accomplish things they previously believed were impossible for them. Through guidance from exercise physiologists, participants take this new sense of accomplishment and use it as the boost of self-esteem they need to accomplish long-term sobriety.

Benefits of fitness training include enhanced belief in ability to accomplish goals, increased energy level, improved balance, increased coordination, increased immune system activity, improved overall strength and endurance, and improved posture.

Importance of Recreation in Treatment Setting

By the time an individual enters addiction treatment, their leisure and social activities most likely revolve entirely around alcohol and drug use. Individuals recovering from substance abuse need to learn how to manage stress and have fun without the use of chemicals. Finding leisure activities they enjoy can provide them with a constructive use of their free time. In addition, they can learn better ways to achieve goals, effective ways to solve problems, be able to handle stressful situations without the use of drugs or alcohol, and learn to socialize while sober.

Importance of Outdoor Recreation in Treatment Setting

The restorative effects of nature are very powerful and can be highly therapeutic, especially to those in treatment for drug or alcohol abuse. Outdoor recreation during treatment gives individuals a chance to rest and refocus their energies on their recovery.

Benefits of outdoor recreation include reduced stress levels, increased attention span, improved relaxation, decreased anxiety, reduction of blood pressure, and decreased risk of depression.

“It is critical to incorporate fitness and leisure activities in the treatment setting to spark a client's life-long interest in sober activities.”

Fitness and Recreation at Vinland Center

At Vinland Center, we strongly believe that an active role in sober recreation activities leads to a fuller and more rewarding life. Our participants have the opportunity to enjoy a variety of recreational activities coordinated by Vinland staff. No matter what the activity is, the intended result is to show participants how to find enjoyment in a leisure activity, encourage them to be socially active, and help them learn new skills that they can apply to other areas of their lives. The activities are varied and include things such as ice fishing, snowshoeing, canoeing, basketball, and Wii video games.

Each participant receives a personalized fitness program designed under the supervision of Vinland's exercise physiologists. Vinland's staff works closely with each participant to encourage a life-long interest in physical fitness.

Building Full Lives for People with Disabilities

For more than 20 years, Vinland has provided specialized chemical dependency treatment for adults with disabilities. We incorporate a whole-body approach to recovery, which includes not only fitness and recreation programming, but also includes family programming, grief and loss, anger management, and life skills such as computer training. At six-months post discharge, 80 percent of our program graduates report sustained sobriety and an improved quality of life, well-above the industry average rate of 20 percent.

To learn more, visit VinlandCenter.org or call 763.479.3555.



When Psychiatry Saved a Foot

Jeanie Tse, Director of Integrated Health, Institute for Community Living

Interviewed by Meena Dayak, Vice President, Marketing and Communications, National Council for Community Behavioral Healthcare

Jeanie Tse, Director of Integrated Health at the Institute for Community Living in New York City, says one of the most satisfying moments in her psychiatric career was when she learned that a wellness program she instituted saved a patient's foot. Psychiatry and foot care? Not surprising when you consider the fact that more than 25 percent of patients with serious mental illness in participating programs also had diabetes. The only doctor most of these patients see regularly is their psychiatrist, who is likely too stretched for time and resources to provide primary care and often lacks good primary care resources to refer patients to.

"Diabetes prevalence in the population with serious mental illness is three times that in the rest of the population," Tse points out. "So if we only treated people for mental illness and ignored the preventable physical conditions that can result in death, it would be poor medical practice," she comments.

Recognizing the challenges that persons with serious mental illness have in accessing physical health-care, Tse developed the Diabetes Self-Management and Healthy Living Workbooks in 2008 along with her colleague Elisa Chow.

In 2008, ICL launched the Diabetes Comorbidity Initiative in collaboration with the Urban Institute for Behavioral Health, a consortium of 21 behavioral health agencies committed to implementing evidence-based and best practices, directed by Andrew Cleek. Using the DCI Toolkit, patients work toward self-management of their diabetes, in close conjunction with case managers who are familiar with their lifestyles, needs, and challenges. But how do non-clinical staff like the case managers support physical health prevention and treatment? Collaborative learning is the foundation of the diabetes initiative — universal tools like self-management workbooks allow non-clinical staff and consumers

to learn about physical health together. Motivational interviewing and psycho-educational group facilitation leverage some of the major strengths of the behavioral health workforce — therapeutic relationship building and recovery-oriented service planning — to improve physical health outcomes for patients. The case managers truly take a person-centered approach, respecting what patients want.

ICL and UIBH have had to think about sustainability from day one — by ensuring buy-in and providing ongoing training to create culture change and organizational capacity. They started by piloting the DCI Toolkit in eight New York City agencies — a total of 30+ housing, case management, and clinic programs with more than 300 participants — with funding from the New York State Health Foundation. Agency executives were engaged as part of a steering committee, while a multi-agency interdisciplinary learning collaborative allowed a diverse group of

Tools Used in ICL's Diabetes Comorbidity and Healthy Living Initiatives

- >> Diabetes Self-Management and Healthy Living Workbooks — incorporate motivational interviewing language in a fun, easy-to-read format to facilitate case manager-consumer conversations around goal-setting to improve health.
- >> Diabetes Co-morbidity Initiative and Healthy Living Quik Guides — single laminated sheets highlighting key concepts from trainings.
- >> Diabetes and Healthy Living Info Cards — pocket-sized cards that help consumers track key elements of their health information.
- >> Healthy Living TV — video clips from the talk show featuring guest panelists and motivational interviewing role-plays.
- >> Letters to Primary Care Providers and Psychiatrists — providers can put these on their letterhead to facilitate collaboration with other members of patients' healthcare team.



Collaborative learning is the foundation of the diabetes initiative – universal tools like self-management workbooks allow non-clinical staff and consumers to learn about physical health together. Motivational interviewing and psycho-educational group facilitation leverage some of the major strengths of the behavioral health workforce – therapeutic relationship building and recovery-oriented service planning – to improve physical health outcomes for patients.

staff to problem-solve and share successes.

Ensuring buy-in at multiple organizational levels – agency leadership, program management, direct care staff and patients – has been accomplished via multimedia educational and marketing approaches.

Data analysis from the first two years suggest that diabetes self-management groups and individual counseling, facilitated primarily by non-clinical staff, are associated with significant reductions in A1c levels (a marker of diabetes-related risk), significant increases in the proportions of consumers receiving recommended diabetes interventions, and significant decreases in emergency department and hospital utilization, with the potential for health care cost savings. An expansion phase, piloting the DCI toolkit in 10 more New York City agencies, has been launched in 2010.

The Healthy Living Initiative has been piloted in-house at ICL as a multidisciplinary, multi-pronged approach to improving preventive care for ICL consumers. The initiative is supported by a modest grant from the New York Community Trust.

The Healthy Living Workbook – focused on preventive care and featuring basic guidelines on diet, exercise, and primary care visits – has been piloted in 49 of ICL's housing, case management, and clinic programs. In ICL's residential programs, patients fill out health screening forms on admission. Case managers review the forms and monitor health status on a monthly basis through discussions with patients and a primary care nurse. This on-the-ground nursing support may have resulted in the greatest degree of change being found in ICL's housing programs for consumers

with both serious mental illness and substance use disorders. Town Hall meetings with ICL's CEO Peter Campanelli and a Healthy Living TV program were broadcast via videoconferencing equipment as part of a multimedia campaign to encourage continued interest in the initiative. Early results in a sample of over 1,000 consumers suggest significant improvements on the SF-8 Health Outcomes Questionnaire. In the second year of the pilot, ICL is beginning to look at whether participation in the Healthy Living Initiative results in changes in emergency department and inpatient utilization.

Funding and staffing the wellness initiatives are challenging, says Tse. You can't bill for diabetes care in a mental health clinic. Supporting 80 programs in multiple agencies with one clinical coordinator, Rosemarie Sultana-Cordero, (who has a case management and therapy background) seems impossible. Tse says they rely on the enthusiasm and dedication of case managers, nurses, physicians and administrators who participate in the initiatives with no incentive other than the desire to help people with serious mental illness improve their physical health. CEO Peter Campanelli's championship of the initiatives has been significant and responsible for their success to date.

Private grants have partly funded the initiatives and ICL has approached city, state and national organizations for future support.

Despite the struggles, ICL's commitment continues. "It's our responsibility; we do this because we care about the whole health of our patients," declares Tse. And the reward is in hearing a patient say "I joined the group because I needed to know more about my ill-

Motivational Interviewing in Healthy Living Initiative ("FRAMES")

- >> Feedback regarding health behaviors, given by reviewing the Healthy Living Questionnaire.
- >> Responsibility for change lies with the consumer, who has the right to make choices.
- >> Advice about making healthy choices is given in a non-judgmental manner.
- >> Menu of options for action steps towards change are offered and explored.
- >> Empathic counseling using warmth, respect and understanding.
- >> Self-efficacy and optimism are fostered to promote change.

ness. Most helpful is that I learned that mental health and health are connected."

Jeanie Tse, MD, is a staff psychiatrist and Director of Integrated Health at the Institute for Community Living. She is an alumnus of the National Council for Community Behavioral Healthcare's Psychiatric Leadership Development Program, Class of 2009. She serves on the faculty of the New York University Public Psychiatry Fellowship program and is an alumnus/lecturer of the Columbia University Public Psychiatry Fellowship program. She is immediate past president of the joint New York chapter of the American Association of Community Psychiatrists and American Association of Psychiatric Administrators. Her goal is to bridge the gap between academic psychiatry and the clinical realities of urban communities.

Wellness Self-Management for Chronic Illnesses

Anthony Salerno, PhD, Co-Director: Evidence Based Practices Initiative, New York State Office of Mental Health; **Paul J. Margolies, PhD**, Associate Director, Evidence-Based Practices Technical Assistance Center, Division of Mental Health Services and Policy Research, New York State Psychiatric Institute

Our healthcare system is increasingly focusing on chronic conditions as well as acute illnesses and injuries. With this shift in focus has come a shift in the role for users of these services. This change is true in behavioral healthcare as well as in general medicine.

Health self-management has been used widely in the treatment of chronic physical health problems and is being applied in behavioral healthcare. The concept refers to the important role that patients must play in the management of their ongoing medical, mental health, and substance use problems.

For adults with serious mental health or substance use problems, the term “wellness self-management” refers to the integration of recovery principles with interventions that enhance a person’s ability to self-manage these problems as well as physical health problems. This term emphasizes the importance of an activated and involved client in managing health problems and recognizes the interdependence

The workbook was designed to emphasize and reinforce principles of recovery such as shared decision making as well as choice and hope; recognize the role of cultural beliefs and values; highlight the connection between mental and physical health; and address the challenges of providing wellness self-management services in a group modality. ...the focus is on identifying, reinforcing, and applying one’s strengths to support recovery.

”



of mental health, substance use, and physical health issues. Each type of health influences and is influenced by the other.

In our mental health system today, services that address mental health, substance use, and related physical health problems are typically provided as separate and uncoordinated interventions rather than aspects of a comprehensive approach. The concept of wellness self-management is one way of organizing the many interventions that share the common purpose of activating and strengthening a person's personal responsibility for maintaining wellness in all three areas. These interventions include strategies such as problem solving; practical skills training; stress management; relapse prevention; and education about symptoms, diagnosis, causes, and treatment options.

One effort to bring wellness self-management approaches to the mental health system grew out of New York State's participation in the Substance Abuse and Mental Health Services Administration's national evidence-based practice dissemination project in 2002–2005. At that time, the state implemented the Illness Management and Recovery Practice, a structured and curriculum-based approach that focuses on enhancing knowledge and skills related to mental illness management and recovery goal attainment. On the basis of the feedback, experiences, and recommendations of stakeholders involved in this project, several adaptations were made to promote widespread adoption and sustainability of the approach, including a name change to wellness self-management. Other adaptations included expanding the curriculum to include physical health concerns, creating a bound workbook with structured lessons, developing a group format that is aligned with the workbook, embedding practitioner core competencies into the workbook, and emphasizing self-directed action steps rather than homework assignments.

In wellness self-management, the entire curriculum, consisting of 57 lessons, is organized into a workbook that belongs to each participant. The workbook was designed to emphasize and reinforce principles of recovery such as shared decision making as well as choice and hope; recognize the role of cultural beliefs and values; highlight the connection between mental and physical health; and address the challenges of providing wellness self-management services in a group modality.

Several lessons focus on providing participants with an opportunity to identify and gauge their progress with respect to high-priority, quality-of-life goal areas. Throughout the workbook, the focus is on identifying, reinforcing, and applying one's strengths to support recovery. Workbook topics include the following:

- >> Understanding what helps and what hinders recovery.
- >> Understanding how having goals helps recovery.
- >> Understanding how a person's cultural and family backgrounds affect decisions about mental health services.
- >> Understanding mental health symptoms, treatment, and causes.
- >> Using social support and community resources to help recovery.
- >> Engaging family and friends to support the participant's goals.
- >> Developing and using a relapse prevention plan.
- >> Knowing and using personal strengths to support recovery.

>> Finding and implementing coping strategies that work.

>> Understanding the connection between physical and mental health.

The workbook is the heart of the wellness self-management approach. The workbook, which participants can take away from the treatment setting, has several distinct advantages over the usual practice of relying on handouts (which may require organizing folders) or binders that typically remain at the treatment location. It enables clients to read ahead, prepare for upcoming lessons, and review or complete any lesson at any time. They can bring their workbook into individual meetings with other care providers and show the workbook to family and friends. Clients report a sense of ownership and empowerment as a result of this approach.

The wellness self-management program is most often delivered in a group format, although it can be used in individual treatment as well. Sessions are held a minimum of once weekly, with variations of back-to-back sessions and multiple sessions per week. Although the duration of the program varies, it typically takes a year or more to complete the entire curriculum. Programs with shorter lengths of stay, such as inpatient hospitals, can select specific lessons from the curriculum that most closely match the needs of patients at that time.

Optimally, wellness self-management groups are closed so as to provide members with a secure environment in which they can build a sense of trust and camaraderie. Some programs, however, have been successfully conducted in open groups. In fact, the use of the workbook facilitates the entry of participants at various points throughout the program. Each group ideally consists of 8 to 10 members and is led by two group facilitators; peer facilitation is strongly encouraged. The program also assists participants with involving family and friends who may be able to support their work by assisting with action steps, giving encouragement, providing needed information, and discussing topics of interest.

Wellness self-management has been successfully implemented in more than 100 agencies serving more than 5,000 consumers across numerous program types, clinical conditions, and cultural populations. The workbook is available in English, Spanish, Korean, and Chinese.

The New York Office of Mental Health established the Center for Practice Innovations (www.practiceinnovations.org) at Columbia Psychiatry to offer interested practitioners, programs, or agencies the information, tools, and resources needed to successfully implement and sustain evidence-based practices, including wellness self-management.

Anthony Salerno, PhD, Co-Director, Evidence Based Practices Initiative New York State Office of Mental Health, is a New York state licensed psychologist with more than 25 years of public mental health experience in inpatient and outpatient settings. He has extensive experience in designing rehabilitation programs and training multidisciplinary staff in the principles and practices of psychiatric rehabilitation, illness self-management, family psychoeducation, consumer-centered family consultation, and core clinical competencies. He is currently involved in developing system wide quality improvement strategies to promote evidence-based practices in New York state mental health programs, particularly in the areas of family psychoeducation and wellness self-management for adults with serious mental health problems.

Paul J. Margolies, PhD, is associate director for practice innovation and implementation, Center for Practice Innovations, Division of Mental Health Services and Policy Research, New York State Psychiatric Institute. He is a licensed psychologist who received his doctoral degree in clinical psychology from the State University of New York at Stony Brook. For the past 30 years, he has worked in community and inpatient settings in a variety of clinical, supervisory, and administrative roles.

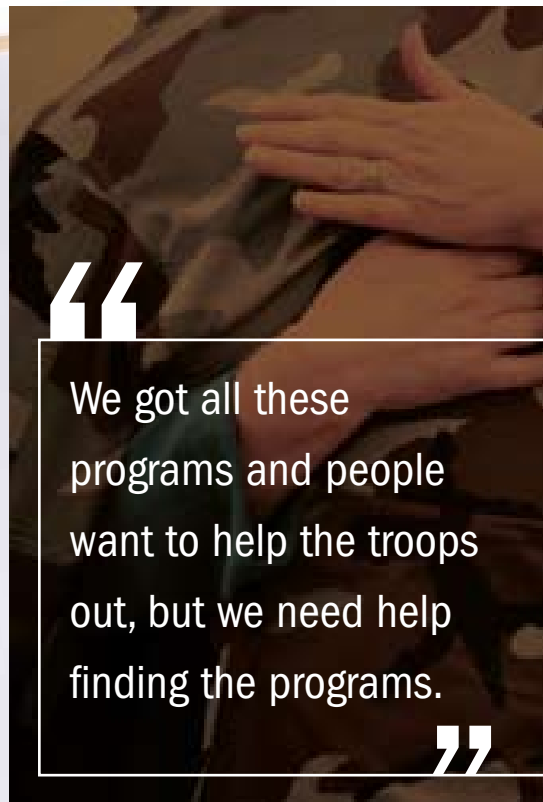
From the Field ***Wellness and Health Promotion Spotlight***

National Council member organizations across America share programs to promote health and wellness, that help to save and improve the lives of persons with mental and addiction disorders, and ensure their full inclusion in the community.



AspenPointe's Peer Navigator Helps Veterans Transition Back to the Community

Kevin Porter, Director of Public Affairs, AspenPointe, Colorado Springs, CO / Kevin.Porter@AspenPointe.org



“We got all these programs and people want to help the troops out, but we need help finding the programs.”

Concerned with how multiple deployments and combat stress affect military service members, veterans, families, and communities, AspenPointe developed, field-tested, and implemented a specific case management model in early 2009 in El Paso County, Colorado. The Peer Navigator model has served more than 200 veterans since that time. Its unique approach to helping wounded warriors transition back into the civilian environment has been featured in media across the country and discussed inside the White House as well as at a roundtable about combat stress disorders on Capitol Hill.

El Paso County is home to five military installations, and veterans make up 17 percent of its approximately 600,000 residents. Although the community has a plethora of resources, veterans — especially those suffering from posttraumatic stress disorder and traumatic brain injury — need help getting connected.

The Peer Navigator Model was put in place to prevent veterans from feeling isolated as they transition from military life and from making choices such as alcohol and drug abuse, domestic violence, criminal activity, and so many other things that can keep them from being healthy and successful in life after service. The model is based on the individualized services provided by peer navigators, that is, one-on-one mentors who have a military background and understand how to assist military members, veterans, and their families obtain assistance in four different areas of need: behavioral health, community outreach, physical health, and career development.

“It’s not just about a 1-800 number or a website,” says Paul Sexton, AspenPointe’s chief operating officer. “What makes this program unique is that an actual human being shows up, and it’s a human being who knows military acronyms. We know the different roles of the military. We know the patches they wear on their sleeves. It’s a human being who gets it.”

Retired Chief Master Sergeant Rich Lindsey is one of three peer navigators at AspenPointe. He says most of the veterans he helps are unexpectedly leaving the military for medical reasons. Lindsey provides direction, free of charge, to help them “navigate” the community and assists in their transition, whether that’s using their G.I. Bill, finding a new career, or joining a softball league.

Justin is one of the soldiers Lindsey has helped. In 2006, a roadside bomb in Iraq killed two of Justin’s comrades and knocked him unconscious for hours. He woke with a TBI. At just 25 years old, he struggles to remember details and has trouble focusing on multiple tasks. He is always on guard; something as simple as a car backfiring sends him into a dizzying flashback.

“It’s really hard,” Justin says. “We got all these programs and people want to help the troops out, but we need help finding the programs.” For Justin, that meant navigating through culinary school applications, connecting with local supply companies for employment, and continuing therapy for his TBI and PTSD.

With Lindsey’s help, Justin hopes to find permanent work and enroll in a culinary school to pursue his dream of being a chef specializing in international foods. “We’ll go to any lengths; we do whatever we can to help them along the way,” Lindsey says.

New research commissioned by AspenPointe shows that, on average, military veterans who suffer from TBI or PTSD and do not seek help will cost the community about \$60,000 a year for the expenses such as unemployment benefits and, in some cases, incarceration. Contact between a veteran and a peer navigator, however, reduces that cost to society to about \$11,000 a year per person.

“We know we have something that works,” says Sexton. “We also know that there’s too much volume coming at the Department of Veterans Affairs and the Department of Defense. We need community agencies like us to pull alongside and do some of the heavy lifting.”

The Department of Labor recently awarded AspenPointe more than \$350,000 over 3 years to help incarcerated soldiers find jobs. The Oklahoma-based Inasmuch Foundation, which has ties to Colorado, also recently awarded the program \$10,000 to work with veterans.

Cherokee Strives to Increase Health Literacy

Carter Miller, Behavioral Health Consultant and **Stella Melton, LPN, CPRP**, Coordinator of Day Program Services — Cherokee Health Systems, East Tennessee, TN / Stella.Melton@cherokeehealth.com

The difficulties in meeting the primary care needs of persons with serious and persistent mental illnesses have been well documented. Just as well documented is the inability for the traditional healthcare system to adequately meet these needs. Various strategies have been proposed and implemented to address these needs, including the idea of combining primary care services with mental healthcare in a model often referred to as integrated care. The staff at Cherokee Health Systems have also long recognized this problem and 30 years ago embarked to develop a system of integrated care whereby primary care providers and mental health providers work side by side in the same location to meet the needs of patients in both of these areas.

To further develop the integrated model of care, Cherokee has made use of two particular psychosocial group strategies to help treat comorbidities in this population. First, we increasingly incorporated integrated care practices into a longstanding mental health day program. Second, in recent years, we have expanded this concept into our peer support program, employing peer counselors to help clients meet their holistic health needs. Activities in both programs are geared toward increasing health literacy, examining motivational issues, demonstrating healthy meals and activities, and coordinating services with providers from various disciplines.

All program staff — with or without academic degrees — receive training in health issues applicable to their position. The programs also provide clients with daily access to professional staff, including primary care providers, psychologists, psychiatrists, nurse practitioners, and nurses, as needed.

Although some of these efforts are still relatively new, there is reason to believe that we are having an impact on clients' lives. For example, our adult day treatment programs offer efficient and cost-effective access to primary care treatment, with 96 percent of our clients reporting seeing a primary care provider regularly in 2009. In addition to primary care, these programs also provide an array of mental health services, including education about mental health issues, coping skills training, peer support, illness management classes, and linkage to other mental health providers. In 2009, the average psychiatric rehospitalization rate for adults in our day programs was 0.7 percent.



The programs also provide clients with daily access to professional staff, including primary care providers, psychologists, psychiatrists, nurse practitioners, and nurses, as needed.

Chrysalis' Healthy Hartford Nurtures Healthy Choices

Anthony Hebert, Chief Operating Officer, Chrysalis Center, Inc., Hartford, CT / mfeliciano@chrysaliscenterct.org

Chrysalis Center Recovery and Empowerment Center serves adults who live in poverty who struggle with mental illness or substance abuse, giving them skills and resources needed to live self-sufficiently in the community.

People struggling with psychiatric disabilities have shorter than average life expectancy, higher rates of obesity, and a host of other medical challenges. Many Chrysalis Center clients are unemployed or have very low income, limiting healthy choices and making medical care difficult to obtain.

To address these issues, the Chrysalis Center offers Healthy Hartford, a service providing health screenings, transportation to free health clinics, and additional healthcare resources. A mobile health van visits the center monthly, and clients can receive a variety of health screenings. Once a health need is identified, center staff set up appointments with free healthcare clinics in the Hartford area. Staff also provide transportation to appointments.

One Chrysalis Center participant affected by both mental illness and substance abuse describes how he has been helped by the center's programs:

"I had struggled with various addictions for many years, including heroin. I was still using when I started coming to Chrysalis Center. I wanted to change but didn't know how. The staff told me that I didn't have to live the way I had been living, that I had choices with my life and my health. I decided to go into detox. When I got out, I started on methadone and kept coming to Chrysalis Center. I learned a lot about myself and my health. I decided to stop the methadone. I came to the mobile health van and worked with staff to arrange healthcare needs. I'm now off of the methadone. It's still really hard, but I know I can come to Chrysalis Center anytime to learn more about my health and be reminded I have choices in my life."

FINDING THE JOY AGAIN Versie Reeves, Skyland Trail



"I was carrying a lot of pain and confusion," recalls Versie Reeves, remembering the enormous grief over her brother's death. The stress from work and her responsibilities taking care of her ailing mother set into motion a dangerous downward spiral. Reeves' depression and anxiety overshadowed her ability to grieve. She was also suffering from high blood pressure and excruciating back pain from previous surgery. "I wasn't able to cope with it," she says.

Her health was in serious jeopardy, so Reeves' sons and her sister unanimously agreed that she should try Skyland Trail, a nonprofit, community-based residential and day treatment facility for adults with serious mental illness in Atlanta, Georgia. It was here that Reeves learned how to grieve and begin the healing — in mind and body. "I wasn't able to do that before," she says quietly. "Versie is being treated physically and mentally," adds Lissa Tchernis, Reeves' primary counselor. "From a counselor's standpoint, it's great to have a primary care clinic right across from my office."

When Reeves first arrived, she was numb; she wasn't dealing with anything, says Tchernis. "I was so overwhelmed," Reeves adds. "The stress was enormous. I was in the mode of 'none of this is happening.' I was blank." She pauses and continues, "But my body was dealing with it physically." Reeves' physicians discovered another problem, her thyroid, and began treating that as well. They monitor her medications and watch for side effects.

This oversight is critical, says Tchernis. "If you're trying out new coping skills and the next week you're tired and anxious, you need to know if it's the coping skills that aren't working or if there is a physical illness going on."

An accomplished cook after raising her family, Reeves began learning about the benefits of nutrition and physical activity. "Exercise helps me to de-stress. When I go to the gym, I enjoy it," Reeves says. "It helps me to relax and sleep better. I give Lissa a great deal of credit. When I first came here, I didn't want to talk. But Lissa has a warm heart. She had the passion to help me pull myself out."

"Versie looks completely different," Tchernis chimes in, "Her face — she smiles and shows expression. She doesn't look like she's in pain."

Versie is very sophisticated. She has that insight, she always had it in her."

Skyland also helped Reeves tap into her spiritual side. "I'm very impressed and grateful for the spirituality group and the pastoral counselor," she says. "The services on Wednesday afternoons are very joyful. They help me get through the week and help me to stay focused," she says.

"It puts the joy back into my heart."



Cobb CSB Brings in Health on Wheels

Tod Citron, Executive Director, Cobb Community Services Board, Smyrna, GA / tcitron@cobbcsb.com

Utilizing funds from a Kaiser Foundation award, the Georgia based Cobb Community Services Board, a suburban public provider of behavioral healthcare services, is partnering with West End Medical Center of Atlanta, a local Federally Qualified Health Center to reverse the trend of premature mortality for Cobb CSB clients who have a severe and persistent mental illness.

The Cobb CSB provides mental health, substance abuse, and developmental disability services to approximately 12,000 people annually. West End provides a range of primary healthcare services. Working together, the two providers can offer integrated healthcare.

Through the Kaiser Grant, Cobb CSB is able to increase access to medical services that otherwise would not be met for its mental health outpatient clients. West End Medical Center has begun providing primary care through its MOBILE outreach services at one of Cobb CSB's local mental health outpatient sites. A client receiving mental health services is seen at the CSB outpatient site. Screening is coordinated by Annis Gayle for the CSB with Sonja McWhorter for the West End Mobile Unit. If additional medical services are needed, the client is seen at one of the West End medical facilities.

"Working with West End Medical Center, the CSB is creating teamwork to bring the best medical and mental health care to our clients," said Cheryl Holt, director of CSB outpatient services. "We are able to access each other's medical records to ensure quality care."

West End Medical Center's Mobile Unit comes to the CSB outpatient site in Austell, Georgia, once a week for about five hours. Physician Assistant, Lorenzo Anderson, sees about 20 patients per Mobile Unit visit. He hopes that number will increase as the program continues.

"The focus is addressing health issues with a concentration on people with cardio-metabolic concerns. We are addressing health disparity for folks with serious and persistent mental illness in the Cobb Community Services Board's outpatient programs," said Debbie Strotz, director of CSB Rehabilitative and Recovery Services.

Barbara Peterson, a Cobb CSB client, has returned to the mental health outpatient program partly for the medical tie in. "Part of coming back was for the medical care; to be seen on a regular basis to keep up with my symptoms and medications. This has been a wonderful experience as a consumer," she said. "I have been treated as a whole person. I was seen as a medical patient for the concerns I brought to West End."



Working with West End Medical Center, the CSB is creating teamwork to bring the best medical and mental health care to our clients

Community Support Services Knows It Takes More Than Building a Clinic

Kim Shontz, Director of Outpatient Services, Community Support Services, Inc., Summit County, OH / shontkim@cssbh.org

When planners at Community Support Services, Inc., a Community Mental Health Center for adults with serious mental illness, envisioned an onsite integrated care clinic, they thought that surely if they built it, people would come. Many of the agency's clients mirrored national statistics: They suffered from treatable and preventable chronic health conditions and died significantly sooner than those without mental illness.

Many partners worked with Community Support Services to plan the clinic — the Best Practices in Schizophrenia Treatment Center; Northeastern Ohio Universities Colleges of Medicine and Pharmacy; the University of Akron's College of Nursing; Klein's Pharmacy; and the County of Summit Alcohol, Drug Addiction, and Mental Health Services Board. In addition, clients played an integral role in clinic design. With the generous support of The Margaret Clark Morgan Foundation, the state-of-the-art Margaret Clark Morgan Integrated Care Clinic opened its doors in November 2008. The clinic recently received a 3-year accreditation as a "Medical Home" through the Accreditation Association of Ambulatory Health Care.



The clinic offers primary care, behavioral health care, pharmacy services, specialty and dental care referrals, prevention and wellness programs, and laboratory services — all in a comfortable setting. In addition, clients can schedule several appointments on the same day, and records are integrated so that health information can be easily shared among practitioners.

At first, clients did NOT come.

The Community Support Services team took action. A peer recovery specialist recruited clients to the clinic. Case managers promoted clinic services. Wellness fairs that included health screenings (and scheduling of follow-up appointments if necessary), health education, nutritious snacks, and prizes were offered.

And then clients came to the clinic.

John came. He now has a new prosthesis, which he had been unable to obtain because of difficulties navigating the health system. Karl came. His previously undiagnosed diabetes and renal disease are now under control, and he receives treatment for these conditions and for major depression. When asked about the clinic, Karl smiles and says, “They make you feel like life is worth living.” Mary and Judy and their friends came. They were among the 80 participants whose high blood pressure was discovered during a wellness fair.

More than 550 clients now call the integrated care clinic their healthcare home.

Genesee County Adopts InSHAPE for Social Integration

Shante Burke, Carter Miller, Health and Wellness Manager and Tracey Malin, Clinical Risk Officer, Genesee County Community Mental Health, Flint, MI / sburke@gencmh.org

In August 2009, Genesee County Community Mental Health launched InSHAPE (self-help action plan for empowerment), the only wellness promotion program of its type in Michigan; created “wellness stations” to provide health and wellness resources as well as educational materials; and established the GCCMH Garden Project.

Mortality and morbidity among the Genesee County population with serious mental illnesses mirror the national study — the average age at death is 52 years, and the most common cause of death is cardiovascular disease. InSHAPE serves to lengthen life expectancy and improve the quality of life for people with SMI through a combination of exercise, diet, health mentor (certified personal trainer) coaching, and active use of healthcare services to reduce risk factors for chronic disease and symptoms of mental illness.

Social inclusion and integration are key concepts underlying InSHAPE. By recruiting local organizations as partners and using accessible facilities and exercise venues, our program helps people with serious mental illnesses build pathways into the community and erase the stigma associated with mental illness.

Since InSHAPE's inception, participants have achieved a combined weight loss of 184.1 pounds, a decrease of 75 centimeters in waist circumference, and a decrease of 40 centimeters in hip circumference. Mental and emotional functioning has also improved. One participant states, “Since I've started InSHAPE, I still get angry, but I don't show it anymore. My mind is clearer.”

We are currently collaborating with the University of Michigan's Department of Psychiatry, School of Public Health, and Prevention Research Center of Michigan to conduct a comparative effectiveness study of InSHAPE in Genesee County. An 18-month study by the Dartmouth Psychiatric Research Center of InSHAPE's effects on the health of 98 participants in New Hampshire indicated that the program is successful in reducing disease risk factors and improving physical health. We expect similar results.

Since InSHAPE's inception, participants have achieved a combined weight loss of 184.1 pounds, a decrease of 75 centimeters in waist circumference, and a decrease of 40 centimeters in hip circumference.



Hartford Dispensary Restores Smiles

Paul McLaughlin, Executive Director, Hartford Dispensary, Hartford, CT / Paul.McLaughlin@hdisp.org

Hartford Dispensary was established in Connecticut in 1871 as a nonprofit agency chartered to provide medical, dental, and rehabilitative services to indigent persons. In 1971, the agency was transformed into an Opioid Treatment Program. We now operate nine OTPs serving more than 3,900 patients daily.

In 2006, the agency integrated dental and primary care services into the Hartford-area OTP network. These programs are independent but interrelated entities because they are colocated and share space, equipment, and support staff.

The two key factors in the desire to develop the dental program were the agency's history of dental services and patient satisfaction surveys indicating high interest in dental services. The agency first established dental referral services with a local Federally Qualified Health Center. After one year, however, we saw that scheduling and logistics issues limited patient access. To address those problems, Hartford Dispensary, in collaboration with the FQHC, submitted a Health Resources and Services Administration dental grant application, which was unsuccessful.

Ultimately, we partnered with the University of Connecticut School of Dental Medicine to develop a contract service agreement, and dental services began in September 2006. The services have been extremely successful, and as a result, in 2010 the contract was expanded to increase services. As one patient noted, "You have given me back my smile."

Other factors resulted in the agency's development of a primary care program. For instance, as the opioid patient population has aged, chronic disease management issues have been identified. In addition, since the 1990s, the agency's services have expanded to address the medical complications of infectious diseases such as HIV and hepatitis C. In 2000, Hartford Dispensary began on-site hepatitis C treatment. In 2002, in collaboration with the Connecticut Department of Public Health, the agency started to administer hepatitis A and B vaccinations. By mid-2009, more than 2,400 patients had completed the vaccination protocol. As with the dental program, patient survey results revealed high patient interest in accessible medical services.

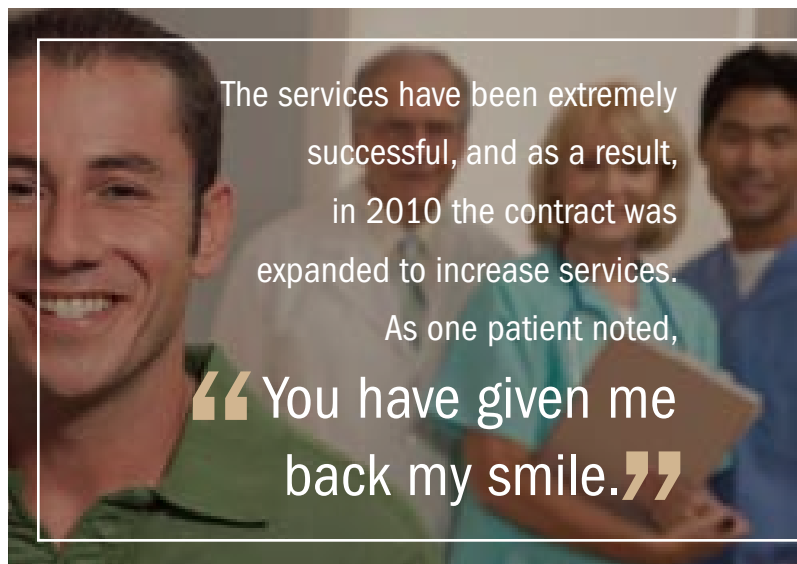
Hartford Dispensary was able to implement dental and primary care programs as we were financially healthy and had 5,000 square feet of space at one of our clinics. We also had the support of the Commissioner of the Connecticut Department of Mental Health and Substance Abuse Services for integrating comprehensive services in OTPs and the support of our board of directors.

In 2005, the second floor of an agency OTP building was renovated to house both services. Primary care staffing was accomplished by reorganizing and centralizing existing medical positions from two Hartford-area OTP clinics. This change resulted in the employment of two full-time physicians and three medical support staff. One new administrative position to serve both programs was created. The dental program was staffed by a contract dentist and four third-year dental students on six-month rotations. The agency also hired two dental assistants.

Medical services now include physicals; diagnosis and referrals; treatment of acute illnesses; chronic disease management; infectious disease services, including hepatitis C assessment, screening, and treatment; weight management; and nutritional services.

Through the process of developing integrated dental and primary care service, Hartford Dispensary has learned several lessons:

- >> Medical and dental service models need to be flexible enough to change based on resources and population changes.
- >> The selection of primary care-oriented physicians is critical.
- >> Colocation of multiple services creates synergy and can improve patient utilization of these services.
- >> Monitoring clinician productivity, billing, and claims data is essential for managing services.
- >> It is useful to collaborate with dental and medical schools.



The services have been extremely successful, and as a result, in 2010 the contract was expanded to increase services.

As one patient noted,

“You have given me back my smile.”



Lexington Clubhouse Persists With New Year Resolutions

Kristen Barr, Director, Lexington Clubhouse, Home Nursing Agency Community Services, Altoona, PA / kbarr@homenursingagency.com

Members and staff at Lexington Clubhouse have decided to focus on wellness as an overall goal for everyone. In the fall of 2009, staff began to brainstorm ways to improve the menus and snacks available at the clubhouse. Food choices are often based on what is affordable and tastes good and not what is affordable, tastes good, and is healthy. They also decided that it is important to introduce exercise and education about healthy choices to the members. Staff and members made a New Year's resolution to make healthier food choices and begin exercising.

On January 4, 2010, the clubhouse menu began featuring Weight Watchers recipes, and members and staff began working out at the KNY 2 days a week. Several staff members tried to set a good example by going to the gym together every Monday and Wednesday at 2 pm and encouraging members to go with them. Lexington Clubhouse also joined Weight Watchers online for recipes and ideas and created a support group.

As the months went by, more and more members became interested and started to enjoy finding new recipes and going to the gym even when staff weren't able to do so. One member in particular made an effort to go to the gym every day for at least 20 minutes. She is proud of herself for this accomplishment and finally feels in control of her own weight loss. Other members have shared that they buy only whole wheat pasta and breads now. At least two other members have lost more than 30 pounds each; they say the support they have at the clubhouse has helped

them stick to their weight-loss plans.

These achievements mean a lot for the health of the people attending Lexington Clubhouse. Giving them information to make educated choices and supporting them on the journey have been important to success. We value working together in this process and have enjoyed giving and receiving support in our efforts to move toward a more healthful way of living.

As with most people who make New Year's resolutions, we have had some problems sticking with our healthy eating and exercise plan. We became busy, overwhelmed, and stressed, and our wellness plan was the first to suffer. We are beginning to get back on track, though. This stumble is another important lesson for us to learn along with our members: With success comes failure. The important message is to start over and work harder — to not give up. We have resumed our Weight Watchers menu, and staff will be heading back to the gym with members several times a week. We are also considering having the trainer at a local fitness center work with several staff so that they are better educated about correct form when working out to help avoid injury.

The Home Nursing Agency Foundation has given Lexington Clubhouse \$1,320 through a grant that will pay for five fitness center memberships for members who are not able to afford the fee but will benefit greatly from the exercise.

Jefferson Center's Wellnessnow! Motivates Staff and Clients

Vicki MacKenzie, Senior Human Resource Generalist, and **Mark Jones, MA, LPC**, Director of Wellness Services — Jefferson Center for Mental Health, Wheat Ridge, CO / markj@jcmh.org

To prepare for healthcare reform and to pursue its growing interest in integrated health, Jefferson Center for Mental Health created and launched the Wellnessnow! program in 2006. This innovative program offers holistic, nontraditional classes to people struggling with severe and persistent mental illness. A team of eight full-time staff creates original content specific to the needs of its client base and forms partnerships with groups such as LiveWell Wheat Ridge and Operation Frontline, a ground-breaking, cooking-based nutrition education program for families.

The Jefferson Center's focus on developing wellness programs for clients had an interesting result: The center employees began to look within and ask how they could take the same approach to their health. As one human resources specialist says, "The majority of the center's employees are clinical staff that are in the business of counseling others, but they may not always set aside the time to help themselves." In 2007, the Jefferson Center's Employee Wellness Plan was born, encouraging a healthier workforce and reducing the rising insurance premiums for the organization.

More than two-thirds of the center's employees now participate in the program. Involvement continues to grow and produce encouraging outcomes. Half of the Jefferson Center's smoking population has quit. More employees are getting regular

exercise, and cholesterol and triglyceride levels have dropped. The center realized a positive return on investment after the first year, and its health insurance premiums have risen less than 5 percent since 2007.

In early 2009, The Colorado Health Foundation approved a generous grant for the Jefferson Center's consumer-focused Wellnessnow! program. This funding allowed the Wellnessnow! team to expand once again by targeting specific health concerns of its current clientele. New clients are now offered health screenings when they begin services at the center. These clients are tested for metabolic risk, and after meeting with a health coach, they are given a prescribed wellness plan that includes appointments for individualized health coaching and registration for health-related wellness classes. All screening information is then documented in the center's electronic medical records to facilitate the integration of healthcare.

One client reports, "Up until one year ago, I have never been stable in my life. I love the walking groups, which have been much more than exercise...and, so far, I have lost 34 pounds."

The Jefferson Center's commitment to integrating healthcare is paying off. Setting high expectations for health among staff and clients is generating a future that is full of excitement and wellness.

Mental Health Resources Sees Results from Medication Therapy Management

Kathy Gregersen, MSW, Executive Director, Mental Health Resources, Inc., Saint Paul, MN / kgregersen@mhresources.com

Mental Health Resources, Inc. serves adults with chronic mental illness. Our clients have multiple chronic diseases that require them to take multiple medications, putting them at higher risk for adverse medication events.

In partnership with our onsite pharmacy, Genoa, MHR conducted a Medication Therapy Management service with some of our most symptomatic clients. Although MTM is a relatively new model of care and is traditionally provided to people with chronic physical illnesses, it is beginning to be recognized as critical for people with serious mental illness because it addresses the premature mortality rates of this population.

During the MTM session, a specially trained pharmacist (at MHR, the pharmacist is a doctor of pharmacy) meets individually with clients to review current prescriptions, potential drug interactions, side effects, and unique issues. The session provides essential medication and wellness education for clients and family members. Clients are also encouraged to discuss potential medication compliance reluctance. To supplement the learning, the pharmacist sends a written report to the client and all treating physicians with recommendations for medication adjustments, changes, and laboratory work when appropriate.

The most significant MTM finding has been the high incidence at which medications have been prescribed at less than therapeutic levels for medical conditions such as hypertension, cardiovascular disease, hyperlipidemia, and diabetes. MTM demonstrated cost effectiveness by recommending that current medication dosages be increased for therapeutic benefit.

Future considerations for MTM include

- >> Scheduling longer or multiple sessions for the assessment phase.
- >> Having a case manager attend the session to assist with recommendations.
- >> Developing a feedback survey for participants.

MTM should be considered an essential component in providing integrated care for persons with chronic mental illness. This service may play a role in increasing the lifespan for this population by monitoring both medical and psychiatric medications.

Providence Center Promotes Wellness through Community Engagement

Dale Klatzker, PhD, President and CEO, The Providence Center, Providence, RI / dklatzker@provctr.org

Since 1998, The Providence Center has incorporated exercise and nutrition activities into standard clinical practices for 450 Assertive Community Treatment team clients. In 2007, TPC expanded wellness programming to all of its clients through a grant from the Rhode Island Office of Minority Health. Clients benefit from bilingual, culturally competent services at TPC and exercise classes at the YMCA. They take walks in local parks, participate in an annual family barbecue, and join health promotion events.

To address the need for integrated primary and behavioral healthcare, TPC partnered with community health centers to provide colocation services. Through these programs, clients reduced risk factors that lead to chronic disease in people with serious mental illness and decreased behavioral health symptoms.

Client engagement in the community was a turning point for TPC's wellness programming. Bilingual Health Mentor Jetzabel Mills found that through community-based wellness activities, "Clients have the opportunity to connect with both their bodies and their communities. Many of our participants had never been exposed to exercise in a positive way before. It improves their outlook and their health."

Owing to the positive outcomes that resulted from services with a community reach and the wide range of people served, TPC began providing population-specific wellness programs along with the integrated wellness services that are available to all TPC clients. In Shape Seniors, a program funded by Tufts University, identifies the needs of seniors with behavioral health problems and integrates wellness activities and social engagement with behavioral health treatment and primary care using health mentors to guide participants toward achieving their goals. Fit2BHealthy, funded by the Rhode Island Foundation, teaches overweight children and their families behavioral, environmental, and physical approaches to reduce weight in collaboration with the child's pediatrician.

FROM NURSING HOME TO DIRECTOR Ron Otto, Director of Recovery, Thresholds



At one time, Ron Otto, director of recovery at Thresholds in Chicago, Illinois, was living in a nursing home. He was gravely ill. "I didn't know where to go for help; I thought I was going to spend the rest of my life in that nursing home," he recalls. He had been diagnosed with schizophrenia and major depression and was living a sedentary lifestyle. He was also a heavy smoker. Poor meal choices and alcohol packed on extra calories, and eventually Otto found himself overweight and unhappy with his self-image. "I self-medicated with alcohol," he says, which worsened his depression. Thresholds turned all that around.

Now, biking is Otto's newfound passion. After participating in a Thresholds biking fundraiser several years ago, Otto got a bike and became an avid cyclist. "Biking around the lake here in Chicago is one of the most normalizing things to do. It helps me manage my weight and my mood," he explains. Otto quit smoking through hypnosis and recently cofacilitated a smoking cessation group at Thresholds specifically designed for people with mental illness. He also stopped using alcohol. Encouraged by everything he was learning about physical activity and food, he read about nutrition and explored dietary supplements such as fish oil.

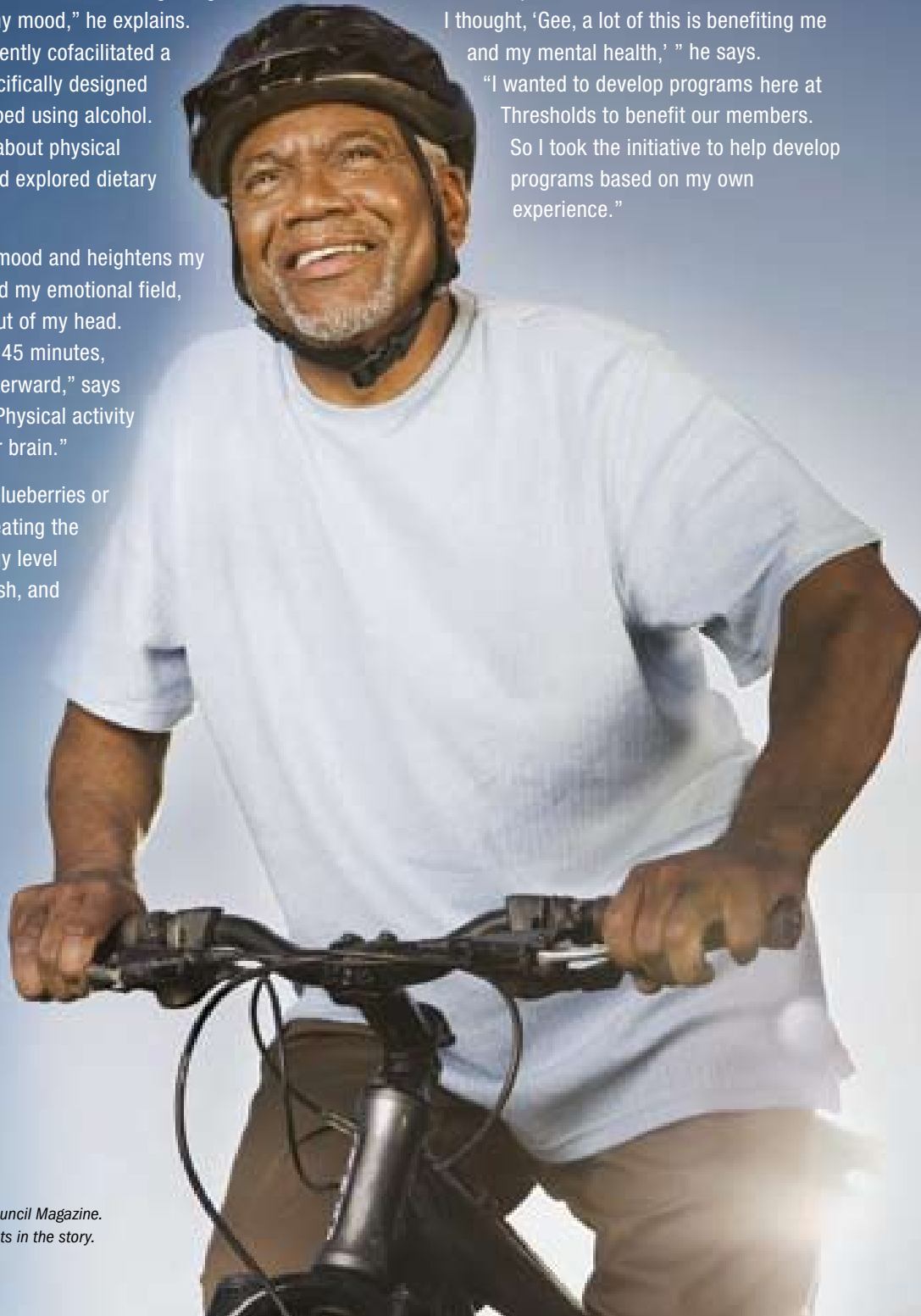
"The physical activity always improves my mood and heightens my problem-solving skills. It clears my mind and my emotional field, and sweeps a lot of worries and cobwebs out of my head. I found out right away that if I exercised for 45 minutes, my mood was elevated for several hours afterward," says Otto. "It was a pretty immediate discovery. Physical activity is one of the best things you can do for your brain."

For breakfast, Otto has a yogurt shake with blueberries or strawberries. "I get a positive feeling from eating the berries," he adds. Soda sapped Otto's energy level and made him feel mentally anxious, sluggish, and

anemic. Instead, he focuses on getting enough fiber as well as vitamin D and other vitamins into his diet.

The integrated services at Thresholds gave him support when he needed it most and also put him in touch with education and job opportunities. Otto eventually went back to school and got an accounting degree. The wide-ranging services made a significant difference in his life, and he wanted to help others. "Because of what I learned, I thought, 'Gee, a lot of this is benefiting me and my mental health,' " he says.

"I wanted to develop programs here at Thresholds to benefit our members. So I took the initiative to help develop programs based on my own experience."



Skyland Trail Brings Primary Care and Wellness Onsite

Susan Lindsey, Communications Coordinator, Skyland Trail, Atlanta, GA /slindsey@skylandtrail.org

Responding to a treatment gap between psychiatrists and primary care physicians, Skyland Trail was among the pioneering organizations that opened an on-site, full-time primary care clinic for its clients. Skyland Trail provides residential and day treatment for adults with mental illness. The facility specializes in treating depression, schizophrenia, and bipolar disorder and serves clients from Atlanta, throughout Georgia and the south-east, and from across the country.

The primary care clinic, which has been operating on a full-time basis since 2008, includes a pharmacy, exam rooms, infirmary, laboratory, and reception areas along with additional space for offices and research. The budget for the entire initiative, including construction and operating expenses, is \$850,000 for a 5-year period. Initial funding came from several local private foundations.

Upon admission to Skyland Trail, clients are provided with basic primary care, which includes a medical history and physical exam as well as a measurement and review of metabolic panels, blood counts, thyroid functioning, and other tests. The clinic also incorporates a wellness education program focused on smoking cessation, healthy eating and exercise, diabetes prevention, and avoidance of high-risk drug use.

Having the clinic on site saves both time and money. The treatment team can get lab results quickly, and clients can receive urgent primary care without the time and expense of transport to an outside facility. Clients have responded favorably to receiving medical care in a setting where they are comfortable. An additional benefit has been a reduction in admission time because clients do not leave the facility for medical tests, thus eliminating disruption in their treatment.

The additional ability to treat a client's medical needs on site fulfills Skyland Trail's mission of treating the whole patient: mentally, emotionally, spiritually, and physically.

Having the clinic on site saves both time and money. The treatment team can get lab results quickly, and clients can receive urgent primary care without the time and expense of transport to an outside facility.

At Stepping Stones Clubhouse, Small Changes Make a Big Difference

Jennifer Kirsch, BFA, CPRP, Clubhouse Director, Stepping Stones Clubhouse and Mike Barnard, MPH, CHES, Community Health Educator, Ches Penn Health Services, Coatsville, PA / jennifer_ssche@yahoo.com

Since 2006, I've attended 10 funerals associated with my job. In 4 short years, my program has lost more people than I have in the previous 26 years of my life combined. After the fifth memorial, I decided it was time to focus everyone's attention on the various health issues that have been stealing members, most before the age of 55.

I began brainstorming with a community health educator. We decided to start our wellness initiative by getting members to become more physically active — and so began our walking club. In the course of 6 weeks, we rallied 20 people to walk 1 mile, twice a week. A mile has about 2,000 steps, which means our group took 480,000 steps toward better health in that time. Even after the program ended, members continued to walk, despite cooler temperatures or rainy days.

We then turned our sights onto smoking cessation; 35 percent of our members smoke and several of them have been hospitalized for smoking-related illnesses. Every week, for 16 weeks, we discussed the health risks associated with smoking, how to deal with cravings, and how to develop a quit plan. Participants were provided with free nicotine-replacement therapy when they committed to a quit date. Despite several setbacks along the way, three members were able to overcome their addiction and are smoke free today.

Positive results encouraged us to maintain momentum; our next endeavor was the nutrition group. Our goal was to educate and empower the members to make healthier food choices. Once a week, for 12 weeks, we focused on reading food labels, portion control, and nutritional values. Participants were surveyed before and after the 12-week program to monitor their progress. The results were remarkable: The amount of people eating fruits and vegetables daily nearly doubled. We've also seen a huge decline in the amount of sugary beverages consumed and a significant increase in the amount of water.

Change isn't easy, but with the help and support of peers, it becomes less of a chore and more of a desire.

Truman Educates Clients on Chronic Disease Management

Darlene Heinz, RN, MA, Nurse Liaison for Missouri Department of Mental Health Net and **Kirby Randolph, PhD**, Special Projects Coordinator, Truman Medical Center–Behavioral Health, Kansas City, MO / kirby.randolph@tmcmcd.org

T Truman Medical Center–Behavioral Health is the safety net community mental health center within Truman Medical Centers, an urban hospital that provides healthcare to underserved people. In 2008 TMC–BH joined the MO DMH Net initiative, which was designed to comprehensively address the comorbid physical health diseases of mental health clients.

With financial support from the MO DMH Net initiative, TMC–BH has implemented strategies to bridge the gap between physical and mental health. Clients enrolled in specialty programming designed for those who take at least one antipsychotic medication meet with a community support specialist, who is educated about chronic physical diseases, with an emphasis on anatomy, physiology, and signs and symptoms of disease exacerbation. In addition, a nurse liaison staff position was created to provide chronic disease education and management for clients and staff. Each program within TMC–BH is staffed by one registered nurse to oversee clients' health, make health recommendations, monitor medication adherence, and refer for consultative services. Information technology was upgraded to allow viewing of health histories as well as monitoring and surveying of data on chronic health diagnoses, diagnostic criteria, parameters to be monitored, and lab tests.

Because many clients struggle with weight control, one of the initial focuses of the initiative was on obesity, prediabetes, metabolic syndrome, and type I and II diabetes. Clients receive baseline screenings, receive ongoing nutrition and physical activity education, and are educated about medication adherence. TMC–BH has more than 16,000 clients a year and medication adherence is nearly 70 percent.

The initiative's financial and educational resources have motivated TMC–BH to assimilate new insights and behaviors to facilitate improvement of integrated care for clients. We are working to align our practices with the Chronic Care Model to expand and improve our service delivery.

University Behavioral HealthCare Says Don't Wait to Fight Weight

Betty Vreeland, MSN, APNC, PMHCNS-BC, ANP-BC, Advanced Practice Nurse, UMDNJ–University Behavioral HealthCare, Piscataway, NJ / vreelaeb@umdnj.edu

There are many weight management interventions that can be easily implemented and accomplished without outside funding.

The scale is one of the simplest tools to fight weight gain. As a prescriber, in addition to selecting medications with lower risk of weight gain, I keep a scale in my office. During an initial appointment, I ask the consumer to step on the scale for a baseline weight. Then I ask the person to rate the weight: "Do you consider yourself underweight, normal weight, or overweight?" This simple question can provide invaluable information about whether a person is aware of having a weight problem.

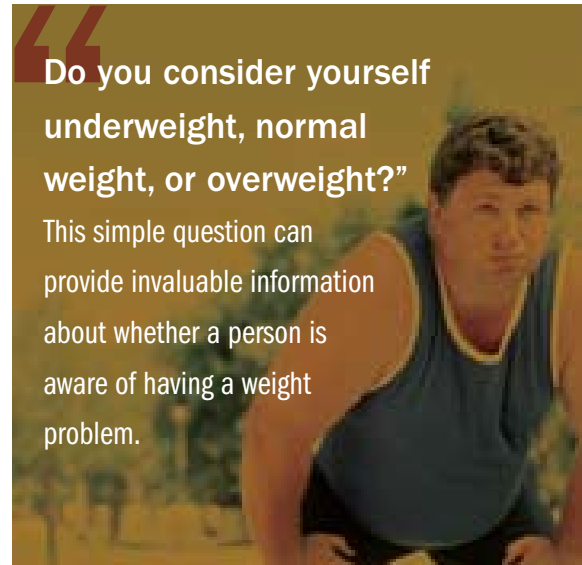
I also keep a Body Mass Index chart handy. BMI is a measure of body fat based on height and weight that applies to adult men and women. It also educates consumers about their weight and health. A BMI calculator and other health information can be found at www.nhlbhsupport.com/bmi/. My organization, UMDNJ–University Behavioral HealthCare, recently implemented "wellness stations" for consumers to self-monitor health measures. The wellness stations are in accessible locations and have scales, BMI charts, tape measures, and educational materials.

When I start someone on psychotropic medication that can cause weight gain, I advise "simple steps" to prevent weight gain, such as increasing physical activity, self-monitoring weight, and avoiding sugar-laden beverages. When simple steps are not enough and a weight problem exists, nonpharmacologic programs that combine nutrition, behavior change, and physical activity have successfully helped people with mental illness lose weight.

One such program is Solutions for Wellness. SFW is a science-based, no-cost, lifestyle program designed specifically for people with mental illness. SFW groups have been implemented throughout UBHC, are popular with consumers, and are helpful in managing weight problems. Consumers who have participated in SFW at UBHC have experienced significant improvement in BMI, blood pressure, and waist circumference. The SFW manual can be downloaded at www.treatmentteam.com/Pages/solutionsForWellness.aspx.

Do you consider yourself underweight, normal weight, or overweight?"

This simple question can provide invaluable information about whether a person is aware of having a weight problem.



Western Montana's Workers Now Promotes Recovery through Employment

Jodi Daly, LCPC, CMHP, Deputy Director, Western Montana Mental Health, Butte, MT/jdaly@wmmhc.org

As the national unemployment rate soars to 9.6 percent, Montana's unemployment rate has risen to a high of 7.6 percent. For people with serious disabling mental illness, who often have to overcome stigma and discrimination when seeking employment, the unemployment rate is 90 percent. According to a recent study, 56 percent of employers would not hire a qualified candidate if he or she disclosed a mental illness.

Supportive employment has helped decrease unemployment rates among people with serious mental illnesses and helped to move consumers of mental health toward recovery. Supportive employment is an occupational intervention that emphasizes the development of specialized teams whose job it is to offer early intervention, assertive outreach, and crisis intervention. Promising outcomes of this model include allowing people with a mental illness to maintain long-term employment and reducing disability, boredom, fear, social isolation, discrimination, and stigma.

Knowing that work serves as a vehicle for people with mental illness to move forward in the recovery process, Western Montana Mental Health Center in Butte and Missoula Montana, has developed a supportive employment programs, Workers Now. Anecdotal reports from Workers Now employees have revealed that people with mental illness who work not only increase their self-respect and self-esteem but also decrease their social isolation as they become integrated into the fabric of the community. Additionally, consumers report that having "money in their pocket" opens doors that once were closed (eg. eating at nicer restaurants, going to the movies, dating).

Workers Now was developed in 2008 through a supportive recovery grant from the State of Montana. The organization's principles include competitive employment; rapid job search; integration of employment services with mental health services; consumer-centered job preferences; continuous and comprehensive assessments; time-unlimited support; a place-and-train-on-the-job approach; and acceptance, knowledge, and understanding of those with a mental illness.

Workers Now serves the community of Butte and its mental health consumers by offering a variety of places for on-the-job training. It operates a thrift store, has a contract for a concession stand at a raceway, and owns a traveling kitchen trailer that has been a successful vendor at local festivals. Additionally, Workers Now has worked within the community to secure "spot jobs" such as landscaping, gardening, painting, moving, and small construction.

From 2008 to 2010, Workers Now has put to work 404 of the 2,351 adults served by our clinic. The program has successfully placed 36 consumers in permanent job placements. Consumers receive \$9 per hour; this rate translates to about \$50,000 in payroll for the past 2 years. Job placements include maintenance, food service, customer service, construction, janitorial, landscaping, sales, peer support, and auto maintenance. Additionally, the program has assisted 5 consumers with pursuing educational opportunities to further their careers.

The response from the community has been overwhelmingly supportive. Other community-based providers have sought out the program's staff for consultation. Workers Now has shared its business templates with many providers in Montana in the hope that this program will continue to support others in their quest for recovery.



Supportive employment is an occupational intervention that emphasizes the development of specialized teams whose job it is to offer early intervention, assertive outreach, and crisis intervention.

Prepare today for the changes tomorrow.

Meaningful Use. Certification. Interoperability. New initiatives are transforming behavioral healthcare, and Anasazi is staying ahead of all developments. This is the only way to make sure your agency gets the full benefit of enhanced revenue, increased productivity and improved quality of care. As the industry changes around you, choose the solution that evolves with your needs today, tomorrow and beyond.

***Only Anasazi provides
this level of confidence.***

- Electronic Clinical Records
- ePrescribing
- Clinician's Home Page
- Revenue Management
- Robust Reporting
- Scheduling
- Managed Care Organization
- Cost Accounting
- Human Resources
- Fiscal



Learn more about our community of confidence
866 529 7547 anasazisoftware.com

Bringing Mental Health Into the Mainstream, Worldwide

Vijay Ganju, Secretary General and Chief Executive Officer,
World Federation for Mental Health

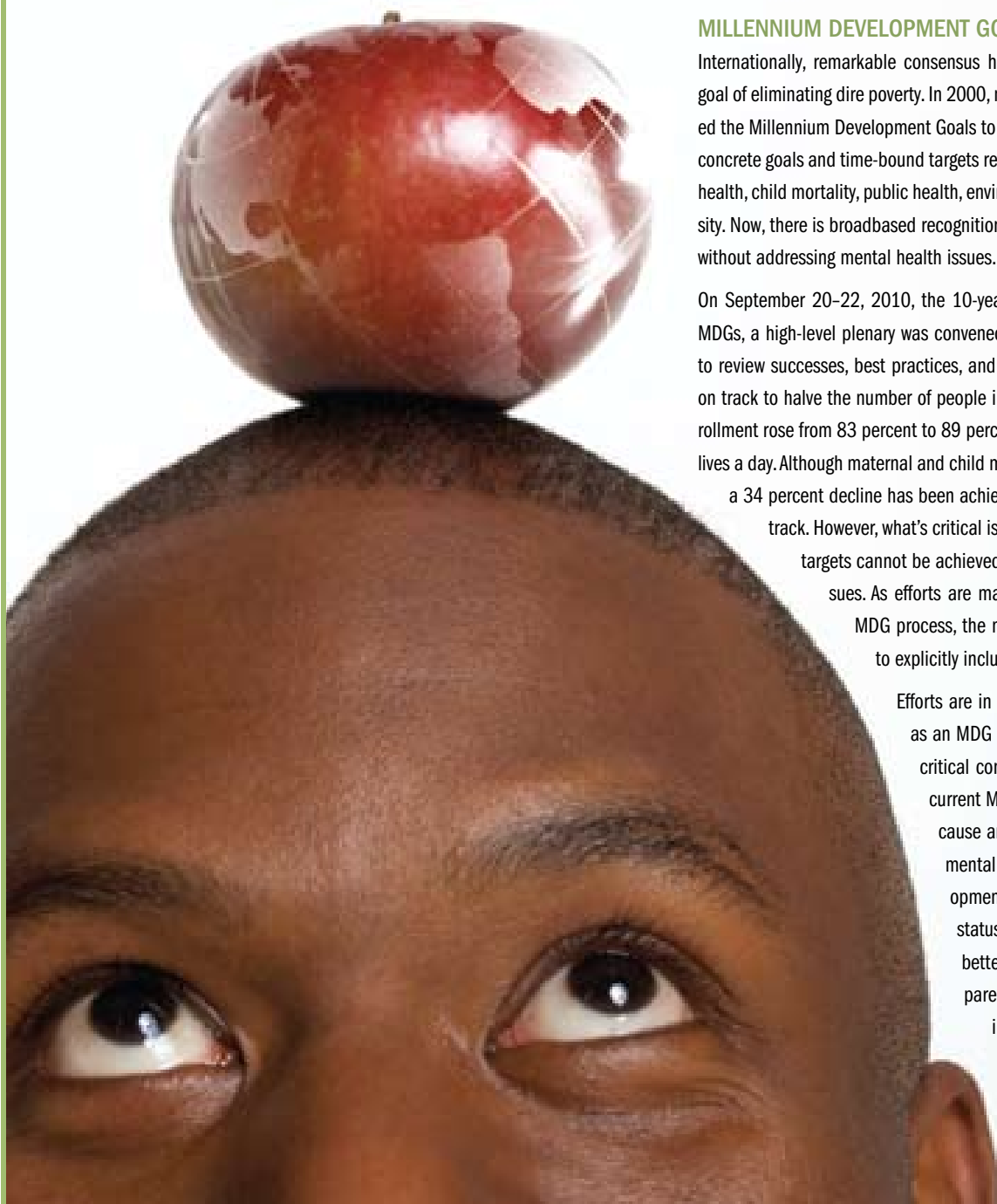
Several initiatives are currently underway to help make mental health a global priority. Around the world, mental health services get short shrift. However, now, there is increasing recognition that mental health is integral to achieving social, economic, and health goals.

MILLENNIUM DEVELOPMENT GOALS AND MENTAL HEALTH

Internationally, remarkable consensus has been reached on the overarching goal of eliminating dire poverty. In 2000, more than 200 countries jointly adopted the Millennium Development Goals to eliminate poverty and hunger through concrete goals and time-bound targets related to universal education, maternal health, child mortality, public health, environmental sustainability, and biodiversity. Now, there is broadbased recognition that these goals cannot be achieved without addressing mental health issues.

On September 20–22, 2010, the 10-year anniversary of the adoption of the MDGs, a high-level plenary was convened at the United Nations headquarters to review successes, best practices, and lessons learned. Overall, the world is on track to halve the number of people in extreme poverty; primary school enrollment rose from 83 percent to 89 percent; and the Global Fund saves 4,000 lives a day. Although maternal and child mortality targets are unlikely to be met, a 34 percent decline has been achieved. HIV/AIDS targets are also not on track. However, what's critical is the growing understanding that these targets cannot be achieved without addressing mental health issues. As efforts are made to streamline and accelerate the MDG process, the next generation of activity is expected to explicitly include mental health.

Efforts are in place both to promote mental health as an MDG and to ensure that mental health is a critical consideration in the achievement of the current MDGs, because mental illness is both a cause and a consequence of poverty. Positive mental health is linked to a range of development outcomes, including better health status, enhanced productivity and earnings, better interpersonal relationships, better parenting, closer social connections, and improved quality of life. Poor mental health leads to homelessness,





“

The bottom line of these global initiatives is that mental health is a vital component for increasing human productivity, enhancing social inclusion, and improving quality of life. International initiatives teach us that mental health must be population-based and that we must emphasize early intervention, family and community support, public education, and public mobilization. ”

poor educational and health outcomes, and high unemployment rates culminating in high rates of poverty. All these issues are linked to the MDGs. The World Health Organization report, *Mental Health and Development* (September 2010), buttresses this position.

THE MOVEMENT FOR GLOBAL MENTAL HEALTH

The Movement for Global Mental Health aims to improve services for people with mental disorders worldwide. In so doing, two principles are fundamental: first, the action should be informed by the best available scientific evidence, and, second, it should be in accordance with human rights. The movement is a global network of individuals and institutions that support this mission.

The movement has emerged from the recent Lancet series of articles on global mental health. Its goal is to implement the final “call for action” article of the series, which demands the scaling up of treatments for mental disorders, for the human rights of those affected to be protected, and for more research in low- and middle-income countries. Through a range of activities, the objective is for the Movement for Global Mental Health to take its place alongside organizations that support HIV/AIDS treatment and maternal and child survival, and is considered one of the great public health successes of our times.

WORLD FEDERATION FOR MENTAL HEALTH

The World Federation for Mental Health, a 62-year-old international advocacy organization with consultative status to the United Nations, has developed an alliance with the global mental health initiatives described above and provides an organizational and coordinating focal point for these activities. This alliance has been put under the rubric of the “Great Push for Mental Health.”

The major themes of the Great Push are:

- » **UNITY:** Building consensus and dispelling the realities and perceptions of disunity in the mental health world.
- » **VISIBILITY:** Raising awareness of mental health among the public and policy makers as well as encouraging public mobilization.
- » **RIGHTS:** Building a grassroots effort to bring together legal experts and existing organizations to collect evidence and lobby governments to address mental health issues and bring them to public attention.
- » **RECOVERY:** Legitimizing and promulgating the concept of recovery, with an emphasis on empowerment, self-agency, and the voice of consumers and their families, in culturally acceptable ways.

Some major WMH activities are — a grassroots campaign to make mental health more visible in the public mind internationally; participating in the UN process to reformulate the MDGs; partnering with international agencies and advocacy groups to promote the Great Push using both traditional and social media. WMH also created World Mental Health Day on October 10 and most recently, sponsored the Sixth World Conference on the Promotion of Mental Health and Prevention of Mental and Behavioral Disorders in Washington, DC, in November 2010.

LESSONS FROM GLOBAL INITIATIVES

The bottom line of these global initiatives is that mental health is a vital component for increasing human productivity, enhancing social inclusion, and improving quality of life. People with mental illness are denied opportunities in education, employment, and housing. Additionally, they have higher mortality rates and poorer health outcomes.


Given common mental health issues around the world, what can be learned from the international initiatives described in this article?

- » Recognition that mental health must be population-based rather than focused on a small set of individuals with severe problems. Mental ill health is pervasive and occurs at different levels of severity, and all of these levels affect desired societal outcomes.
- » Many countries are emphasizing early intervention — early in life and early in the course of an illness — and designing front-end versus back-end systems.
- » In areas of the world where professional help is scarce, the role of families and communities is critical. A strong relationship exists between resilience in a person with mental illness and support from these groups.
- » Public education is continually needed to combat stigma and social exclusion and to ensure human rights.
- » Public education is necessary but not sufficient; public mobilization is also needed.

Vijay Ganju directed the Texas Mental Health System Transformation project and was Director of Planning, Research and Evaluation at the state's mental health and mental retardation agency. At the national level, he was the director of the SAMHSA-supported Center for Mental Health Quality and Accountability. He coordinated the development and implementation of an outcomes system, components of which are being implemented across the U.S. Dr. Ganju has worked with the World Health Organization on the development of mental health training modules. He has also provided consultation to mental health systems in Albania, Macedonia, and Canada. He has taught international economic development, international communication, operations research and statistics at the University of Texas.

Making the Workplace Mentally Healthy

Clare Miller, Director, Partnership for Workplace Mental Health, American Psychiatric Foundation



Not long ago, one of the biggest challenges for the Partnership for Workplace Mental Health was identifying employers willing to step forward to address mental health in their organizations. Despite the high prevalence of mental illnesses, company representatives quietly explained that they didn't want to be known for anything connected to mental health — even if it was something positive, such as a successful approach to designing benefit programs for employees with mental health and substance use disorders.

We've come a long way. Today's challenge is to find the best ways to leverage all the case examples of successful employer programs we have amassed. The partnership now runs a database of these examples called Employer Innovations. Employer Innovations houses examples from more than 40 corporations that together purchase healthcare on behalf of 1.4 million employees. The companies include DuPont, Caterpillar, Cisco Systems, H-E-B, IBM, JPMorgan Chase, and PPG Industries. The corporate strategies that the partnership highlights vary widely and include innovations related to disease management, employee assistance programs, and efforts to integrate benefits and services.

The partnership's programming focuses on articulating the business case for quality mental health and promoting case examples of what employers are doing to successfully address mental health in their companies. The partnership works with a variety of corporate personnel who purchase or manage employee health and wellness benefits and



Employers, generally speaking, get it.

They recognize that the key to a healthy bottom line is healthy employees. The challenge — one the mental health community can help surmount — is how to encourage all employers to develop mental health benefits and programs.

programs, including medical directors, human resource directors, compensation and benefit managers, disability managers, work-life and wellness professionals, and employee assistance providers.

The partnership fields about 70 queries from employers per month, and in recent months, many of them have related to mental health parity. Some questions are easily answered by referring to a specific portion of the parity Interim Final Rule. Increasingly, however, employers are asking sophisticated questions for which no clear answer can be given. For instance, after years spent encouraging employees to reach out to their company's employee assistance program, employers are trying to figure out how to continue to do that without violating the requirement that the EAP not act as a gatekeeper. They are trying to determine how to structure their benefits in ways that drive quality care. They are concerned about the high costs associated with high numbers of prescriptions for antidepressants and the lack of commensurate rates of therapy. They ask tough questions for which there are no easy answers. I'm struck by how similar their concerns are to the very problems that the mental health and substance use disorder communities struggle to overcome. We spend a lot of time trying to break down complex problems into specific action steps that employers, in their role as healthcare purchasers, can take to improve healthcare delivery.

Employers are right to be frustrated. Many are taking healthcare on, not because they want to, but because there seems to be no other option. And many have been burned by a healthcare system that is costly, inefficient, cumbersome, and broken — and they have to foot a huge part of the bill. It's no wonder they are reticent to throw in more financial resources toward healthcare, especially in a time of fierce economic pressures, when the need to justify concrete return on investment is a basic requirement for continued investment.

However it is heartening to note the lengths to which many employers are going to focus on improving the system. The partnership has been privileged to highlight initiatives by employers to educate primary care practices about depression, coalitions of employers that have conducted community initiatives on depression, campaigns to get EAPs to universally implement screening and brief intervention for alcohol, and countless innovative approaches to educate employees about mental health issues.

Employers, generally speaking, get it. They recognize that the key to a healthy bottom line is healthy employees. The challenge — one the mental health community can help surmount — is how to encourage all employers to develop mental health benefits and programs. The following suggestions are to help people in mental

health agencies involve local employers in obtaining services for their employees:

- >> Reach out to employers in your community. Find out their concerns and see how your agency might be able to assist.
- >> Identify employer representatives to serve on your boards.
- >> Use tools to help make the business case, such as the depression calculator and the alcohol cost calculator.
- >> Offer to hold a lunch-and-learn session for employers.
- >> Identify employers doing a good job addressing mental health in the workplace and share their stories with the partnership.
- >> Sign up to receive the partnership's materials by emailing mhw@psych.org.

Through the generosity of grants, the partnership is able to provide its resources and tools to employers at no charge, including the following:

- >> The publication *Mental Health Works* highlights innovative employer approaches, research of relevance to workplace mental health, and resources that help employers improve workplace mental health.
- >> *Research Works* issue briefs focus on a specific mental health topic, review the research literature, suggest action steps, and offer employer best practice case examples.
- >> *Employer Innovations* helps employers learn and connect with one another by sharing innovative practices that improve workplace mental health through an interactive web database. Employers can search practices based on criteria such as industry and type of program.

The partnership encourages National Council members to make use of our publications and share them with employers in your community. To learn more, visit www.workplacentalhealth.org or call 703.907.8561.

Clare Miller serves as the director of the Partnership for Workplace Mental Health, a program of the American Psychiatric Foundation that advances effective employer approaches to mental health by combining the knowledge and experience of the American Psychiatric Association and its employer partners. Before joining the partnership, Miller was manager of the Center for Prevention and Health Services at the National Business Group on Health (formerly the Washington Business Group on Health), a membership group representing large employers.



Stress Busters: Promoting Mental Wellness

David L. Shern, PhD, President and CEO,
Mental Health America

In 2009, Mental Health America launched the Live Your Life Well campaign. This web-based public education effort offers a series of 10 research-based tools that anyone can use to help manage the debilitating effects of stress and improve well-being.

The campaign has several goals. The first is to bring a common-sense approach to common life stressors to help reposition mental health issues as central to health and well-being rather than as peripheral problems that exclusively involve people with severe mental illness. By doing so, the campaign should help reduce the social distance and stigma that are associated with mental health conditions.

The second goal is to generate a broad public movement aimed at improving the health and well-being

of the population that can be mobilized to help support public initiatives in treatment and prevention. The LYLW campaign can provide an engaging platform to help build a movement that appeals to people on the basis of their own health and well-being and not one that simply plays on the public's sympathies for people with severe illnesses.

The campaign will help achieve these goals by capitalizing on our changing conceptualization of the determinants of health. Over the past decade, a welcome paradigm shift in how mental health is viewed in the United States has occurred. It is now recognized as integral to health and well-being. The body of evidence that has been developed on factors that ameliorate risk for the development of mental and substance use conditions argues for affirmative and assertive policy and public education initiatives in which proven prevention and wellness interventions are deployed.

The milestone parity and health reform laws – and their recognition of the need to integrate mental health within overall health – will significantly re-focus our healthcare system toward prevention and wellness rather than its current, nearly exclusive focus on illness and treatment. However, equally broad steps need to be taken in the public arena to promote mental wellness, reduce the number of people in need of care, and respond to the many sources of risk and stress in society as well as the special challenges – from economic upheaval to natural disasters – that test people and put their mental health at risk.

With its renaming 3 years ago, from the National Mental Health Association to Mental Health America, our organization emphasized the centrality of mental health to overall health and our intention to develop and implement new wellness strategies that are relevant to the entire population. These



Broad steps need to be taken in the public arena to promote mental wellness, reduce the number of people in need of care, and respond to the many sources of risk and stress in society as well as the special challenges – from economic upheaval to natural disasters – that test people and put their mental health at risk.



goals are being pursued through MHA's Mental Health Month initiatives, which focus first on wellness and then on social connections. A Promotion and Prevention Summit presented at MHA's annual conference informed the behavioral health field on advances and strategies that work.

A separate program, FundaMental Health, is engaging the business community by raising awareness of the impact of mental health conditions on the U.S. workforce and educating employers about approaches to improve workers' health and their bottom line.

Recognizing the need to place health promotion strategies within the grasp of Americans, Mental Health America not only created the LYLW campaign but also produced a website, www.LiveYourLifeWell.org, to bring together decades of evidence and practical suggestions to promote mental health. It is unique and accessible because it uses consumer-friendly language and tools to educate site goers about protective factors such as exercise, good nutrition, and support from peers. The organization has also produced

materials such as stress cards and de-stress balls.

In response to the ubiquitous nature of interactive and mobile communications, Mental Health America partnered with Signal Patterns, developers of science-based web and mobile applications, in promoting the Live Happy™ iPhone application. This first-of-its-kind mobile tool guides users through a set of daily activities that research indicates can boost both short- and long-term happiness. It also introduced the "Gratitude Stream"—an interactive mood tool allowing live, worldwide posting of good thoughts and thanks.

The LYLW campaign has won praise and was featured in Time magazine's special health issue. It has also become synonymous with Mental Health Month, and other organizations have communicated the campaign's theme and tools through social media platforms. In addition, the tools in campaign are winning acceptance and circulation in other venues. The PBS series This Emotional Life (which Mental Health America partnered with in its outreach campaign) explored the importance of connections and social

support, the first tool of the campaign. The series also recognized that millions of Americans continue to search for healthy ways to respond to stresses and challenges and often rely on ineffective strategies.

As mental health advocates and behavioral health professionals, our charge is to continue to take steps to reach and inform all Americans and promote mental health in the general population.

With more than 30 years of distinguished service in mental health services research and system reform, David Shern is one of the nation's leading mental health experts. He is president and CEO of Mental Health America and served as dean of the Louis de la Parte Florida Mental Health Institute at the University of South Florida, one of the largest research and training institutes in behavioral health services in the United States. He also founded and directed the National Center for the Study of Issues in Public Mental Health, a National Institute of Mental Health-funded services research center located in the New York State Office of Mental Health. Shern not only has an extensive research background but is an advocate committed to representing the interests of mental health consumers. He serves on the board of the Campaign for Mental Health Reform and on the National Advisory Committee for the Agency for Healthcare Research and Quality.

Your Resource for Living with Schizophrenia

Subscribe to SZ Magazine and receive...

- Enlightening and stimulating feature stories pertaining to schizophrenia and all aspects of mental wellness
- Inspirational stories about people living and thriving with schizophrenia
- The latest news and research developments on mental health issues around the world
- Tips on healthy living, financial planning, and nutrition

Subscribe Today

1-866-672-3038

or visit www.szmagazine.com
to learn more about living with schizophrenia



Addressing Depression In the Workplace

Julie Totten, President and Founder, Families for Depression Awareness

In the current recession, employees are more stressed and at risk for depression than ever. The American Psychological Association's 2010 Stress in America survey found that a majority of Americans—51 percent—are living with “moderate” stress. Although that's about the same level of stress as the survey found last year, fewer adults reported being satisfied with how their employer helps employees balance work and non-work. Twenty-four percent say they are experiencing severe stress.

Even without a recession, untreated depression in the workplace is common (on average: 7% of employees) and leads to increased absenteeism, disability, and medical costs for companies. For a company with a few hundred employees, the cost of untreated or poorly treated depression can be \$50,000 to \$100,000, NOT including sizable disability leave costs. For a large company with a hundred thousand employees, the costs can be in the tens of millions of dollars.

Although many companies have an employee assistance program to counsel employees with depression, these types of programs typically only have a 5% utilization rate. Families for Depression Awareness offers a Depression in the Workplace program that consists of a cost of depression presentation for human resource managers and employee depression training, screening, and communication. Since launching this program two years ago, we have worked with more than 25 companies such as JetBlue, Ernst & Young, and EMC to increase their employees' awareness of depression and utilization of their employers' EAP.

National Council members can help many people — their own employees, patients that they treat, and employees of companies in their communities — with the Depression in the Workplace program. The main component of our program is our Coping with Stress (and Depression) workshop for employees. This 75-minute workshop covers what stress is,



how to reduce stress, depression and anxiety, and where to go for help. National Council members can provide the training using our facilitator's guide and brochures.

The results we have seen from this workshop are:

- >> Increased referrals to the company's EAP.
- >> More employee commitment and action taken to reduce stress in their lives.
- >> Employee satisfaction with the employer, for addressing their primary issue in the workplace: stress.
- >> Improved employee understanding of the difference between stress and depression and when to seek help.
- >> Better understanding of how employees can help their spouses, children, and other family members who have depression.
- >> Employee appreciation for a forum to learn about depression, a topic surrounded by stigma.

Companies that combine this training with enhanced online anonymous screening and ongoing communication (through employee emails, newsletters, posters) can achieve even better results. After an Ernst & Young employee agreed to share her personal experience with depression, we helped her tell her story in the company's email newsletter, which reached thousands of other employees.

Equipping your employees, patients, and corporate partners with the tools to combat stress and depression will not only reduce healthcare costs, but will also dramatically improve people's lives.

In 1990, Julie Totten lost her brother, who was undiagnosed, to suicide. A year later, after learning about depression, she helped her father get diagnosed for this condition. She founded Families for Depression Awareness to help others understand depression and reduce stigma associated with the condition. Totten has built her career in marketing, developing strategic marketing plans and promotional campaigns for Internet companies, educational firms, and marketing organizations. She received her MBA from Babson College where she was a winner of the prestigious Douglass Business Plan competition.

New Research in Employee Health and Wellness

Colleen Michelle Allen, DBA, Chief Operating Officer, UNI/CARE Systems, Inc.

THE CHALLENGE OF TODAY'S BEHAVIORAL HEALTH INDUSTRY IS TO ATTRACT QUALITY PERSONNEL

The behavioral health industry has struggled to maintain its funding over the past 10 to 30 years. Because of funding cuts and the low-income status of those receiving treatment, behavioral health providers aren't paid competitively and they are seeking more lucrative employment. This results in a lack of quality staff available to provide care to an increasing number of people. The maintenance of quality staff is critical to the success of an organization.

HEALTHY STAFF EQUALS BETTER CARE

Organizations can provide additional resources to their employees to retain them and increase motivation. Research has demonstrated that a high level of employee whole health and wellness has a positive impact on employee retention and results in increased productivity. The health, wellness, and productivity of staff can help an organization meet its goals and provide better care to consumers.

DO WELLNESS PROGRAMS MEAN BETTER EMPLOYEE PERFORMANCE?

This study attempted to address the following question: could wellness programs created for providers of behavioral health care improve their quality of life and result in higher work productivity? It is reasonable to assume that behavioral health centers cannot justify the expense of costly wellness programs without the promise of organizational benefit. Therefore a research study to investigate the relationship between the wellness and productivity would certainly have value to the behavioral health care industry. The measurements in this study included health, motivation, decreased accidents, and attendance. This research attempted to determine if employees who participated in employer sponsored fitness centers demonstrated differences from those who did not. Specifically, did participating employees show increased productivity resulting in organizational benefit?

WHOLE HEALTH AND WELLNESS WORK

The employee focused whole health and wellness study surveyed full and part time employees from ten behavioral health organizations in the following states: Florida, Virginia, Minnesota, Washington, Georgia and Indiana. Three of the ten organizations provided fitness center memberships to employees. The other organizations provided



a wellness component such as a walking track, Weight Watchers and Alcohol Anonymous meetings, but not specifically a fitness center membership. Each of the ten organizations was either committed to a wellness program or implementation of a wellness program. The study demonstrated positive relationships between employee whole health and wellness programs. Specifically, employees who engaged in fitness center benefits were absent less than non-participating counterparts. Consequently, employers could provide and encourage an employee fitness center membership and see reduced absenteeism as a reward.

WELLNESS PARTICIPANTS ARE MORE MOTIVATED

Motivation strongly impacts the overall quality of employee performance. There is a link between motivation and fitness center participation which is meaningful information for an organization's whole health and wellness programming plan. This research also showed that employees who engaged in a fitness center membership benefit reported fewer instances of going to work sick than the non-participating employees. In this day of infection control concerns, knowing that wellness minded direct care employees are more likely to choose to stay home when they are sick is a valuable research outcome.

THE IDEAL BALANCE OF COST TO BENEFIT RATIO IN WELLNESS PROGRAMMING REMAINS TO BE SEEN

This research project has demonstrated that there is a relationship between motivation, health, absenteeism, and accidents and whole health and wellness programs. Moreover, it has demonstrated that corporate wellness programming is important in maintaining a healthy workforce. The essential remaining question is what combination of wellness programs will create the ideal environment for staff and management balancing costs in this financially challenging and difficult time in behavioral health care.

Innovations Beyond Our Borders

Francis Silvestri, MBA, Director, International Initiative for Mental Health Leadership

In light of the recent economic crisis, governments around the world are looking for ways to make best use of the reduced funds available for health and social care. In behavioral health, many governments are focusing on health promotion and early intervention, where the impact on health relative to expenditure is greatest; on integrating behavioral health, social services, and physical healthcare to avoid duplication and address the interplay between behavioral and physical health issues; and on providing peer support to people with established mental health conditions or substance abuse to enable them to play a lead role in their own recovery, thereby improving the effectiveness of the services they receive.

Now may be a good time for behavioral health service leaders in the U.S. to look beyond our borders for potential innovations that, with some adaptation, could be relevant here. Why look outside? Other English-speaking countries spend less gross domestic product on healthcare and have universal coverage. Therefore, they have been focused on cost efficiency for a long time, well before the economic crisis occurred. This concentration on efficiency has encouraged creative ideas to be tried, some of which have been locally generated and some of which are derived from work in other countries.

One of the goals of the International Initiative for Mental Health Leadership is to share knowledge and innovations among mental health leaders in seven English-speaking countries: Australia, Canada, England, Ireland, New Zealand, Scotland, and the United States. Some innovations that relate to early intervention, integration of services, and self-care are briefly described below.

>> The Australian Mental Health First Aid initiative developed by Betty Kitchener and Tony Jorm, both of the University of Melbourne, is an example of a program aimed at promoting mental well-being and early intervention that has been adapted for the United States by the National Council for Community Behavioral Healthcare and the state mental health departments of



In behavioral health, many governments are focusing on health promotion and early intervention, where the impact on health relative to expenditure is greatest.

Maryland and Missouri. It has also been adapted in New Zealand for use with indigenous families, who have high rates of mental illness and substance abuse and in 13 other countries.

- >> Pat McGorry, of the University of Melbourne, has developed an effective early intervention program for adolescents. This concept has been adapted in the United Kingdom, Ireland, and Canada.
- >> The Improving Access to Psychological Therapies program in England aims to improve access to evidence-based talk therapies for people using primary care by expanding the psychological therapy workforce and service.
- >> One early example of efforts to create closer working relationships between behavioral health service and primary care providers was the Trailblazers initiative in England, which was developed in 1996 by Andre Tylee. This program supported pairs of primary care and mental health clinicians to collaborate in their professional development and in designing better services for people with mental health needs.

>> Two New Zealand websites have been developed that use and support electronic technology to promote prevention, education, early intervention, and self-care for depression. The Low Down (www.thelowdown.co.nz) is for adolescents and

The Journal (www.depression.org.nz) is for adults. These sites are backed up by emails, texts, and an on-call phone system to immediately extend help when needed.

>> Consumer-operated peer support and other peer-led services (based on the early work of Jen Koberstein and the later work of Larry Fricks, Gene Johnson and Lori Ashcraft) in the United States have been developed to support people in leading their own recovery. These programs have been adapted and implemented in many of the partnering countries.

Note: IIMHL's twice-weekly newsletter regularly shares innovations like the ones discussed here. In addition, you can receive IIMHL's analysis of peer support services, including current research, national policies, and contacts in all seven sponsoring countries. Join IIMHL (www.iimhl.com/join.asp); membership is free.

Francis Silvestri, MBA, is the director of the International Initiative for Mental Health Leadership. The IIMHL is jointly funded by seven countries — Australia, Canada, England, Ireland, New Zealand, Scotland, and the United States — to facilitate the sharing of best practices and to provide the needed support and collaboration for leaders of mental health services to develop robust managerial and operational practices. Silvestri was CEO of Monadhock Family Services from 1988 to 1998. A long-time advocate for mental health consumers, he has consistently promoted the development of innovative service delivery and support models for long-term consumers of mental health services.

LAUGHTER — THE BEST MEDICINE Cynthia Morse, Lifestyle Balance



"I started with Lifestyles about 6 months ago," says Cynthia Morse, "and it changed my life." The Lifestyle Balance program in Northampton, Massachusetts, provided Morse with the support she needed to regain her self-esteem and have confidence making day-to-day decisions, especially when it came to her health. "It's nice to have someone support you when you're not feeling well," she says.

When Morse needed transportation to doctors' appointments after cataract surgery, the Lifestyles staff helped her get there. She attends the nutrition and exercise programs to achieve her weight-loss goals and to help better manage chronic asthma and schizoaffective disorder. "They helped me to understand how to take my medications," she says, "and I'm not as nervous as I used to be — I don't have to rely on others to make my decisions. I'm much friendlier now."

"I'm going to the gym, and that really helps," Morse says. "We do different things. And the gym, medication, acupuncture, and Reiki, it's all free! It's included in our membership." She liked the results and doing things she's never done before that help her to feel good. Morse reflects, "I used to panic a lot. Now I go to the gym 3 days a week, and the activity gives me a more positive outlook. I'm taking care of my health, and I'm eating better. And I love the buddy system here. Once, I was ready to quit on the treadmill after 20 minutes. But the member I was exercising with suggested we try to go for 45 minutes. She kept track of the time and we did it, together!" The gym also has a Wii, and Morse loves bowling. "Baseball is hard though," she says with a little laugh.

"For too many years, I had a hard time with my illness," says Morse. Yet, she loves to joke around. "When we make people laugh, it's a really nice feeling," she explains. Morse attended her father's 80th birthday celebration at a huge picnic in the park. "For the first time in my life, I felt comfortable with my family and being around a large group of people — that's a huge step for me," she says. "I'm a better friend, a better sister, and a better daughter for the help I've received here."

Morse's quality of life and health have improved immensely. "The other members are really gung ho," she says. "I get inspired watching other people exercise despite their disabilities." "All in all," Morse says, "We all have a great time together."



Smartphoning Your Health: A Sampling of Wellness and Medical Apps

Reprint from the *Harvard Health Letter*



If you have an iPhone or Android, you no doubt appreciate why they're called smartphones. The pocket-sized devices, while nominally telephones, are also powerful computers with operating systems capable of running hundreds of thousands of software programs called applications, or "apps."

Most of the apps are designed to keep you entertained, but many have a practical purpose, including helping you manage your health. While a lot of health and medical apps provide little more than an alternative to pen and paper for note taking, an increasing number are harnessing the phones' computing power, cameras, audio and video capabilities, motion sensors, and GPS systems to create new ways to help you manage your health.

THE WILD WORLD OF APPS

Apps are a new frontier of medicine – a territory still largely uncharted, unregulated, and unstable. No one knows exactly how many apps there are, how well they perform, or whether they are worth their prices, which may vary from day to day.

That said, it's worth browsing through the health and medicine section of your phone's app store occasionally. You'll find all sorts of inexpensive apps to help you sleep better, quit smoking, abstain from alcohol, and relieve stress. Others might help you manage medical conditions from the common cold to cancer. And if you want to better understand your doctor, you can download medical texts and dictionaries.

If an app is free, you lose nothing by downloading it; you can always delete it. If it costs something, user reviews, which link to the product descriptions in your phone's app store, can help you decide whether to spend the money. Many app producers also offer free test runs. The following are a few examples of the highest-rated and most widely used apps for common health problems. Some are free; none cost more than a one-time charge of \$5.



FITNESS AND WEIGHT CONTROL

Tap & Track is an all-in-one app for diet and exercise. You enter what you eat, your physical activity, your actual weight, and your target weight. It computes your nutritional intake (calories, carbs, protein, saturated and unsaturated fats, and sodium) from a database of about 250,000 items found in restaurant chains, supermarkets, and even your backyard garden plot. It also offers a selection of 180 physical activities. Each time you enter a snack or plug in a workout, you'll receive a nutritional tally as well the number of calories you have left for the day. A food score — a proprietary measurement developed by Weight Watchers International, Inc. — is also given for dieters enrolled in that program. The \$3.99 app can generate graphs and spreadsheets tracking your progress, which can be e-mailed to your computer.

Calorie Counter by FatSecret, a free app for Androids, gives the nutritional content of thousands of foods and allows you to enter your weight and exercise regimens. But it doesn't do the math for you or create charts or spreadsheets.

iTreadmill: Pedometer Ultra with PocketStep is available for iPhones for 99 cents. Although the name promises more than it delivers (it doesn't make the sidewalk move in reverse), it is a very good pedometer. It senses your motion as you walk and determines the length of your stride. Once you establish your pace, it can select a tune with a matching beat to keep you on track. It also estimates calories burned.

Walk It! and **Pedometer-Widget**, both pedometers for Androids, are similar to iTreadmill, but get lower user ratings for being less reliable.

DIABETES MANAGEMENT

Glucose Buddy tracks glucose readings you enter four times a day, as well as food consumed, exercise, and medication. You can set alarms to remind you to take the glucose readings. The app also allows you to write notes to explain any unusual circumstances, such as high-carbohydrate meals. The data can be uploaded to www.glucosebuddy.com for more detailed analysis. Glucose Buddy can be downloaded free to an iPhone.

Handylogs Sugar, also free, is available for all smartphones. It offers most of the same functions as Glucose Buddy, but its functions are executed on the Internet, so its accessibility may vary with the quality of your phone's Internet connection. Handylogs also has apps for blood pressure, fitness, and diet.

HIGH BLOOD PRESSURE

HeartWise simplifies the task if your doctor has asked you to log your blood pressure at home. You enter your systolic pressure (the top number) and diastolic pressure (the bottom number) as well as your pulse and weight. The app will calculate your average arterial pressure and pulse pressure and generate graphs showing fluctuations in these values over time. It's available for the iPhone for 99 cents.

My Blood Pressure and Heart Rate, available free for Androids, is similar to HeartWise. You enter your systolic and diastolic pressures and heart rate as well

as other information — including which arm was measured and whether you were standing, sitting, or lying down when your pressure was taken.

SLEEP HYGIENE

Sleep Cycle Alarm Clock. If anything attests to a growing global sleep deficit, it's the overwhelming popularity of this quirky 99-cent iPhone app, a top seller in the G-8 countries. You place your phone on a corner of your mattress, secure it under a contour sheet, and allow it to "observe" you for a few nights. The app uses your phone's motion sensor to chart your sleep patterns. Within a week it supposedly knows you well enough to find the best moment (within a pre-set 30-minute period) to awaken you with your choice of tones or tunes. Most reviewers report that they are rarely jolted from a deep sleep and usually feel refreshed, although a few have dashed their phones to the floor during fitful episodes. Others have forgotten their phones were there and made them into the bed the next morning.

Smart Alarm Clock, which works much the same way, is being developed for Android and should be in Android Market in 2011.

STRESS REDUCTION

Several stress-reduction celebrities have jumped on the apps wagon. All of the following have garnered kudos from users and critics, and the choice depends largely on which "brand" appeals most to you.

Stress Free with Deepak Chopra offers a whole bag of relaxation tricks and exercises — meditation, yoga, journaling, and even e-mailing privileges with the master himself. It's available for the iPhone for \$1.99. Or you can try **Stress Free with Andrew Johnson** for \$2.99 for the iPhone, \$1.99 for the Android. The UK hypnotherapist puts you under with good thoughts and a Scottish burr. This is not an app for midday meltdowns.

If you're really stressed, keep an eye out for **iBreathe**, developed by the Department of Defense's National Center for Telehealth and Technology. Designed for troops under the pressures of combat, it uses videos to coach you through deep-breathing exercises and can be used as an adjunct to professional therapy. You should be able to get it on your iPhone or Android early in 2011.

Rage Eraser is the app for you if you're mad as hell and can't take yourself any more. You may want to start by using the "Rant" feature to record your next tirade and listen to yourself after you cool down. The app can help you track the situations that trigger your anger and identify the distorted thoughts that feed it. There are male and female voices to talk you down from a tantrum in progress as well as techniques for transforming your anger into more productive emotions over time. It's \$4.99 for iPhones only.

FIRST AID

The cool heads we need to guide us in a health emergency are now available at a finger's touch: there are a slew of first aid apps. The highest rated and most comprehensive is **Pocket First Aid & CPR** from the American Heart Association.

tion for iPhone and Androids. It offers detailed instructions for assisting accident victims and people who have been taken ill, including video instructions for performing procedures like CPR or using a cardiac defibrillator. Although the app is easy to navigate, it's important to familiarize yourself with the content before you need it; some of the instructions are so lengthy and intricate that they may be hard to follow if you first try them during a crisis.

HEARING AND VISION ASSISTS

One of the best-kept secrets is that smartphones can function as hearing and vision aids. Moreover, they'll make you look more like a hipster than an oldster in the bargain.

You can turn your phone's camera into a magnifier by activating the zoom function. (If it doesn't have one, you can download a zoom-lens app.) When you pass your phone over the tiny type on a menu or medicine label, you'll find a readable version on the screen. If you have macular degeneration or low vision, the iPhone's "Accessibility" menu in "Settings" has two features that may help — a button to change the contrast from black-on-white to white-on-black and a "voice-over" function that can read aloud any text on the phone's screen, including words you type.

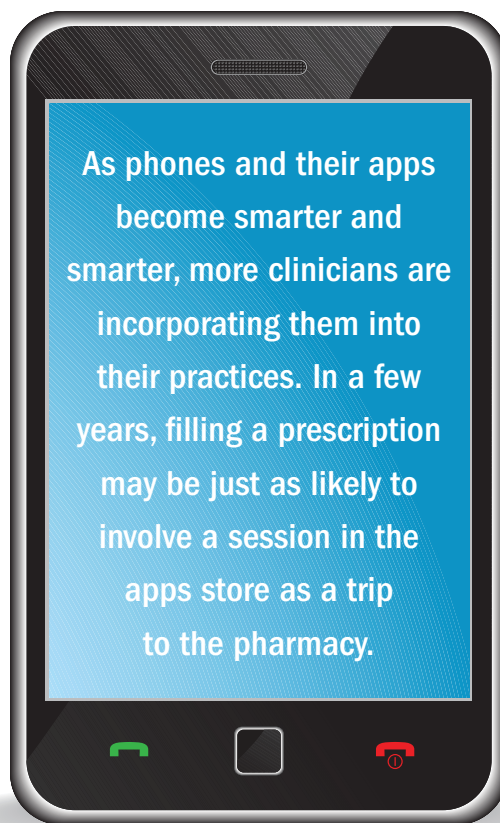
You'll need a \$1.99 app, **SoundAmpR**, to turn your iPhone into a hearing aid. To use it, plug the phone's ear buds into the jack and adjust the controls that appear on the screen. The "tune" slider adjusts the volume in each ear; the "zoom" slider screens out background noise. Activate the recorder if you want to capture the conversation for replay.

NOT FOR DOCTORS ONLY

Medical professionals were early iPhone app adopters, and there are hundreds of apps directed at them. (Expect Android apps to narrow the gap soon.) A few of them can be great aids for patients, too.

Quick Medical Terminology by Simple Tree can help you translate your clinicians on the spot, should they lapse into jargon. The 99-cent iPhone app displays hundreds of medical terms, acronyms, and abbreviations at a touch. Once your doctors realize you can communicate on their terms, they'll describe you as A&O++++ (alert and oriented in every respect).

According to its developer, more than a quarter of a million doctors have **Epocrates** apps on their phones. Epocrates is actually a network of medical-refer-



ence apps sold by subscription for upwards of \$100. However, basic versions for iPhones and Androids are free and are more than adequate for most of us.

Epocrates Rx has everything you need to know about almost any drug you take, from complete package information in legible type to interactions between drugs. Its pill identifier is especially helpful if you're trying to determine what the stray tablet on the kitchen counter is. Just dial in the pill's suspected name, or just its shape and color, and you'll get an image to match it to.

The Epocrates BMI app not only calculates your body mass index but also your basic metabolic rate and daily calorie needs based on your height, weight, age and exercise level. It flags your disease risk and offers treatment guidelines if you are overweight or obese. You'll have to set up an account with Epocrates before you download any of their apps and dodge several "opportunities" to upgrade in the process.

If you want a nonstop diet of news from medical conferences and journals, the **Medpage Today** app will feed it to your iPhone or Android at no charge. Like the namesake Web site, the app gives you an array of news channels to choose from, including a general "Latest News," reports from medical specialties, product alerts (approvals and recalls from the FDA) and Washington Watch (coverage of national health policy). Since the app is aimed at health professionals, you may need to activate the medical terminology app for occasional help.

APPS COME OF AGE

In July 2010, the FDA signaled that apps should be taken seriously when it allowed the WellDoc DiabetesManager System to be marketed as a medical device. DiabetesManager came under FDA scrutiny because it differs from earlier apps in one important respect: it not only collects and analyzes data, but also offers users medical advice and coaching based on the results. The app passed muster because clinical trials demonstrated that patients who used it had greater reductions in blood sugar than those who didn't. It's slated to be available in the apps stores early in 2011, and apps for asthma, cardiovascular disease, and cancer will be on its heels.

And that's just the beginning. As phones and their apps become smarter and smarter, more clinicians are incorporating them into their practices. In a few years, filling a prescription may be just as likely to involve a session in the apps store as a trip to the pharmacy.



BETTER BUSINESS PROCESSES... BETTER CLINICAL OUTCOMES...

RESULTS

Community behavioral health organizations have achieved:

- **\$200,000 in annual savings through access efficiencies.**
- **40% reduction in client wait times – with greater engagement and reduced no-shows.**
- **450 hours of additional services, without additional staff.**

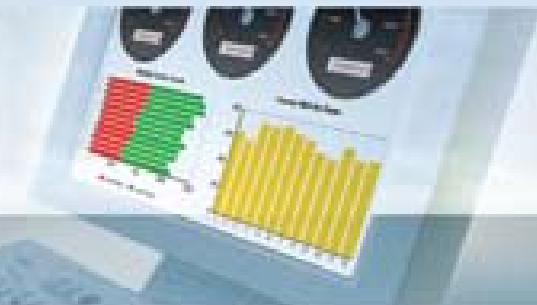
To replicate the results in your organization, schedule an SPQM test drive with David Lloyd and his team – contact Jeannie Campbell at 202.684.7457 or JeannieC@thenationalcouncil.org.

STRATEGIES

The SPQM team has implemented winning change concepts in 500+ community behavioral health organizations:

- SPQM Dashboards
- Enhancing Revenue
- Streamlining Documentation
- Improving Access and Retention
- Leadership and Workforce Development
- Clinical Assessment Tools

... A BETTER BOTTOM LINE



The SPQM Services Suite is brought to you by the National Council for Community Behavioral Healthcare and MTM Services



NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE



We ask you to consider joining **REACH OUT**

The Research and Evaluation of Antipsychotic
Treatment in Community Behavioral Health
Organizations Outcomes Study

If you:

- work in a community behavioral health organization
- have a psychiatrist (MD) or psychologist/researcher (PhD, PsyD, PharmD) on staff that is able and willing to serve as a site principal investigator
- treat a sufficient number of patients with schizophrenia or bipolar 1 disorder
- providing long-acting injectable antipsychotics to your patients

To learn more, contact Mohini Venkatesh,
Senior Director of Public Policy, National Council for
Community Behavioral Healthcare

202.684.3730

MohiniV@thenationalcouncil.org

Integration,
Expansion,
Reform...

Is Your Insurance Keeping Up?



Are you prepared...

- ➔ To think outside the box?
- ➔ To integrate primary care with your behavioral health services?
- ➔ To take on the risks of expanded service?

Turn to the gold standard for behavioral health insurance solutions...

MHRRG and Negley Associates offer customized insurance coverage for primary care services delivered in behavioral healthcare organizations.

MHRRG and Negley Associates also provide a comprehensive insurance program and an exclusive loss prevention series for behavioral healthcare providers:

- Professional Liability • General Liability
- Directors and Officers Liability
- Business Automobile • Commercial Property
- Workers Compensation • Excess Liability

We understand the importance of treating the physical and mental healthcare needs of individuals with serious mental illnesses and responding to the behavioral healthcare needs of all Americans. This is creating a series of exciting opportunities for the behavioral health community and a series of unprecedented challenges.

— Linda Rosenberg, President and CEO,
National Council for Community Behavioral Healthcare



Mental Health
Risk Retention Group, Inc.

NEGLEY
ASSOCIATES
UNDERWRITING MANAGERS

qsiconnect.com

Does your vendor connect with you?

With Qualifacts, you get much more than an EHR - you are joining a network of users across the country, working towards the same goals.

**Qsiconnect.com is an online forum,
connecting you to Qualifacts and your peers through:**

- *Online training and support*
- *State and national user groups*
- *Discussion of new features and industry trends*
- *Announcements of grants and industry events*

getconnected!

(And put a smile on your face.)



Are you a Qualifacts user that hasn't connected yet?

Visit www.qsiconnect.com and click "Sign Up"

www.qualifacts.com | 866-386-6755

qualifacts