A Two-Way Street
Behavioral Health and Primary Care Collaboration

Getting Well in My Mind and Body, Page 3
A New ‘Home’ for Persons with Serious Mental Illness, Page 6
Revised Four Quadrant Model, Page 10
From the Field: Making Whole Health Work, Page 24
Team Solutions: Psychoeducation Tools for Treatment Teams, Page 44
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EDITORIAL
2 Together We Will Save and Improve Lives
   Linda Rosenberg

IN MY OWN WORDS
3 Getting Well in My Mind and Body
   Cassandra McCallister

WASHINGTON UPDATE
4 Promoting Whole Health for the Mentally Ill
   Charles Ingoglia

HEALTHCARE REFORM
6 A New ‘Home’ for Persons with Serious Mental Illness
   Barbara Mauer

FRAMEWORK
10 National Council’s Revised Four Quadrant Model

FINANCING
12 Financing Integrated Healthcare:
   Working Creatively With Existing Opportunities
   Kathleen Reynolds

PROJECT REPORT
14 Learning Collaboratives Enhance Population Health
   Barbara Mauer, Laura Galbreath

ADDICTIONS UPDATE
18 Primary Care Screenings Connect Patients to Specialized Care
   Alexa Eggleston

PEER SUPPORT
20 Consumers Take Charge of Wellness
   Larry Fricks

STRAIGHT TALK
22 Life as an FQHC for a Behavioral Health Provider
   Interview with Karl Wilson

FROM THE FIELD
24 Making Whole Health Work

WELLNESS
42 Physical Health Screenings for the Mentally Ill: Key Health Indicators
   Joseph Parks, Alan Radke, Noel Mazade

44 Team Solutions: Psychoeducation Tools for Treatment Teams
   Patricia Scheifler

46 Smoking Cessation Along the Road to Recovery
   Chad Morris

TECH NOTES
50 Sharing Patients Requires Sharing Data
   Mike Lardiere

54 EHRs Improve Care and Increase Revenue in Integrated Settings
   Virna Little

56 Ensuring Patient Safety through Medication Management
   Charles Klein

TIPS AND TOOLS
60 Resources for Healthcare Collaboration

PDF available at www.TheNationalCouncil.org
Together We Will Save and Improve Lives

Linda Rosenberg, MSW, President & CEO, National Council for Community Behavioral Healthcare

If someone told you they had access to specialty cardiology treatment but not to primary care, you’d find it ironic. If someone told you they are being treated for their cancer but not for their co-occurring diabetes, it would seem ridiculous. Yet that is exactly what we’ve done to persons with serious mental illness.

The National Association of State Mental Health Program Directors 2007 study Morbidity and Mortality in People with Serious Mental Illness, which revealed that, on average, people with severe mental illness die 25 years earlier than the general population, was a bombshell. But the tragic report findings corroborated what those in the trenches — community behavioral healthcare providers — suspected, we’re helping people recover from mental illness when their lives are endangered due to neglect of other serious health issues.

The barriers to complete care seem daunting. A National Council survey of community behavioral organizations revealed that although over 90% consider general healthcare for consumers a priority, only one in two organizations has any general healthcare capacity, and less than one in three has the capacity to provide the services onsite. The most common barriers to obtaining general medical services are problems in reimbursement, workforce limitations, physical plant constraints, and lack of community referral options.

The National Council’s report, “The Person-Centered Healthcare Home,” featuring an overview of evidence-based approaches makes a strong case — to policymakers, planners, and providers of general healthcare and behavioral health services — for creating a patient-centered healthcare home for people with serious mental illnesses either by creating general healthcare capacity within the behavioral health care organization or through a seamless collaborative relationship with a primary care provider.

We also cannot ignore the large unmet need for mental health and substance abuse specialty services within general healthcare. A 2007 Health Affairs article notes that community health centers reported that over 40% of uninsured patients and 20% of Medicaid patients had difficulty accessing mental health services; and over 50% of uninsured patients and 30% of Medicaid patients were challenged in accessing substance abuse treatment. Primary care needs the staff and skills to assess behavioral health conditions; and behavioral health care providers need the capacity to accept and treat the complex cases referred to them from primary care.

There are community behavioral health organizations that have implemented innovative clinical and financing models that make possible the provision of comprehensive care in collaboration with primary care centers. As you will see in the range of model programs showcased in this issue of National Council Magazine, collaboration is evident in colocated mental health and primary care services, enhanced referral processes between mental health and primary care, sharing of patient information, and cross-training of staff. We’re proud of our members’ work and applaud their commitment.

The National Council’s job is to help our member organizations do their jobs — saving and improving lives. We’ve played a leading role in advocating for policies that break down barriers to integration and collaboration, developing clinical and business models that support seamless and comprehensive healthcare, and fostering collaborative opportunities. Advocating for funds to bring primary care services to behavioral health organizations has been a National Council legislative priority. And last week, we achieved a small but significant legislative victory when the 111th Congress authorized one of the key provisions in the Community Mental Health Services Act championed by the National Council — a new $7 million grant program, housed at the Substance Abuse and Mental Health Services Administration, giving people with serious mental illnesses the promise of a healthcare home.

In addition to our legislative activity, we’ve been active on the practice improvement front. The National Council Four Quadrant Model is widely used to guide collaborative efforts across the country. Our Primary Care-Behavioral Health Collaborative project — currently in its third phase — has provided a wealth of guidance and hands-on training, helping member organizations and their primary care partners to overcome clinical, cultural, and communication
Getting Well in My Mind and Body...

Cassandra McCallister, Board Member, Washtenaw Community Health Organization

“I had been diagnosed with depression but was not properly diagnosed with bipolar disorder until 2003. Fortunately, I was able to find help at Community Support Treatment Services in Michigan. I joined a wellness group, and between this service and my medications, I haven’t had a hospitalization in more than 5 years. I am also proud to say that I have been sober for 15 years.

Around the time that my bipolar condition was identified, I was diagnosed with kidney disease. I am currently on a waiting list for a kidney transplant. Between the two disorders, it was a pretty upsetting time in my life. Even so, I was excited to have my bipolar illness properly identified and to be receiving treatment. I was determined to do whatever it took to get well in my mind and body.

My doctors, dialysis clinic staff, and mental health case manager are well connected. They take a team approach, and they each check on the status of my health. When I go to my primary care doctor, he asks about my mental health. When I go to my mental health counselor, the office has the information on my health status. Today I have control over my health; it doesn’t have control of me. The coordinated care allows me to feel like I can go out and be a part of the community.

Before this kind of collaborative relationship was available, it was all on me to keep things straight. It was hard to get all my providers communicating with each other, but I knew that it was important that they receive the same information that I was getting. If it had not been for the involvement of my case manager, I don’t know that I could have navigated the healthcare system. Given that I was still in early recovery for bipolar disorder, my mental health provider was able to speak with my primary care doctors and help me think through my options and decide what I needed to get healthy. The mental health therapy I received from my counselor has helped me react to symptoms and learn how to deal with them so that I am not paralyzed by them. It’s also been tremendously important to the management of my physical health. When I’m mentally well, I am better equipped to take care of my health.

Over the past 3 years, I’ve made a lot of changes in my life. I walk every day, have changed my eating habits, and have managed to lose 97 pounds. I tell other people who struggle with a mental illness and physical health conditions that collaborative care has worked for me. When everyone is working together for the benefit of the consumer, the outcomes can only be positive. It can take a certain amount of determination to overcome stigma and other barriers, but it’s my health, and I need my care provider’s support.

The more we work out the kinks and come to expect care that looks at the whole person, the easier it will become for future generations.

The more we work out the kinks and come to expect care that looks at the whole person, the easier it will become for future generations.

In My Own Words

Cassandra McCallister offered this testimony in an interview with Laura Galbreath, Director of Policy and Advocacy, National Council for Community Behavioral Healthcare

NATIONAL COUNCIL MAGAZINE • WINTER 2009/ 3
Promoting Whole Health for the Mentally Ill

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

“Only 32% of the nation’s community mental health providers are able to afford the resources and staff they need to provide onsite treatment for medical conditions. But it’s ironic to address mental illnesses and let people die from unattended medical conditions! We must provide integrated healthcare where it is easiest for patients to access.”

The National Council has long been dedicated to developing programs and advocating for policies that improve access to effective physical healthcare for people with mental illness.

After reviewing the policy recommendations contained in the 2006 NASMHPD morbidity and mortality report, surveying our members on their current activities and barriers, and consulting with our Board of Directors’ Public Policy Committee, the National Council launched a series of policy initiatives to help close the death and disability gap for people with serious mental illness — highlights follow.

COMMUNITY MENTAL HEALTH SERVICES IMPROVEMENT ACT

People with behavioral health disorders need access to quality healthcare that is timely, affordable, appropriate, and coordinated with the behavioral health treatments and services they receive. Currently, many people served by the mental health and substance use treatment systems are not able to access care in primary care settings due to coverage issues, stigma, and the difficulties of fitting into the fast-paced-visit model of primary care.

Last week, we achieved a small but significant legislative victory when the 111th Congress authorized one of the key provisions in the Community Mental Health Services Act — a new $7 million grant program, housed at the Substance Abuse and Mental Health Services Administration, giving people with serious mental illnesses the promise of a healthcare home.

HEALTH DISPARITIES DESIGNATION

As a key first step, one of the recommendations of the morbidity and mortality report to create a federal designation for people with serious mental illness as a distinct at-risk health disparities population, followed by the development and adaptation of materials and methods for prevention and for inclusion of this population in morbidity and mortality surveillance demographics.

The National Council continues to work with federal agencies and with Congress to obtain this designation as it would help to prioritize persons with serious mental illness to receive physical healthcare from community health centers.

MEDICAID CHRONIC CARE MANAGEMENT DEMONSTRATION

Congress has a history of creating targeted Medicaid demonstration programs to establish the effectiveness of particular interventions. In this spirit, the National Council is seeking a $250 million Medicaid demonstration targeted toward agencies that serve people with serious mental illness to help those agencies better coordinate care and to provide baseline physical healthcare services on site.

Watch for further updates in the National Council’s Public Policy Update weekly e-newsletter. Subscribe at www.TheNationalCouncil.org (click on the Subscriptions link at the top of the page). Email federal policy questions and suggestions to ChuckI@thenationalcouncil.org.

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 1,600 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.

“Indeed, the causes of physical illness and death among psychiatric patients are much the same as those in other groups — cigarette smoking, obesity, diabetes — and are treatable. The problem is that people with serious mental illness tend to be low on the socioeconomic totem pole and often don’t get the best available healthcare.”

Kate Torgovnick in “Why Do the Mentally Ill Die Younger?”
TIME Magazine, Dec 3, 2008
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Bring a team—board members, medical directors, local law enforcement allies, state legislators, county commissioners, consumers, and family members.
A New “Home”
For People With Serious Mental Illnesses

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

The patient-centered medical home, along with universal coverage, is one of the frequently recommended changes in healthcare reform. The treatment of depression, anxiety, and related conditions in primary care requires behavioral health as an element of the medical home. On the other hand schizophrenia, bipolar disorder, and other serious mental illnesses present a unique set of challenges, requiring easy access to effective physical healthcare services.

The National Association of State Mental Health Program Directors found that people living with SMI die 25 years earlier than the rest of the population, in large part because of unmanaged physical health conditions. The report found that three out of every five people with SMI died from preventable health conditions. A Maine study of Medicaid members with and without SMI revealed that people living with SMI had a significantly higher prevalence of major — mostly preventable — medical conditions than did an age- and gender-matched Medicaid population.

To address the gaps in current national thinking on healthcare reform, the National Council for Community Behavioral Healthcare is releasing, in April 2009, The Person-Centered Healthcare Home, a report that brings together current developments around the patient-centered medical home with evidence-based approaches to the integration of primary care and behavioral health. The report also proposes renaming of the patient-centered medical home as the Person-Centered Healthcare Home. The name change is more than cosmetic. Person-Centered Healthcare Home emphasizes that behavioral health is a central part of healthcare, and such a shift in perspective can begin to address some significant health disparities for people with SMI.

INTEGRATION IS A 2-WAY ROAD
The National Council report also highlights the need for a bi-directional approach, addressing the integration of primary care services in behavioral health settings as well as the need for behavioral health services in primary care settings.

A full-scope Person-Centered Healthcare Home as defined in the report would accept 24/7 accountability for a population and include preventive screening/health services, acute primary care, women and children’s health, behavioral health, management of chronic health conditions and end of life care. These services are supported by enabling services, electronic health records, registries, and access to lab, x-ray, medical/surgical specialties, and hospital care.

The proposed Person-Centered Healthcare Home is based on the stepped care clinical approach, which assures that the need for a changing level of care is addressed appropriately for each person by creating a structure for feedback from specialty care to primary care.

The concept calls for healthcare to be implemented bi-directionally:
A. Identify people in primary care with behavioral health conditions and serve them there unless they need stepped specialty behavioral care; and,
B. Identify and serve people in behavioral health care that need routine primary care and step them to their full-scope healthcare home for more complex care.

LESSONS FROM IMPACT DEPRESSION TREATMENT MODEL
The Person-Centered Healthcare Home report draws recommendations from a preeminent research example, IMPACT, one of the largest treatment trials for depression, in which Dr. Jurgen Unutzer and his colleagues followed 1,801 depressed, older adults in 18 diverse primary care clinics across the United States for two years, utilizing care management within a stepped care approach. The IMPACT model...
The Person-Centered Healthcare Home is a new National Council report, releasing April 2009, that features evidence-based approaches to a patient-centered healthcare home for the population with serious mental illnesses. Prepared by National Council senior consultant Barbara Mauer, the report presents an overview — for policymakers, planners, and providers of general healthcare and behavioral health services — of the integration of behavioral health and general healthcare services in light of the national conversation regarding the development of patient-centered medical homes. Access the full report at www.thenationalcouncil.org/ResourceCenter.

The Person-Centered Healthcare Home emphasizes the need for a bi-directional approach, addressing the integration of primary care services in behavioral health settings as well as the need for behavioral health services in primary care settings.

CHEROKEE MODEL
Another excellent model is that of Cherokee Health Systems, an organization with 23 sites in 13 Tennesseee counties that is both a primary care provider and a specialty behavioral health provider. Integrated care is central to the organization’s vision and mission, and this care is practiced across an array of comprehensive primary care, behavioral health, and prevention programs and services. Cherokee is integrated structurally and financially, a structure that supports the focus on clinical integration. A behavioral health consultant is an embedded, full-time member of the primary care team. A psychiatrist is also available for medication consultation. The behavioral health consultant provides brief, targeted, real-time interventions to address the psychosocial needs and concerns in the primary care setting.

For people who need specialty behavioral health services, a primary care provider is embedded in the specialty behavioral health team. Cherokee hires primary care providers who are comfortable with mental health issues and believes that all frontline, administrative, and support staff must be essential players, committed to the holistic approach. The local community is aware that people are treated for all types of illnesses at Cherokee, and mental health consumers find that all are treated in the same way, which reduces the stigma of seeking mental health treatment.

BEHAVIORAL HEALTH RESPONSIBILITIES
Not all behavioral health providers can envision a future role in a Person-Centered Healthcare Home. However, all behavioral health providers have a clinical responsibility and accountability for individuals receiving behavioral health services. If these services include prescribing psychotropic medications, there is an additional set of accountabilities related to the risk of metabolic syndrome and the whole health of the person:

>> Assure regular metabolic screening and tracking at the time of psychiatric visits for all behavioral health consumers receiving psychotropic medications.

>> Identify the current primary care provider for each individual, and when none exists, assist the individual in establishing a relationship with a primary care provider and accessing care.

>> Establish specific methods for communication and treatment coordination with primary care providers and assure that timely information is shared in both directions.

>> Provide education and link individuals to self-management assistance and support groups.
CHALLENGES IN INTEGRATION

Organizations that have attempted to integrate care between primary care and behavioral health practitioners have learned about the different cultures, languages, and processes that primary care and behavioral health clinicians bring to collaborative efforts. The success of person-centered healthcare homes depends on the field’s ability to bridge this set of differences at the clinical level.

At the system level, these differences result in barriers when primary care is integrated into behavioral health and when behavioral health is integrated into primary care. Typical barriers include financing; policy and regulation; workforce; information sharing; and the need for more research relating to the costs, cost offsets, and health outcomes.

The promise of the patient-centered medical home can only be fully realized if it is transformed into the person-centered healthcare home, with behavioral health capacity fully embedded in primary care teams and primary care capacity inlaid in behavioral health teams. Moving the concept forward will require thoughtful, deliberate, and adaptive leadership at every level and across clinical disciplines and sectors that currently segment how people are served, how the delivery of their care is organized, how communication among providers occurs, and how care is reimbursed. For people with SMI who are suffering from unmanaged physical health conditions and dying before their time, the time for this concept to move ahead is now.

The Person-Centered Healthcare Home report also revises the well-known National Council Four Quadrant Model, which describes the subsets of the population that behavioral health and primary care integration must address. The revised model is on page 10 of this issue.

Barbara Mauer is a nationally known expert in behavioral health and primary care integration. She has more than 20 years of experience in consulting to both healthcare and behavioral health organizations and is a managing consultant for MCPP Healthcare Consulting in Seattle, Washington and a National Council senior consultant. 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.

THE MEDICAL HOME CONCEPT

In 2007, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association released the Joint Principles of the Patient-Centered Medical Home (see www.pcpcc.net/node/14). The Joint Principles stated the following:

- Each patient has an ongoing relationship with a personal physician.
- The personal physician leads a practice level team that collectively takes responsibility for the ongoing care of patients.
- The personal physician is responsible for providing for all of the patient’s healthcare needs or appropriately arranging care with other qualified professionals.
- Care is coordinated or integrated across all elements of the healthcare system.
- Quality and safety are hallmarks.
- Enhanced access to care is available.
- Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home.

The clinical approach of the patient-centered medical home focuses on team-based care led by a personal physician who provides continuous and coordinated care management and supports patients in their self-management goals throughout their lifetime. In this model, care management is central to the shift away from a concentration on episodic acute care to a focus on managing the health of defined populations, especially those living with chronic health conditions.

Although the medical home model emphasizes self-care, it has not clearly defined the role of behavioral health, which the Institute of Medicine has identified as a central part of healthcare.

VOICES

“Clearly, overall well-being is a function of both mental and physical health. Just as screening and evaluation for mental illnesses and addictions is increasingly available in primary care settings, screening and evaluation for general health problems should be available to those in mental health settings.”

Linda Rosenberg, President and CEO, National Council for Community Behavioral Healthcare
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We look forward to working with you!
National Council’s Revised Four Quadrant Model

A revised Four Quadrant Model is featured in a new National Council report, The Person-Centered Healthcare Home (see page 6). The revised model is presented and discussed here.

The National Council’s widely used Four Quadrant Model represents a planning framework for the clinical integration of health and behavioral health services and focuses on the populations to be served.

Each quadrant considers the behavioral health and physical health risk and complexity of the population and suggests the major system elements that would be utilized to meet the needs of a subset of the population.

The Four Quadrant model is not intended to be prescriptive about how care is organized in a quadrant or for an individual. It is a conceptual framework and collaborative planning tool for addressing the needs of population subsets (not individuals) in each local system.

While system planning requires a population-based method; service planning should be person-centered. Therefore, the Four Quadrant Model does not specify in which quadrant individuals should receive care and it should be possible to move from one population subset to another over time.

Using the evidence regarding effective clinical practices, each community must develop its uniquely detailed operational arrangements, depending on the factors in their environment, including:

- Array of and capacity of services in the community — what services are available and is there access to sufficient amounts of the services that are needed?
- Consumer preferences — are individuals more likely to accept care in primary care or specialty settings?
- Trained workforce — do current behavioral health and primary care staff have the right skills to deliver planned services onsite?
- Organizational support in providing services — do managers provide encouragement and support for collaborative activities and what is the impact on operations, documentation, billing, and risk management?

- Reimbursement factors — do payers support collaborative care and make it easy or difficult for the behavioral health and primary care sectors to work together?

Most provider organizations will find that they are involved in at least two quadrants (e.g., most primary care clinics have populations in Q I and Q III, most behavioral health organizations have populations in Q II and Q IV, unified program models serve populations in all four quadrants). The principle of stepped care says that each provider needs to be able to address needs for populations in both quadrants (e.g., adding the nurse care manager for those with complex co-morbidity).

**Quadrant I**

**The Population**: Low to moderate behavioral health risk/complexity.

**Quadrant II**

**The Population**: Low to high behavioral health risk/complexity.

**Quadrant III**

**The Population**: Low to moderate behavioral health risk/complexity.

**Quadrant IV**

**The Population**: Low to high behavioral health risk/complexity.

**The Four Quadrant Clinical Integration Model**

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Persons with serious mental illnesses could be served in all settings. Plan for and deliver services based upon the needs of the individual, personal choice and the specifics of the community and collaboration.

- Behavioral health clinician/case manager w/ responsibility for coordination w/ PCP
- PCP (with standard screening tools and guidelines)
- Outstationed medical nurse practitioner/physician at behavioral health site
- Specialty behavioral health
- Residential behavioral health
- Crisis/ED
- Behavioral health inpatient
- Other community supports

- PCP (with standard screening tools and guidelines)
- Outstationed medical nurse practitioner/physician at behavioral health site
- Nurse case manager at behavioral health site
- Behavioral health clinician/case manager
- External care manager
- Specialty medical/surgical
- Specialty behavioral health
- Residential behavioral health
- Crisis/ED
- Behavioral health and medical/surgical inpatient
- Other community supports

- PCP (with standard screening tools and behavioral health practice guidelines)
- PCP-based behavioral health consultant/care manager
- Psychiatric consultation

- PCP (with standard screening tools and behavioral health practice guidelines)
- PCP-based behavioral health consultant/care manager (or in specific specialties)
- Specialty medical/surgical
- Psychiatric consultation
- ED
- Medical/surgical inpatient
- Nursing home/home based care
- Other community supports

Bold text represents revisions to incorporate concept of person-centered healthcare home.
and low to moderate physical health complexity/risk.  

The Model: Person Centered Healthcare Home: a primary care team that includes a behavioral health consultant/care manager, psychiatric consultant, screening for behavioral health concerns, and stepped care.

The Providers: The primary care provider assures the full-scope healthcare home and uses standard behavioral health screening tools and practice guidelines to serve individuals in the primary care practice. Use of standardized behavioral health tools by the primary care provider and a tracking/registry system focuses referrals of a subset of the population to the primary care based behavioral health consultant/care manager. The primary care provider prescribes psychotropic medications using treatment algorithms. Psychiatric consultation is structured to support both the primary care provider and the behavioral health consultant/care manager, with a focus on treatment planning for individuals who are not showing improvement.

QUADRANT II

The Population: Moderate to high behavioral health and low to moderate physical health complexity/risk.

The Model: Person Centered Healthcare Home: primary care capacity in a behavioral health setting, including medical nurse practitioner/primary care physician, wellness programming, screening for health status concerns, and stepped care to a full-scope healthcare home. Access to the array of specialty behavioral health services designed to support recovery.

The Providers: The primary care physician assures the full-scope healthcare home either through practicing on site or supervision of the nurse practitioner, consultation with behavioral health provider and stepped care. Psychiatric consultation with the primary care provider may be an element in these complex behavioral health situations, but it is more likely that psychotropic medication management will be handled by the specialty behavioral health prescriber, in collaboration with the primary care physician. Standard health screening (e.g., glucose, lipids, blood pressure, weight/BMI) and preventive services will be provided.

Wellness programs (e.g., nutrition, smoking cessation, physical activities) are available as primary as well as secondary preventive interventions, incorporating recovery principles and peer leadership and support.

Each quadrant considers the behavioral health and physical health risk and complexity of the population and suggests the major system elements that would be utilized to meet the needs of a subset of the population.

QUADRANT III

The Population: Low to moderate behavioral health and moderate to high physical health complexity/risk.

The Model: Person Centered Healthcare Home: a primary care team that includes a behavioral health consultant/care manager, psychiatric consultant, screening for behavioral health concerns, stepped care, and access to specialty medical/surgical consultation and care management.

The Providers: In addition to the services described in Quadrant I, the primary care provider collaborates with medical/surgical specialty providers and external care managers to manage the physical health concerns of the individual. Specialty healthcare and care management programs could also integrate behavioral health screening and the behavioral health consultant/care manager into a wide array of self management and rehabilitation programs, building on research findings regarding the frequency and impact of depression in cardiovascular or diabetes populations.

QUADRANT IV

The Population: Moderate to high behavioral health and moderate to high physical health complexity/risk.

The Model: Person Centered Healthcare Home: primary care capacity in a behavioral health setting, including medical nurse practitioner/primary care physician, nurse care manager, wellness programming, screening/tracking for health status concerns, and stepped care to a full-scope healthcare home. Access to the array of specialty behavioral health services designed to support recovery and access to specialty medical/surgical consultation and care management.

The Providers: In addition to the services described in Quadrant II, the primary care physician collaborates with medical/surgical specialty providers and external care managers to manage the physical health concerns of the individual. In some settings, behavioral health consultant/care manager services may also be integrated with specialty provider teams (for example, Kaiser has behavioral health consultants in OB/GYN programs, working with substance abusing pregnant women). Nurse care management is added, along with focused goal setting and self-management planning, to the standard health screening/registry tracking (e.g., glucose, lipids, blood pressure, weight/BMI). Wellness programs (e.g., diabetes groups) are available as secondary and tertiary preventive interventions, incorporating recovery principles and peer leadership and support.

Learn more about the Four Quadrant Model at www.TheNationalCouncil.org/ResourceCenter
Financing is probably the most common perceived barrier in implementing integrated or collaborative healthcare. However, integrated healthcare is fundable in nearly every state right now! Even with the state by state difference in Medicaid programs, the complexity of Medicare billing, and uniqueness of healthcare coverage for those we serve, there are short term solutions that allow programming to proceed and services to be provided in integrated programs. In Medicaid fee-for-service and capitated states there are nearly a dozen ways to fund collaborative care and integrated healthcare initiatives.

Three fundamentals to successfully implementing financing strategies are:

- Think of the healthcare money in a community as a collaborative local resource.
- Generate the will to make it work within existing funding mechanisms.
- Be willing to advocate strongly with your state officials for the implementation of currently approved CPT codes for services provided in integrated settings.

Three fundamentals to successfully implementing financing strategies are:

- Think of the healthcare money in a community as a collaborative local resource.
- Generate the will to make it work within existing funding mechanisms.
- Be willing to advocate strongly with your state officials for the implementation of currently approved CPT codes for services provided in integrated settings.

**THE COMMUNITY’S MONEY**

A consistent barrier in financing integrated healthcare services is that organizations think of the funding in a siloed way. It’s not uncommon to hear “this is my money” or “our money.” With this old approach to financing, the outcomes often need to benefit the organization and sometimes even the individuals within an organization. Success with financing integrated care requires a paradigm shift that involves putting the consumers’ and community’s best interest first. Agencies and organizations are stewards of the public money. It is a behavioral healthcare organization’s responsibility to make behavioral health resources available to the community as part of a package of services. This approach to financing integrated care results in creative, effective service packages that meet everyone’s needs.

**GENERATING THE WILL**

In these difficult financial times it seems natural to hunker down and wait for things to improve. Now, more than ever is the time to be creative and to stretch healthcare resources to the maximum and assist consumers in their path to recovery. It may seem counter-intuitive but now may be when change is most possible and most effective. Now is the time to get the most creative financial minds together with the most conservative financial minds and hammer out exactly what is possible with the funding that is received. Partnering and collaboration are often keys to making money go further. This is particularly true in integrated care where shared resources improve consumer outcomes while enhancing the bottom line of all the partners.

**ADVOCATING FOR STATE LEVEL MEDICAID CHANGES**

Medicaid regulations are made state by state in this country. This is both a blessing and a curse. A blessing in that there is often more ability to influence state policy rather than federal policy and a curse because the same work has to be done 50 times! A number of states already allow for billing two services on one day. It is possible to get a copy of that policy work in one state and work with another state to implement it.

**TIPS FOR FINANCING SERVICES RIGHT NOW**

Two series of codes are already approved for commercial, Medicare and Medicaid billing: SBIRT (Screening, Brief Intervention, Referral and Treatment) and
Improving the health status of those we serve requires all of us to come to the table and work within existing financing structures to find solutions rather than use financing as a way to delay discussions.

the Health and Behavior Assessment/Intervention (96150-96155). The Health and Behavior Assessment/Intervention codes can be used to bill a behavioral health service ancillary to a primary care diagnosis. This would include providing services regarding chronic care management such as diabetes care, cardiac support, and consulting and assistance with COPD management. SBIRT can be billed in the primary care setting for screening for substance use/abuse.

In Wisconsin, case/care management services are billable for primary settings working with individuals with a serious mental illness. In Michigan the Primary Care Association has negotiated a memorandum of understanding that allows for FQHCs to bill two services in one day (www.mpca.net). In states where two services rendered on one day by one provider are not billable, programs have found innovative ways to collaborate that allow both partners to bill, using two provider numbers to provide the services. They key here is creative, collaborative thinking that maximizes the current financing options. Improving the health status of those we serve requires all of us to come to the table and work within existing financing structures to find solutions rather than use financing as way to delay discussions.

In states where capitation is used, it often provides the flexibility for local decision-making regarding services and funding. Don’t be afraid to expand thinking about creative ways to secure better outcomes by integrating staff into primary care setting to provide mental health services. Often, it requires no new approvals for mental health centers to provide community based services. In fee for service states, review the regulations and find any way you can to bill for services at a primary care site. You’ll generate better health outcomes and support your organization’s bottom line.

Kathleen Reynolds, MSW, ACSW is a nationally recognized expert in primary care and behavioral health collaboration. Ms. Reynolds is the former Executive Director of the Washtenaw Community Health Organization and an Adjunct Clinical Instructor in the University of Michigan Department of Psychiatry. The WCHO is an integrated health system that includes a community mental health services program, a substance abuse coordinating agency, and primary healthcare capitation dollars for Medicaid and indigent consumers. For the past seven years Reynolds’ primary emphasis has been developing integrated health care models for Medicaid and indigent consumers. Reynolds has presented at numerous conferences and conventions on the innovative programming in Washtenaw County and is the author/co-author of several articles and has co-authored Raising the Bar: Moving Toward the Integration of Health Care, A Manual for Providers, a National Council publication.

One Individual at a Time

NHS Human Services is a community-based, non-profit provider with 40 years of experience serving children and adults with special needs.

The NHS Human Services family of companies offers a full range of integrated services in the areas of behavioral health, intellectual and developmental disabilities, addictive diseases, autism, foster care, juvenile justice, and elder care.

NHS proudly serves over 50,000 individuals annually throughout Pennsylvania, New Jersey, New York, Delaware, Maryland, Virginia, and Louisiana.

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As more communities realize the value of primary and behavioral health collaboration, they now have more working examples to learn from. The National Council’s Primary Care-Behavioral Health Collaborative project has provided a wealth of valuable outcomes that will help further this growing movement.

A 2007 National Council survey of community behavioral organizations revealed that although 91% of respondents place high or medium priority on increasing the quality of general medical healthcare for their clients, only one in two providers has the capacity to provide any treatment for those conditions, and one in three has the capacity to provide the services onsite. The most common barriers to providing general medical services were problems in reimbursement (72.1%), workforce limitations (68.4%), physical plant constraints (60.8%), and lack of community referral options (55.8%).

The National Council’s Primary Care-Behavioral Health Collaborative Project—funded in part through the generosity of AstraZeneca and Bristol-Myers Squibb—is intended to help member organizations and their partnering primary care sites overcome some of these barriers and collaborate effectively to provide integrated healthcare. The learning collaborative model that the National Council has adopted for this project is based on 20 years of pioneering work by the Institute for Healthcare Improvement and the application of that work in the Health Disparities Collaboratives sponsored by the Health Resources and Services.

LEARNING COLLABORATIVE GOALS

- Increase ability of primary care clinics to screen for bipolar, addictions, and suicide risk as a part of depression screening.
- Increase capacity of primary care clinics to provide proactive follow-up and management of patients identified with depression.
- Increase community mental health organizations’ provision of psychiatry training and clinical support for primary care, to enable a more comprehensive stepped care model.
- Establish processes for ongoing communication regarding collaborative care between primary care and community mental health organizations, including:
  > Protocols for referral of individuals with bipolar disorder and suicide risk from primary care clinics to community mental health organizations, to assure seamless transition from primary care to specialty mental healthcare.
  > Return of stable patients to primary care follow up as appropriate.
  > Establish shared methods for medical management of patients treated in community mental health settings who are at risk for metabolic syndrome.
- Increase capacity of both primary care and community mental health organizations to document and track care processes and performance.

The Primary Care-Behavioral Health Collaborative project started with four Phase 1 sites in January 2007. Each site is a partnership between a mental health agency and a community health center. The first sites were located in Massachusetts, Iowa, Montana, and Washington.

Phase 2, the focus in this article, expanded into an additional eight sites in fall 2007:

- Colorado: Colorado West Regional Mental Health and Summit Community Care Clinic
- Colorado: North Range Behavioral Health and Sunrise Community Health
- Florida: Life Stream Behavioral Center and Thomas E. Langley Medical Center
- Illinois: Heritage Behavioral Health Center and Community Health Improvement Center
- Indiana: Porter-Starke Services and HealthLinc
- South Dakota: This site dropped out a few months into the project due to a loss of provider capacity in the primary care clinic
- Texas: Austin Travis Mental Health/Mental Retardation and Community Care Services Department
- Washington: Navos and Neighborcare High Point

GETTING STARTED

When the Phase 2 sites were convened for their initial learning session in September 2007, they were provided training in rapid cycle improvement, evidence-based practices related to delivering behavioral health services in primary care, and
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AstraZeneca AZ&Me™ Prescription Savings programs

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<td>SEROQUEL XR® (quetiapine fumarate) Extended-Release Tablets</td>
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approaches to primary care services for the population of people with serious mental illnesses in behavioral health. The goals for the sites are summarized by the graphic at right — to improve the health of their shared population through changes in services and collaboration between the two organizations.

**TESTING IMPROVEMENTS**

Although each site developed unique project plans, collectively they worked on plan–do–study–act improvement cycles in the following areas:

- Establish systematic screening and tracking processes.
- Establish a care manager/behavioral health consultant role.
- Develop systematic referral protocols from primary care to mental health.
- Develop systematic referral protocols from mental health to primary care.
- Improve communication mechanisms between primary care and mental health.
- Establish measurement protocols regarding weight, lipids, and blood sugars for patients on antipsychotic medications.
- Train primary care providers in mood disorder and bipolar screening and treatment.
- Establish primary care services in behavioral health settings.

At the Phase 2 Learning Congress in December 2008, each site presented the lessons it had learned during the course of the project. Each site team also developed plans for joint next steps. As teams reflected on the improvement cycles, the following themes emerged at the end of the project:

- **Workflows** — Studying each of the steps from check-in and registration to the end of the primary care visit and establishing consistent processes of initial screening, rescreening, and decision making about care are core system improvement tasks that generally require skill development on the part of the organization and partnership.
- **Clear responsibilities** — Spreading the responsibility for screening and registry tracking to all practitioners can result in less consistent screening and follow-up than making the tasks the responsibility of an assigned person on the team. This model requires strong organizational support to pursue effectively.
- **Data constitutes clinical information** — Collecting data related to clinical progress in mental health typically requires a change of culture, one in which data are used to inform clinical practice, not just to document clinical encounters. Instigating this cultural change needs to be a focus of practice and reinforced at the organizational level.
- **Registry tracking** — Chart audits are time intensive and don’t support real-time care management in the same way that registry tracking (chronic disease management) systems do. Unfortunately, most electronic health records do not yet have robust registry functions (see California HealthCare Foundation, 2008). Use of a distinct registry, with assigned responsibility, leads to closer monitoring of treatment success.
- **Scale matters** — Implementing change in one practice versus across a clinic results in significant differences in volumes of patients and tracking to be managed. Rapid-cycle improvement methodologies are best suited for starting small and scaling up change within an organization. Scale should be a key factor considered in the development of Quality Improvement strategies.

The National Council’s current Phase 3 Collaborative Care project, initiated in August 2008, includes four sites located in Maryland, Indiana, Colorado, and Florida.

Learn more about the Primary Care — Behavioral Health Collaborative Project at www.TheNationalCouncil.org/ResourceCenter.

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**References**


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**VOICES**

At a NAMI New York focus group to address the health concerns of persons with mental illness, patients revealed the simple desire to feel deserving of good health. "The most shocking thing was that people really wanted to be healthy but there was a disconnect," says program associate Katie Linn, who ran the focus groups. "A lot of it came down to self-worth — they didn’t feel like they were worthy of taking care of themselves.”
Primary Care Screenings Connect Patients to Specialized Care

Alexa Eggleston, JD, Director of Public Policy, National Council for Community Behavioral Healthcare

The National Council’s Primary Care-Behavioral Health Collaborative project has resulted in promising collaborations and positive developments in the integration of primary care and behavioral healthcare for its participants. The project has also shed new light on the role that screening and brief intervention for substance use disorders play in successful integration efforts. Although screening for alcohol and drug use is not a new concept, the financial support of the federal government and infusion of dollars through reimbursement codes is. The Substance Abuse and Mental Health Services Administration and the Office of National Drug Control Policy Resources are prioritizing the support of Screening, Brief Intervention, and Referral to Treatment programs. And National Council member agencies have been at the forefront of the effort to use these dollars to implement screening programs in primary healthcare settings to help people with substance use disorders connect to the appropriate level of addiction care.

Launched in 2005, SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for people with substance use disorders and those who are at risk for developing those disorders. SBIRT research has shown that many people at risk for developing serious alcohol or other drug problems may be identified through primary care screening. Interventions such as SBIRT have been found to decrease the frequency and severity of drug and alcohol use, reduce the risk of trauma, and increase the percentage of patients who enter specialized substance abuse treatment. Screening and brief interventions have also been associated with fewer hospital days and fewer emergency department visits. A recent study found increased remission from substance use disorders through integrated care, regardless of whether the patient had medical conditions related to substance abuse, and increased remission among patients with related conditions with greater primary care engagement (Mertens, Fisher, Satre, & Weisner, 2008). These findings support efforts to integrate substance abuse treatment with primary care and to manage substance use disorders as chronic diseases.

Reimbursement for screening and brief intervention is available through commercial insurance Current Procedural Terminology codes, Medicare G codes, and Medicaid Healthcare Common Procedure Coding System codes. However, relatively few states — Alaska, Iowa, Indiana, Maine, Maryland, Minnesota, Montana, Oklahoma, Oregon, Virginia, and Wisconsin (as well as Washington under limited circumstances) — have activated the Medicaid codes. Federally funded SBIRT grant programs have been established in 17 states, including Colorado, and have played a key role in the inclusion of screening and linkage to treatment for substance use disorders in integration efforts.

National Council’s Primary Care-Behavioral Health Collaborative project participant North Range Behavioral Health, in Greeley, Colorado, has used the SBIRT-funded staff to work closely with the local Federally Qualified Health Center as well as its behavioral healthcare staff on several integrated care efforts. Behavioral health consultants work directly with the physicians in the exam rooms, and a substance use disorder specialist works closely with the SBIRT program and with pregnant women in the OB/GYN clinic.

Another Collaborative project participant, the Summit Community Care Clinic, in Frisco, Colorado, is a research site for SBIRT. The Summit Clinic coordinates substance use disorder treatment with Colorado West Mental Health, which has successfully used Access to Recovery funds to engage clients in brief motivational interviewing and more intensive services when necessary. Both sites emphasize the importance of building capacity for specialty addiction care to be able to transition people into higher levels of care if and when they are identified as being in need.

For more information on the SBIRT program, visit http://sbirt.samhsa.gov/ and www.whitehousedrugpolicy.gov/treat/screen_brief_intv.html.

Alexa Eggleston is Director of Public Policy at the National Council. She works with National Council’s members to shape an assertive legislative agenda and with other national organizations and federal agencies to ensure that all people have the opportunity to achieve and sustain recovery from mental illness and addictions disorders. Eggleston is an attorney and has served as Director of National Policy for the Legal Action Center. She has advocated for increased federal funding for substance use disorders; educated Congress about the employment, education and other barriers facing people with criminal records; lobbied to pass Second Chance Act Reentry legislation to ease such barriers; and advocated for rehabilitative services, including mental health and addiction treatment in the Temporary Assistance for Needy Families Welfare program.

REFERENCES
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Peer Support

Peer Support Whole Health is a peer-driven plan for transformation of the mental health system. In this approach, a peer specialist helps a peer choose and record a health goal in an individual service plan funded by Medicaid-billable peer support and then provides peer support to help the person reach that goal.

Peer Support Whole Health was created when Georgia received a $221,000 Transformation Transfer Initiative grant from the National Association of State Mental Health Program Directors in 2009 to transform its trained peer workforce to promote holistic recovery to offset the premature death of public sector mental health consumers.

The five objectives of the new Transformation Transfer Initiative grant, to be completed by October 2009, are to:

- Demonstrate that Medicaid will pay for the utilization of peer support services to achieve whole-health goals.
- Demonstrate with data collection at two peer centers the impact of peer support services on the achievement of whole-health goals.
- Introduce Georgia providers and management to the concept of Peer Support Whole Health and how to bill Medicaid for the services.
- Train more than 10 percent of Georgia’s peer specialist workforce in Peer Support Whole Health.
- Train mental health consumers statewide on Peer Support Whole Health.

“In Georgia, we’re beginning with peer support to emphasize wellness and then hope to learn where we go next in transforming mental healthcare systems,” says Wendy White Tiegreen, who oversees the provider network for Georgia’s Division of Mental Health, Developmental Disabilities and Addictive Diseases.

“It was an awakening moment for our leadership,” says Sherry Jenkins Tucker, GMHCN’s executive director. “We began to shift our focus to wellness, securing a federal grant to promote WRAP (Wellness Recovery Action Plans) and using our annual conferences to promote whole health.”

That focus on holistic recovery has grown: GMHCN has been funded by the state to open the first peer support and wellness center in an Atlanta suburb. So far, the center has cut hospitalizations by a third using peer support and a focus on staying well. The program has been so successful that Georgia plans to expand the peer-operated wellness centers statewide.

SUCCESS IN MICHIGAN AND NEW JERSEY

It appears that training peers to promote holistic recovery is gaining momentum nationwide. Georgia is joined by Michigan and New Jersey in landing TTI grants to use the peer workforce to focus on health.

Among preventable medical conditions, cardiovascular disease is the primary cause of death for mental health consumers. In Michigan, the Georgia-based Appalachian Consulting Group, designed and piloted Peer Support Whole Health training focused on reducing risk factors for cardiovascular disease and metabolic factors.

“Michigan has a big investment in a peer specialist network of more than 500 peers,” says Pam Werner, who directs the peer support program for the Michigan Department of Community Health. “When peers learned of NASMHPD’s morbidity and mortality report [persons with mental illness dying 25 years younger], they were outraged and demanded that we as policymakers do something about it. We’ve listened to their demands and have begun our whole-health initiative with peers in the forefront.”

According to Jean Dukarski, program director for Justice in Mental Health Organization, a consumer-run center in Lansing that participated in the Michigan pilot project, “The focus on Peer Support Whole Health changed the center; individuals started ad-

Consumers Take Charge of Wellness

Larry Fricks, Director, Appalachian Consulting Group, and Vice President of Peer Services, Depression and Bipolar Support Alliance

Peers connect with peers, creating a network that understands their health issues and supports their actions for self-directed whole health.

Ike Powell, Director of Training, Appalachian Consulting Group

The concept of Peer Support Whole Health and how to bill Medicaid for the services.

The focus on Peer Support Whole Health changed the center; individuals started ad-
dressing their overall health. One quit smoking, another stopped drinking pop and lost 20 pounds, and a walking group started."

“The Peer Support Whole Health training is designed to increase the participant’s belief in [his or her] own ability to improve [his or her] overall health,” says Ike Powell, director of training for ACG, which has teamed up with the Depression and Bipolar Support Alliance to train peer specialists in 20 states. “Peers connect with peers, creating a network that understands their health issues and supports their actions for self-directed whole health.”

In New Jersey, the new TTI grant is funding the education of peer specialists as wellness coaches, according to Peggy Swarbrick at the Institute for Wellness and Recovery Initiatives. The wellness coaches help peers to link to primary healthcare and promote health and wellness needs from a self-management perspective.

**RESEARCH AND DEVELOPMENT**

A significant part of the ACG training includes modules developed in partnership with the Benson-Henry Institute for Mind Body Medicine at Massachusetts General Hospital. BHI was founded by Harvard cardiologist Herbert Benson, famous for the relaxation response shown to reduce stress and the release of cortisol, a stress hormone that can increase dangerous belly fat. A BHI study completed by the state of Georgia at two peer centers showed that practicing the relaxation response reduced stress and anxiety.

Another reason Peer Support Whole Health is gaining traction in Georgia is a research project being developed by Benjamin Druss, the Rosalynn Carter Chair of Mental Health at the Rollins School of Public Health at Emory University. Druss’ project – funded by the National Institute of Mental Health – is adapting to public mental health, an evidence-based program that uses peers to help peers change their whole-health behavior. The program chosen for adaptation is the Chronic Disease Self-Management Program, developed by Kate Lorig at Stanford University.

According to Druss, CDSMP is “a peer-led, evidence-based disease self-management program demonstrated to result in sustainable change in healthy behaviors and health in persons with a range of chronic conditions. The intervention is also consistent with current efforts to incorporate self-management and peer-support strategies in efforts to foster recovery in persons with serious mental illness.”

Peer Support Whole Health demonstrates that like self-directed recovery, the peer support movement, illness self-management, and disease management all have a common thread — a person taking control of his or her wellness.

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Larry Fricks is director of the Appalachian Consulting Group and vice president of peer services for the Depression and Bipolar Support Alliance. For 13 years, Fricks was Georgia’s director of the Office of Consumer Relations and Recovery in the Division of Mental Health, Developmental Disabilities and Addictive Diseases. He is a founder of the Georgia Mental Health Consumer Network. He served on the planning board for the Surgeon General’s Report on Mental Health and serves on the Board of Directors of Mental Health America and on the Advisory Board for the Carter Center Mental Health Journalism Fellowships. The story of Fricks’ recovery and his life’s work to support the recovery of others was published in the New York Times best-selling book *Strong at the Broken Places*, by Richard M. Cohen.
Life as an FQHC for a Behavioral Health Provider

Karl Wilson, PhD, President and CEO, Crider Center, in an interview with Laura Galbreath, Director of Policy and Advocacy, National Council for Community Behavioral Healthcare

In 2008, the Crider Center, a community behavioral health provider in Missouri, started the quest to be designated as a Federally Qualified Health Center. The National Council interviewed Karl Wilson, President/CEO of the Crider Health Center, to get a progress report on their efforts to integrate primary and behavioral healthcare.

Interviewer: Can you give us a sense of what is different now that you’re also a community health center?

Karl Wilson: There are some basic ways that life has changed for us. For example, there has been a lot to learn in terms of language, new skills and concepts. In behavioral health we bill on time increments such as quarter-hour units and the number of people we serve a year. Primary care traditionally thinks in terms of encounters. When you change the way services are counted, the incentives also change and it can throw things off when you have to use two systems of accounting. While we are adjusting to how we track the services we provide, we continue to work with the Missouri Department of Mental Health and other state agencies to ensure that we are correctly reporting according to their different requirements.

Interviewer: Are you coming across policy barriers that hinder your efforts?

Karl Wilson: In Missouri, we have difficulty with billing primary care and behavioral health encounters on the same day. It makes sense for us to try and address as much as possible while the client is with us since transportation and other family life issues can be problematic. Our current billing mechanisms discourage integrated care and therefore clients are required to return on a different day to receive needed services. Tennessee is one of only a handful of states that have been able to change their Medicaid billing codes to accommodate a Behavioral Health Consultant model of integration. The Crider Health Center is part of a broad-based coalition of primary care and behavioral health stakeholders currently working to change the regulations and eliminate one of the biggest barriers to integration.

In addition to billing, we are experiencing some workforce related issues. There are services that social workers can deliver under the FQHC that licensed professional counselors cannot. We have a real interest in working with the state to change the regulations. If and when we bring additional behavioral health services under our FQHC scope of work, which we would do in order to bill Medicaid under the FQHC, we would have all of our staff, LPCs in addition to social workers, be eligible providers for billing. We are confronted by Medicaid officials that this will open a window in which all LPCs in private practice will have the opportunity to bill under Medicaid.

Interviewer: You’ve mentioned working with the primary care association — is this a new relationship?

Karl Wilson: I now have a much more complicated life, as does my key staff. We sit on the boards and committees of both the Missouri Coalition of Community Mental Health Centers and the Missouri Primary Care Association. As a result of this expanded outreach, I’ve come to learn that primary care and behavioral health providers have a lot in common. We serve the same population of underserved individuals who have multiple chronic conditions and complex needs.

Interviewer: How are you finding the process of becoming an FQHC different from other integration efforts underway in Missouri?

Karl Wilson: We looked around the country and modeled our integration work on Cherokee Health Systems in Tennessee. The Cherokee model features a Behavioral Health Consultant embedded in the primary care team and includes psychiatric consultation. In 2008, the Missouri legislature allocated funding to develop integrative general health and mental health services in seven paired sites. There are many similarities as well as unique organizational and clinical challenges depending on the integration model. Six of the paired sites involve FQHCs and CMHCs in the same geographic area that are trading staff. Crider Health Center is the seventh site and the only one where full integration is underway. We plan on ultimately having every program of the agency operating under an integrated model. In other words, the term integration is being used very broadly and represents a whole continuum of approaches from collaboration to full integration, as would be seen at Cherokee Health Systems and to which Crider Health Center aspires.

… primary care and behavioral health providers have a lot in common. We serve the same population of underserved individuals who have multiple chronic conditions and complex needs.”
outcomes for our target population while also meeting the behavioral health needs of people served in primary care who need to make behavior and lifestyle changes. This is truly a win/win situation that will help us overcome both physical and mental barriers to overall health and wellness.

Interviewer: How have your behavioral health clients responded to Crider Health Center's expansion activities?

Karl Wilson: The response from our behavioral health clients who are accessing the primary care services has been very positive. They value the access to routine check-ups and medical care that was previously not very accessible. We are also working to identify how to build wellness activities into our Clubhouse Program and we hope to open a fitness center in the near future. We're just beginning our efforts in this area and we hope to incorporate evidence-based wellness practices being utilized across the country.

I remember talking to a consumer leader who was concerned that the movement to integrated primary and behavioral healthcare would diminish some of the recovery efforts the mental health community has achieved. It is a valid concern. Some integration efforts may end up inhibiting efforts to help individuals suffering with mental illness lead productive, happy lives by reducing rehabilitative supports that complement medical care. It's taken a long time to build momentum for the recovery movement and to establish peer-oriented services in the mental health community. That shouldn't be traded off by trying to incorporate some of the good things that can happen through integration. We will all need to be diligent to ensure that we maintain a strong consumer and recovery orientation at the core of the organization.

Interviewer: What are your overall impressions of your efforts to become an FQHC?

Karl Wilson: It's not easy, but it's worth it. It takes a lot of capital, time, and effort. We've been fortunate in our timing and were able to secure several grants before the economy slowed. Our staff is invested and is doing a great job of examining situations and making needed translations and changes. We've also learned how important it is to work with our state associations and community coalitions to build relationships that will support local efforts. As more organizations like Crider Health Center experiment with the different models of integration and collaboration, it will get easier for future behavioral health providers seeking to become an FQHC.

Karl Wilson is the first President and CEO of the Crider Health Center, which he has led for 30 years. This safety net community health and mental health center serves the Missouri counties of Lincoln, Warren, Franklin and St. Charles. Wilson has taught at Washington University in St. Louis for 33 years, first in psychology and then in social work, where he teaches mental health policy. He has served as chair of the boards of directors of the Missouri Coalition of Community Mental Health Centers, Mental Health America of Eastern Missouri, Missouri Foundation for Health, Non-Profit Services Center, and Behavioral Health Response. He currently serves on the boards of ten non-profit local, regional, and national organizations including Mental Health America.

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Making Whole Health Work

Community behavioral health organizations and community health centers across the United States share their experiences in behavioral health and primary care integration, collaboration, and colocation, revealing what works and what doesn’t. They are all clearly driven by one common goal — providing holistic healthcare for mind and body to all those they serve.

BHS Uncovers Unmet Medical Needs among Substance Abuse Clients

Jim Gilmore, MBA, CDAC, Director of Development, Behavioral Health Services and Rhondee Benjamin-Johnson, MD, MSC, Robert Wood Johnson Clinical Scholar, University of California, Los Angeles, Los Angeles, CA / RBJohnson@mednet.ucla.edu

Staff at Behavioral Health Services in Los Angeles County have long been concerned that our nearly 6,000 adult clients in substance abuse treatment have unmet medical needs and limited access to medical care — we partnered with the Robert Wood Johnson Clinical Scholars program at the University of California, Los Angeles, to address this issue.

In June 2008, we interviewed 254 clients at seven BHS outpatient and residential treatment sites about their access to general medical services and medical need. 66% of clients interviewed were in residential treatment, 33% were women, and 37% were Latino. 44% had less than a high school education, and half had been released from jail or prison within 6 months of starting treatment.

Our assessment indicated that half of our clients had a usual source of medical care and three-quarters reported having visited a physician about their own health within the past 12 months. 48% of clients used an emergency room or doctor’s office during their treatment episode. We asked clients about use of preventive care services and found that, apart from blood pressure screening, receipt of lipid screening and age-appropriate cancer screenings was low. Clients reported low physical activity, and 40% had a measured height and weight consistent with obesity. 50% of clients surveyed reported one or more chronic illnesses, most commonly hypertension, asthma, and arthritis. 72% of clients described to us one or more current health worries, and almost two-thirds of this group reported receiving no physician care for at least one current health concern. Arthritis, obesity, dental problems, and tobacco cessation were the concerns most frequently cited. Overall, medical needs for our clients included care for chronic conditions, obesity counseling and management, and dental care.

The assessment suggested that substance abuse treatment may represent a favorable time to help clients establish a regular source of medical care and increase receipt of preventive services. Clients are often motivated to improve their health upon entering treatment. For clients with a community source for medical care, a substance abuse treatment provider might assess whether they have unmet health needs and help them arrange appropriate care. We found that in residential treatment sites, staff do help clients obtain needed care in the community, but in an inconsistent manner and usually related to acute complaints.

BHS plans to build on our assessment by engaging local community health centers to develop a collaborative and bidirectional referral process that would benefit our clients as well as theirs.
cT Demonstrates That Refugees Need Mental Health Screenings

James Livingston, PhD, Clinical Services Manager, Center for Survivors of Torture, Asian Americans for Community Involvement, San Jose, CA
James.Livingston@aaci.org

The Center for Survivors of Torture, a component of Asian Americans for Community Involvement in San Jose, California, provides services to political refugees who were tortured in their home countries. We initiated a county-funded project last fall in collaboration with Santa Clara County’s refugee health clinic, which provides health screenings and treatment for newly arriving refugees. Recognizing that a significant proportion of these new arrivals suffer from trauma and other mental health issues, we placed one of our mental health professionals at the clinic.

Our purpose was to provide mental health screenings to identify the need for mental health services and make referrals when indicated. This approach helps new arrivals obtain needed services and collects data on the pervasiveness and severity of their mental health needs.

Physicians conducting the physical examinations introduce the idea of a mental health screening. Clinic staff have designated an interview room equipped with a speakerphone, which allows the use of AT&T translation services. The staff schedule appointments for the mental health clinician and coordinate transportation services. CST maintains its own charts separately from those used by the clinic.

Our mental health clinician conducts an interview and administers the Hopkins Symptom Checklist and the Harvard PTSD Questionnaire; both assessment tools have been translated into several languages and are commonly used by refugee clinics across the United States in screening immigrants. Refugees who are identified as having mental health needs are referred to public and private agencies; those who are identified as torture survivors are referred to CST.

Although the project will continue through spring 2009, we have some preliminary findings. By the end of 2008, 64 refugees had been screened, and 36 (56%) received referral for further evaluation and treatment. Consultation between primary care physicians and the mental health clinician was requested in 14 cases (22 percent), a result indicating a high degree of coordination of services.

The use of AT&T’s translation services has been somewhat challenging. The quality of its service, although high, has been variable. Also concerning is that translators often hear of deeply upsetting experiences without adequate preparation or debriefing.

 Refugees who have followed through on their referral to our torture treatment center have made comments such as, “I never imagined there would be anyone who cared about what happened to me” and “This is a great country. To be safe, and give me someone like you to help me...”
Cherokee Shares Integrated Care Basics

Dennis S. Freeman, PhD, Chief Executive Officer, Cherokee Health Systems, Knoxville, TN / Dennis.Freeman@cherokeehealth.com

Cherokee Health Systems, an organization with 23 sites in 13 Tennessee counties has one of the nation’s most successful systems of integrated care. Integrated care is central to the organization’s vision and mission, and this care is practiced across an array of comprehensive primary care, behavioral health, and prevention programs and services. Cherokee is integrated structurally and financially, a structure that supports the focus on clinical integration. A behavioral health consultant is an embedded, full-time member of the primary care team. A psychiatrist is also available for medication consultation. The behavioral health consultant provides brief, targeted, real-time interventions to address the psychosocial needs and concerns in the primary care setting.

For people who need specialty behavioral health services, a primary care provider is embedded in the specialty behavioral health team. Cherokee hires primary care providers who are comfortable with mental health issues and believes that all frontline, administrative, and support staff must be essential players, committed to the holistic approach. The local community is aware that people are treated for all types of illnesses at Cherokee, and mental health consumers find that all are treated in the same way, which reduces the stigma of seeking mental health treatment.

CEO Dennis Freeman shares lessons from the Cherokee experience.

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Safety net providers across the country recognize the potential benefits of service integration but implementation, especially financing, has often proven challenging. Unfortunately, a universal formula to finance behavioral health and primary care integration does not exist. Variations in service models are one complicating factor. No single reimbursement model fits all the diverse integration programs the providers are putting in place. An even greater source of complexity is imposed by the payers, which vary greatly in terms of both their appreciation and their understanding of clinical integration and, subsequently, their willingness and flexibility to accommodate new or relocated services.

Does all this sound too complicated for you to mount the effort, despite the potential benefits of integrated programming? Fortunately, safety net providers are a persistent, resilient, and creative lot. We expect change and challenge. With respect to the integration of behavioral health into primary care, idealistic trailblazers and risk takers have shown the way. Early adopters have followed and are putting programs of integration in place all across the country. In profiling successful initiatives, it becomes clear that the implementers are adhering to some common principles to establish solid financial support for integrated care:

1. Clinical innovation always precedes the financing mechanism. Anticipate that you will be plowing new ground with payers and policymakers.
2. Track and record outcomes — any service innovation must prove itself.
3. To be viable, integrated programs must deliver value by producing improved outcomes and reducing costs.
4. Providers should use evidence-based practices.
5. The main goal is to increase access to behavioral health interventions in primary care. Finding cases for the specialty mental health sector is likely to increase costs and further tax the overburdened mental health system.
6. Healthcare providers should use a population-based approach; the goal is to increase the personal resiliency and health status of an identified patient population.
7. Behaviorists in primary care bring a flexible and generalist orientation that is broader in scope than the Diagnostic and Statistical Manual of Mental Disorders categories. A focus on a single disorder — depression, for example — may fit academe but has no place in the complex primary care clinical environment.
8. Providers, especially behaviorists, must adopt new roles and display new skills. This is not psychotherapy in the doctor’s office.
9. Colocation of providers is necessary but not sufficient for clinical integration.
10. The care model dictates the financing model, rather than the other way around.
Children’s Health Council’s Multidisciplinary Assessments Enable Early Interventions

Joan Baran, PhD, Assistant Clinical Services Director, Children’s Health Council; Richard Coolman, MD, MPH, Director, KidScope Assessment Center for Developmental and Behavioral Health, Departments of Mental Health and Pediatrics, Santa Clara Valley Health and Hospital System, Palo Alto, CA / geliott@chconline.org

Children in families involved with domestic violence; substance abuse; or developmental, behavioral, or medical issues need access to multiple professionals, who often find communicating with each other difficult. Parents are understandably frustrated and confused by seemingly conflicting diagnoses and recommendations. As the child’s medical home, pediatricians do not have ready access to social services, psychologists, and occupational therapists to provide comprehensive coordinated care.

KidConnections, the result of a relationship built among Children’s Health Council, Santa Clara County Mental Health Department, FIRST5 Santa Clara County, and four other community agencies, is a project aimed at helping high-risk children by providing a one-day multidisciplinary assessment. Our mission is to use a strengths-based, family-centered, and culturally sensitive approach to develop a rapid, shared understanding of a child and then direct and support the family in obtaining appropriate interventions.

All county resident children from birth to age 5 who are insured through Medi-Cal, Healthy Families, or Healthy Kids can receive developmental and behavioral screening. At the clinic, the child and family see a developmental–behavioral pediatrician (or psychiatrist), psychologist, occupational therapist, and social worker. After a lunch break for the family, team members meet with parents to review findings and recommendations and introduce staff from Parents Helping Parents to facilitate referrals and to provide support.

Miguel is an example of the power of collaboration. When he was 3-and-a-half years old, his pediatrician suspected that his behaviors were the result of autistic disorder. The situation was further complicated by the fact that Miguel’s mother was victimized by domestic violence, medicated for seizures, and battling an addiction. The assessment focused on Miguel’s many strengths and his mother’s struggles with parenting. When appropriate behavioral strategies were demonstrated, he began to respond to his name, follow instruction, and play more appropriately. While Miguel and his mother were waiting for the parent conference, the team observed him listening to her talk about the various colors of toys, rather than throwing toys as he had done earlier in the day.

Clinicians bill Medi-Cal and see two children a day, 4 days per week. For families who need help with transportation, bus passes, taxi vouchers, and Family Partners are available. We have learned that having the social worker complete the family’s psychosocial history beforehand to put a face to the
From the Field

Community Support Services Adds Primary Care to Mental Health Services

Frank Sepetauc, PCC, CRC, Vice President of Rehabilitation Services, Community Support Services, Akron, Ohio / sepetfra@cssbh.org

A kron, Ohio’s Community Support Services serves adult residents of Summit County with severe mental illnesses. The agency also serves individuals who are homeless, involved in the criminal justice system, or have a co-occurring mental illness and substance abuse problem.

CSS opened the doors to the Margaret Clark Morgan Integrated Primary Care Clinic and Pharmacy in November 2008. The clinic is a collaborative effort between CSS; the University of Akron College of Nursing; Northeastern Ohio Universities Colleges of Medicine and Pharmacy; local medical provider Summa Physicians, Inc., a division of Summa Health Systems; the County of Summit Alcohol, Drug Addiction, and Mental Health Services Board; several Ohio Medicaid managed care entities; the Ohio Department of Mental Health; the Ohio Department of Job and Family Services; Klein’s Pharmacy; and the Margaret Clark Morgan Foundation.

Clinic staff come from many sources and includes a nurse practitioner through the University of Akron and a primary care physician contracted through Summa Physicians, Inc. The administrative and support staff for the clinic are agency staff redirected to the project. Nurse practitioner students from the University of Akron rotate through the clinic.

Klein’s Pharmacy, with which CSS has a 20-year association, provides staffing for the pharmacy. Additionally, the pharmacy will be a site for students from the College of Pharmacy at NEOUCOM.

Planning for the clinic and pharmacy began two and a half years ago. The MCM Foundation provided $300,000 in funding to renovate existing space. Renovations created a four-room exam suite, a waiting area, the pharmacy, and an on-site laboratory. Donations were obtained for state-of-the-art exam room furnishings through local hospitals, individuals, and the Summit County National Alliance on Mental Illness.

CSS’s information technology staff developed an electronic record for primary care. The goal is the establishment of a totally integrated electronic record that is shared among the primary care clinic, the pharmacy, and behavioral health providers at CSS.

Planning is in process with the NEOUCOM, the ODMH, and CSS to develop outcome measures to assess short-term and long-term improvement in the health and longevity of clients with severe and persistent mental illness. Research will include emphasis on disease management, wellness activities, and nutrition. The goal is to determine the effect of coordinated medical and psychiatric care on a person’s length of life. This longitudinal study will last more than 10 years.

In implementing this clinic, we learned the importance of cooperation and collaboration between the medical and psychiatric communities. Regular meetings were vital as we organized this effort. Also, the presence of a project manager with knowledge and skills in both medical and psychiatric care is essential. It is important that the manager be from outside the agencies involved to ensure that his or her other duties do not undermine the effort. Time must be allocated to “credential” medical providers in a distinct location to include an outpatient behavioral health center — this process took us months to complete.

Future plans include increasing both the APN and the physician to 40 hours per week as well as integrating residents from NEOUCOM by the end of 2010.

Compass Uses Telepsychiatry to Bring Behavioral Healthcare to Rural Patients in Primary Care

Jess C. Jamieson, PhD, former CEO of Compass Health, and Tom Sebastian, MS, MPA, CEO Compass Health, Everett, WA / jess.jamieson@advancesintech.com; / Tom.Sebastian@compassh.org

Telepsychiatry is going beyond the mainstream in two important ways at Compass Health, a behavioral healthcare organization based in Everett, Washington. First, patients are being seen remotely through the latest innovations in telemedicine technology. Second, the patients’ experience is forging...
a new collaboration between primary care providers and the specialty behavioral healthcare provider.

San Juan County comprises 173 islands and is located in rural northwest Washington State. No psychiatrists practice in the county. Psychiatrically ill residents go without treatment, or the responsibility for evaluating and treating psychiatric illness falls to the primary care providers.

The primary medical practice, Inter Island Medical Center, serves the entire region’s healthcare needs and is typical of primary medicine clinics in similar areas. Although patients may present with mental health concerns that the primary care physicians attempt to address, the physicians are among the first to acknowledge the need for access to psychiatric specialty care for their patients.

Compass Health maintains a clinic in Friday Harbor. This clinic serves a broad range of San Juan County residents and provides both mental health and chemical dependency services. Compass Health has flown a psychiatrist to Friday Harbor on a regular basis, but time and travel costs have now made this option untenable.

To address this access problem, Compass Health and the Inter Island Medical Center applied for and were awarded a 3-year, $375,000 Rural Health Services Outreach Grant. With this grant, the two organizations developed and implemented an integrated model of providing psychiatric care through videoconferencing.

We put in place state-of-the-art TelePresence video equipment to ensure high-quality interaction between the patient and the psychiatrist. Before providing psychiatric services, both organizations mapped out the specifics of the clinical process in detail. The key objective was to ensure that all participants (the patients and their family; physicians, nurses, and support personnel; the Compass Health psychiatrist; and support staff) were clear about the clinical process. Everyone participating in the clinical process was actively involved in the design of the practice protocols.

Since December 2007, 45 patients have been referred for psychiatric treatment. Twenty-four have completed their treatment and been referred back to their primary care practitioner for follow-up. All patients report being extremely satisfied with their telepsychiatry experience. The primary reason given is that they do not have to go “off island” for treatment. Additionally, they note that the telepsychiatry experience is “just as good” as face-to-face treatment. They appreciate having the case coordinator available to assist and support them.

The primary care practitioners report that their patients say their experiences with the telepsychiatry application are positive. The practitioners also appreciate the ease with which they can access needed psychiatric services for their patients. The Compass Health psychiatrist says he has received a number of positive comments from the patients. He notes, “They’re surprised at first at how much it feels like a physically present interview.” He further notes, “Some even seem more able to open up, perhaps because the social distance of the telepresence unit is less intimidating than being physically in the room.”

El Paso MHMR Explores Cocase Management, Collaboration, and Colocation

Christy Calderon, MA, LPC, Chief Operations Officer, El Paso Mental Health/Mental Retardation Authority, El Paso, TX / ccalderon@epmhmr.org

By reaching out to local healthcare delivery agencies and care management organizations, El Paso Mental Health Mental Retardation Center has made strides in lowering costs and improving access. El Paso MHMR Center and El Paso First Health Plans, a local health maintenance organization, have collaborated to provide integrated behavioral health services to consumers. Staff from both agencies operate the program, which uses masters level social workers and professional counselors to identify and treat people with comorbid behavioral and primary healthcare concerns through a cocase management model. A consulting physician and psychiatrist provide guidance with patient treatment protocols.

The agencies exchange data, which are recorded and analyzed in a Web-based portal developed specifically for this collaboration. The portal records clinical and financial data, which are then used to analyze resource utilization and costs. Clinical data currently being measured include inpatient psychiatric hospital admissions, emergency room visits and admissions, primary care office visits, specialty care office visits, prescription utilization by physicians, and laboratory visits.

Among the initial outcomes were fewer inpatient psychiatric hospitalizations, a reduction in ER visits for one patient, and excellent customer satisfaction ratings and comments from consumer surveys.

El Paso MHMR also plans to collaborate with a local Federally Qualified Health Center to provide integrated behavioral health services. The proposed plan involves the full integration of an El Paso MHMR outpatient clinic into the FQHC system. This structure results in numerous advantages to behavioral health clients:

- 340(b) drug pricing, which prices medication 30% lower than retail pharmacies.
- Enhanced (cost-based) reimbursement for Medicaid-eligible and Medicare services (with the increased income, FQHCs often provide additional services, such as education and wraparound support for their patients).
- On-site outstationing of Medicaid eligibility workers, which will assist patients who are not enrolled in Medicaid with the enrollment process.

LESSONS LEARNED

- Actively involve the primary care delivery system and the behavioral health delivery system in designing the entire clinical process.
- Ensure that psychiatrists are willing and able to use the telepsychiatry application.
- Have a case coordinator available to help manage the patient’s needs during the treatment process.
- Use state-of-the-art 3D TelePresence technology to make telepsychiatry a real “in-person” experience for both the practitioner and the patient.
Project Health Link, a collaborative undertaking, was originally funded for a 3-year period by the Robert Wood Johnson Foundation. Our goal was to provide primary medical care to 250 clients in four mental health partial care programs and to develop mechanisms to maintain program sustainability after the 3-year funded period. Three organizations participated in this project. The lead agency in this program was Hoboken University Medical Center–Community Mental Health Center (formerly St. Mary Hospital), which has one partial care program. Catholic Community Services was the second partner; it had three partial care programs. The Family Medicine Residency Program at HUMC was the third partner.

We hired a primary care advanced practice nurse to provide the direct care at the four partial care sites. The APN was supervised by one of the attending family physicians in our family medicine residency program and spent 1 day a week at each partial care site and 1 day a week in the residency program to link any of the partial care clients who required specialized or more intensive physician-based care. The nurse conducted physical health assessments and provided direct patient care at the partial care sites.

A key component of our program was the development of a joint-care service delivery model in which the APN worked as part of the partial care team. The nurse attended partial care treatment team meetings to ensure that mental health staff were aware of the patients’ medical conditions.

Of the 250 patients enrolled in the partial care programs, 225 received complete physical health assessments and follow-up treatment. The conditions treated included hypertension, dermatological problems (e.g., psoriasis, seborrhea, rosacea, warts), lipid disorders, diabetes mellitus type 2, asthma, urinary tract infections, hepatitis C, and gastroesophageal reflex disease.

Age- and gender-specific testing protocols were developed. The protocols covered Pap smears, breast self-exams, digital rectal exams, and screening for hepatitis C and HIV for high-risk clients. A number of patients were referred to specialists for care.

Even though the grant has ended, the program has continued. Clients are encouraged to receive their medical care at the Residency Program. Before clients were transitioned to this site, the APN gave them orientation visits to the Family Medicine Residency Program and introduced to the staff. This step helped reduce clients’ fears and made them feel welcome. Before a visit, all necessary paperwork is completed. Most clients have Medicaid or Medicare.

WHAT WE LEARNED

> Pacing of care
Initially, many of our clients were resistant to receiving medical care. It was essential for the nurse practitioner to get to know the clients before an actual assessment or treatment started. To gain client trust, the APN also needed to participate in some of the regular partial care activities.

> Joint care delivery model
Ideally, having the primary care provider meet with mental health providers to plan and discuss specific clients is effective and greatly enhances the coordination of care. An unanticipated outcome of this delivery model was that the mental health staff became more comfortable in dealing with the medical system. As one staff member stated, “There has been a great deal of benefit to our mental health staff in terms of training and awareness of medical issues and resources. It now seems an essential part of our programming.”

> Linkage to family medicine residency program
These programs generally have a community health orientation and are intended to expose residents to different patient populations. Also, behavioral health organizations can provide required educational programming to residents in exchange for medical access.

> Educate primary care providers
Offering education to primary care providers on how to work with the mentally ill is critical. Medical education provides little or no training in this area.

Hoboken University Places Medical Nurses in Partial Care Teams

Michael Swerdlow, PhD, Executive Director, Primary and Behavioral Health Services, Hoboken University Medical Center–Community Mental Health Center, Hudson County, NJ / mswerdlow@Hobokenumc.com

From the Field

> Safe harbor protection under the Federal anti-kickback statute, which allows FQHCs to waive copayments for patients at or below 200% of the Federal Poverty Level, who are entitled to a discount on the basis of the FQHC’s schedule of discounts.

> Free vaccines for underinsured and Medicaid-eligible children, uninsured children, and Indian children under the federal Vaccines for Children Program.

In addition to exploring this fully integrated behavioral health model, El Paso MHMR is pursuing a colocation agreement with a second local FQHC. Through a colocated setting, eligible patients will have access to wellness exams, sick visits, immunizations, chronic disease screenings, health education, behavioral health assessments, diagnosis and prescriptions, behavioral health emergency services, and referrals and follow-up. El Paso MHMR will provide access to behavioral health assessments, diagnosis, prescriptions, psychiatric consultation, and coordination of any referral process. The principal benefit of this agreement is that El Paso MHMR consumers who are also patients of the FQHC will have access to the full menu of services.
ICL Staff Use Workbook Programs to Promote Consumer Health

Ruth Chiles, RD, Director of Food and Nutrition Services; Elisa Chow, PhD, Program Design and Evaluation Specialist; Elizabeth N. Cleek, PsyD, Vice President, Program Design, Evaluation & Systems Implementation; Ben Sher, LMSW, Director of Training and Staff Development; Rosemarie Sultana-Cordero, LMHC, Clinical Coordinator, Diabetes Co-Morbidity Initiative; Jeanie Tse, MD, Director of Integrated Health; and Matt Wofsy, LCSW, Director of Best Practice and Evidence-Based Initiatives – Institute for Community Living, Inc.; Andrew F. Cleek, PsyD, Director, Urban Institute for Behavioral Health, New York, NY / elizabeth.cleek@iclinc.net

The Institute for Community Living, a nonprofit agency in New York City, focuses on supporting people with serious mental illness or intellectual disabilities through a continuum of community services including outreach, clinics, and residential programs. In the past decade, ICL began to recognize that consumers with mental illness and intellectual disabilities were having difficulty accessing quality physical healthcare. To address this disparity, in 2001 ICL opened Health Care Choices, a clinic offering primary and specialty care for people with SMI or intellectual disabilities.

The emphasis on physical health marked the beginning of a shift in thinking at ICL. In 2007, ICL began focusing on what mental health providers could do to support physical and mental well-being. ICL developed two workbook-driven programs, the Healthy Living and Diabetes Comorbidity Initiatives, to help case managers and clinicians introduce physical health-related goals into their work with consumers.

The Healthy Living Initiative uses a simple workbook with built-in motivational strategies to help consumers develop action steps around regular check-ups, healthy food choices, physical activity, and safer sex, among other topics. Programs use the workbook in both group and individual work with consumers, and outcomes are being measured. Ongoing training is offered to staff through monthly Healthy Living TV videoconferences.

The Diabetes Comorbidity Initiative, funded by the New York State Health Foundation, uses a diabetes self-management workbook to help consumers better manage diabetes. The workbook is accompanied by a tool kit that staff can use to facilitate collaboration with medical providers around consumers’ care. DCI is currently being piloted in eight New York City agencies, with an independent evaluation team reviewing whether DCI tool kit use results in better health for consumers with diabetes.

Pilot data are promising: Consumers increasingly report meeting with a primary care provider for diabetes check-ups (80% at baseline and 90% at follow-up; n = 20, p < .01) and asking PCPs about their A1c levels (26% at baseline and 45% at follow-up; n = 19, p < .04). A significant improvement was also found in glucose control, as measured by A1c levels in a small group of consumers. We have collected consumer success stories through a DCI newsletter that is shared with participating agencies, and we see case
managers and clinicians using creative techniques to engage hard-to-reach consumers in lifesaving health interventions.

As ICL works through the process of integrating care, we’ve learned that it is not only about consumers changing but also about staff becoming more comfortable addressing physical health issues with consumers and thinking about healthier choices in their own lives.

LifeWorks Emphasizes Integration Across the Board

Joe Hromco, PhD, Director of Clinical Operations, LifeWorks NW, Portland, OR  joeh@lifeworkswnw.org

LifeWorks NW has been fortunate to have several opportunities to integrate behavioral health and primary care services. Our largest collaboration, with the Virginia Garcia Memorial Health Center (a Federally Qualified Health Center), started with a grant from United Way and Providence Health and Services. It has graduated from a colocational project to an integration that includes “behaviorist” and substance abuse services. The project has particularly focused on Latinos, given the low penetration rates within the community. In addition to this project and other primary care efforts, we have begun a pilot project to provide healthcare services within a program for people with severe mental illness, focusing on metabolic syndrome.

Multiple resources have helped further our projects. For written materials, we have used the many resources of Blount (1998) Integrated Primary Care: The Future of Medical and Mental Health Collaboration, Haas’s (2004) Handbook of Primary Care Psychology, and Robinson and Reiter’s (2006) Behavioral Consultation and Primary Care: A Guide to Integrating Services. Many toolkits have been helpful, including the Substance Abuse and Mental Health Service Administration’s Screening, Brief Intervention, and Treatment; the Primary Care Evaluation of Mental Disorders; and locally derived clinical pathway materials. We have also benefited from multiple trainings and collaborations: Health Resources and Services Administration–sponsored behaviorist statewide collaborative training, the National Council’s Primary Care/Behavioral Health Integration Listserv, a Primary Care Renewal collaborative sponsored by the local health plan CareOregon, a learning collaborative of behaviorists from area FQHCs, and a work group led by the state of Oregon focusing on larger system integration issues.

Data for the projects have been quite positive. First, data on mental health outcomes have shown consistently positive rates of reliable mental health change (e.g., change on the Outcomes Questionnaire 45.2, ORS, and GAF). Second, we have routinely surveyed primary care physicians about their perception of behavioral healthcare — the surveys have shown consistent change in the areas in which we have focused and remained flat in other areas. Last, data have shown improvements in penetration rates for Latino Medicaid members, a focus of our Virginia Garcia collaboration.

Our next steps include expanding our collaboration from five primary care clinics to as many as ten. We are also working with an FQHC collaborative on building an integrated electronic medical record. In addition, we have begun earnest work in integration the “other way” bringing our physical healthcare partners into our programs for people with severe mental illness.

In Missouri, Data Analytics and Primary Care Nurses Reduce Gaps in Medical Care

Paul Stuve, PhD, Account Manager, CNS Care Management Technologies, Morrisville, NC / pstuve@cnsnet.com

In response to rising concern over untreated chronic medical conditions and premature deaths in persons served by the public mental health system, Missouri implemented a statewide disease management and primary care/behavioral healthcare integration initiative. The initiative used data analytics to reduce the fragmentation and gaps in medical care in combination with adding primary care nurses on site in community mental health organizations.

In 2005, the Missouri Department of Mental Health partnered with Missouri Medicaid (now MO Health-
MeHAF Encourages Grantees to Deliver Patient-Centered Care

Barbara A. Leonard, MPH, Vice President for Programs
Maine Health Access Foundation, Augusta, ME / bleonard@mehaf.org

The Maine Health Access Foundation (MeHAF) includes among its strategic goals the promotion of patient- and family-centered care. A lengthy stakeholder engagement process identified integrated care as a critical element in the delivery of patient- and family-centered care in Maine. Integrated care addresses the needs of the whole person, linking mental and behavioral health, physical health and, often, other health needs. Recent research (Agency for Healthcare Research and Quality, 2008) indicates that integrated care has the potential to improve health outcomes cost-effectively.

MeHAF has committed more than $8 million for 37 grants to support the development and enhancement of integrated approaches to care. Grants include planning and implementation projects that focus on a range of clinical services, system transformation, and policy approaches. Diverse grant sites include hospitals, community health centers, mental health agencies, nursing homes, school-based health clinics, state government-run clinics, peer-run mental health advocacy and support organizations, and four statewide organizations. Among the priority populations are adults with chronic diseases, people with serious and persistent mental illness, teens, children with autism spectrum disorders, high-risk infants, nursing home residents, and people leaving jail.

Rather than endorsing a single approach to integrated care, MeHAF encourages grant recipients to explore current and emerging approaches that best meet the health and recovery needs of their populations. The projects seek to achieve key elements of integration, including:

> Patients' choice in the setting of care
> Meaningful participation by patients and families in the development and delivery of services
> Treatment delivered by both physical and behavioral health providers who serve a common population and use common medical records
> Solution-focused treatment for both physical and behavioral conditions that is cost-effective and informed by evidence-based and promising practice protocols.

As part of its technical assistance to the 37 projects, MeHAF facilitates quarterly learning community meetings, where national and local speakers inform grant recipients of the latest research and evidence-based practice. MeHAF is also initiating an integration resource center that will provide virtual and tangible materials, research, and tools to MeHAF grant recipients and others.

MeHAF is overseeing a rigorous evaluation of the initiative to determine the elements of integrated care that lead to successful integration and improved health outcomes.

MeHAF also funded the University of Southern Maine’s Muskie School of Public Service to conduct the Maine Barriers to Integration Study, an in-depth study of the structural, reimbursement, organizational practice, and professional cultural barriers to and opportunities for integration. The study, to be released in early 2009, will help guide policy activities, including a policy committee of key leaders being convened by MeHAF to identify and develop strategies to act on leverage points to enhance the implementation of integrated care.

Net) to implement Comprehensive NeuroScience’s Health Care Optimization program.

Designed for patients with severe mental illness and co-occurring physical illness, the HCO program alerts and informs both psychiatric and medical caregivers of the patient’s potential health risks and present patterns of service so that providers can proactively focus appropriate clinical interventions.

A detailed integrated health profile based on claims data is delivered bimonthly to medical and psychiatric providers, case managers, nurse liaisons, community mental health organizations, and other key contacts. The report provides a comprehensive picture of the patient’s treatment history, including diagnoses; important health and pharmacy alerts; current medications and medication adherence information; and a list of recent hospitalizations, emergency room visits, and outpatient services. Key caregivers are identified, and contact information is provided in a Key Contacts list.

Prescribing patterns that do not reflect best practice standards are highlighted, including patterns that may suggest suboptimal treatment or may reveal similar care from multiple providers, and related educational information is provided to prescribers. Information on the patient’s level of treatment engagement is also included; it consists of medication possession ratio scores and gap analysis information. Further adherence information is provided to designated care contacts through twice-weekly email reports on failure to refill critical medications. The process allows for rapid intervention to minimize adherence-related relapse. Finally, the HCO offers outreach and care coordination through a health liaison and designated nurse managers to ensure linkage across providers, case managers, and CMHOs.

The HCO pilot project enrolled 2,000 patients and provided caregivers with more than 6,400 integrated health profiles during its first year. Training was provided to CMHO case managers and supervisors throughout the state, and an active health liaison maintained contact with each agency’s executive and clinical staff to ensure optimum use of the information provided. The results were impressive: the number of HCO patients who lacked a psychiatric treatment home decreased over the first year from 36% to 9%. Psychiatric inpatient days also decreased by an average of 50%, for an estimated savings of more than $6 million.

More recently, nurse liaisons have been hired for most CMHOs to further ensure the best possible outcomes for enrolled patients. One nurse liaison recently reported that the integrated health profile helped her identify a client with diabetes who was unaware of her condition and was not receiving treatment: “Working with her case manager, we were able to provide diabetic education and follow-up with her PCP, and she is now checking her blood sugars and receiving regular follow-up with her PCP.”

Missouri is currently planning to expand the HCO program to a population of children in state custody who are living in residential care facilities.
Montana Family Medicine Residency Builds a Strong Behavioral Health Team Within an FQHC

Camille Wilson, PsyD, Director of Behavioral Science, Montana Family Medicine Residency, RiverStone Health, Billings, MT
Camille.Sto@riverstonehealth.org

In June 2008, the Federally Qualified Health Center Yellowstone City-County Health Department began doing business as RiverStone Health. RiverStone is home to Montana’s only graduate medical education program, the Montana Family Medicine Residency. The residency provides a comprehensive education in the full scope of primary care family medicine to medical school graduates, preparing them for a practice in rural and underserved areas of Montana.

In 2008, MFMR’s part-time psychiatrist retired, and RiverStone, the FQHC in which the residency is housed acquired a mental health expansion grant. The land was fertile for an early-career psychologist specializing in health psychology and medical education.

In September 2008, I was hired as MFMR’s director of behavioral science. I had just completed a 2-year fellowship in Michigan and was excited to return to my home state of Montana. “Plant seeds, plant seeds, plant seeds” has been my internal mantra for the past 6 months. From Day one, I started preparing the health center’s “soil” for integrated primary care “seeds.” I have established strong rapport and relationships with the residents, faculty attendings, nursing staff, administration, and other ancillary staff members. No person has been more or less important — I have focused on gaining support and buy-in from the clinic as a whole. Coming into my new position pushing an integrated care agenda would have been synonymous with randomly throwing seeds over untilled soil. Unprepared soil struggles to accept seeds and will not result in a flourishing garden. Much of the initial seed planting and rapport building I accomplished through precepting residents and providing brief, yet effective, clinical assessments and interventions (often referred to as curbside consultation) whenever and wherever needed.

I continued to plant seeds by creating a behavioral health team. This team initially consisted of a physician champion, a psychiatric pharmacist, our clinic manager, our charge nurse, and me. More recently, I added two masters-level counselors to the team. I was quite purposeful in hiring two people who were highly motivated and willing to provide behavioral health services in a less traditional model. I was also aware that they would require further training in integrated primary care. Between January and June 2009, we are completing Alexander Blount’s training in behavioral health primary care. In addition, we have moved from a colocated model to providing curbside consultation. A behavioral health provider is on call at every clinic to provide curbside consultation to any provider.

Providers considering pursuing integrated primary care should know that it is a model of care worth cultivating. Although we have few data at this point, we have seen a trend toward increased behavioral health encounters (essential to our mental health expansion grant) and reduced no-show rates. Patients from the community establish care with our clinic because they know that they can receive same-day care with a behavioral health provider, a service that is not offered anywhere else in Montana. In addition, our providers feel better supported and have appreciated the team approach to patient care.

Navos and Neighborcare Evolve from Colocation to 2-Way Integration

Wayne Webster, MD, MPH, Physician; Debra Morrison, Behavioral Health Program Manager, Neighborcare Health, Seattle Washington DebraM@neighborcare.org

In Seattle, Washington integration activities are successfully addressing both sides of the mental health and primary care interface. After several years of successfully integrating behavioral health into primary care, collaborative efforts are addressing the healthcare needs of people with serious mental illness served in the mental health system. The collaborative work between NAVOS and Neighborcare Health demonstrates the power of partnership to address the full health continuum and provides valuable insights for primary care providers serving a traditionally disparate population.

NAVOS is a full spectrum mental health provider in the Seattle region and Neighborcare Health operates six primary care clinics that provide medical and dental services in the area.

The collaborative relationship between NAVOS and Neighborcare began with colocation — NAVOS sends a mental health professional to the primary care center for a set number of clinical hours and helps facilitate needed referrals to specialty mental health services. This helped to improve care and develop a more truly integrated curbside consultation in the exam room. The program has helped both organizations improve access, streamline referrals, develop cross-disciplinary knowledge, problem solve, and improve continuity of care for patients.

Neighborcare also hired a behavioral health program manager to develop a more cohesive and purposeful program and to focus on increasing integration with primary care. The organization provides services based on the IMPACT model of stepped care. Neighborcare’s goal is to provide maximum support to primary care physicians as they deal with increasing numbers of patients needing treatment for depression, anxiety, posttraumatic stress disorder, and bipolar disorder.

Over the course of their work together, staff of NAVOS
and Neighborcare began discussing how they could better serve NAVOS consumers. NAVOS serves a large number of individuals transitioning out of psychiatric hospitalization, homelessness, and the criminal justice system. Staff decided to focus on a client population with co-morbid physical and mental health conditions living in housing on or near the NAVOS campus.

Neighborcare’s High Point Clinic began sending a primary care practitioner, Dr. Webster, and a medical assistant one afternoon each week to a NAVOS facility that serves patients coming from three different residential facilities in the area. Patients come to the same building where they would normally see their case manager or therapist; the PCP has an exam room there, with remote access to Neighborcare’s electronic medical record system.

In a typical afternoon, the PCP sees 10 to 15 patients. Although patients may come initially about an acute illness or injury, the PCP works with all the patients to establish an ongoing relationship and deals with their chronic illnesses, such as diabetes and hypertension, which affect a large number of patients who have chronic mental illness. The goal is to create a medical home for these patients.

All appointments for the primary care clinic located at NAVOS are handled through Neighborcare. Walk-ins are accepted as well and can be quickly registered via Neighborcare’s electronic medical record.

On many occasions the case manager stays in the room as consumers consult with the PCP. Case managers, who spend a lot of time with consumers and get to know the issues in their lives, provide support to recommended health changes and help coordinate care. The case manager can also help when a client’s mental illness impedes his or her ability to communicate.

How are they able to bill for the collaborative? Individuals seen at the primary care clinic located on the NAVOS campus are registered as patients with Neighborcare. All services performed at the clinic are billed to appropriate public/private insurance the client may have access to. When they started the partnership, Neighborcare had to add NAVOS to their malpractice rider in order to see clients off site.

NAVOS and Neighborcare found that two major obstacles to coordination were information sharing and billing. The organizations use different information systems, which made information exchange difficult. For instance, obtaining blood work results and medication information was a big obstacle but through dialogue and exchange, they developed protocols to work within their restraints. They now use patient tracking sheets that include information on an individual’s diagnosis and medications.

Access to the electronic medical record truly helps to coordinate referrals. According to Dr. Webster, “Clients at Navos are like any other patient who may need to see a medical specialist. I am able to identify what they need and communicate with a referral specialist. We have a lot of conversations with NAVOS’ nurse practitioner via phone to make sure that things do not fall between the cracks. Even the pharmacy has our cell phone numbers so that they can consult with us at any time.”

Dr. Webster also learned that primary care staff working in a community behavioral health center needs to be flexible about what they can accomplish visiting the website and calling for more information. We're happy to talk with you about creating a solution that will provide value and recovery to the people we serve.

For acute psychiatric hospital management services, please contact Pat Doyle at 510-227-0558. For all other services, please contact Ross Peterson at 800-977-7471.

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with a patient. It may be difficult to conduct a physical exam depending on their mental health that day, he notes. “Sometimes I’ll just talk to them and maybe I only get an ear, nose, and throat examination. I try to head off some problems and at the next visit, I go a little deeper as the patient’s comfort level rises. It’s important to establish a relationship and help them relax so they’ll come back.”

The close collaboration between the staff of NAVOS and Neighborcare Health has developed a greater understanding and mutual respect between the two agencies and improved the quality of services being provided to patients. Areas for future expansion include extension of the primary care services to clients served in other community-based programs.

New Center Pursues Integration through 2-way Staffing

Roberta Sanders, CEO, New Center Community Mental Health Services, Detroit, MI / rsanders@newcentercmhs.org

New Center Community Mental Health Services is one of 11 agencies selected from across Michigan to be awarded funding from the Michigan Department of Community Health to implement an initiative integrating mental health and substance abuse and physical health services.

The New Center CMHS award funds two positions: a colocated therapist and a nurse/case manager. The colocated therapist is based at the Advantage Health Centers facility (a Federally Qualified Health Center), which serves a large homeless population. The services of the colocated therapist address the untreated or inadequately treated mental health needs of consumers seeking services through the Advantage Health Centers system via mental health screening, psychoeducation, and therapeutic services. Once consumer mental health needs are addressed, the colocated therapist refers homeless consumers to the New Center CMHS Transformational Housing Unit for housing stabilization services.

The nurse/case manager is based at the New Center CMHS Grand-Dex facility. This person coordinates the mental healthcare services being offered to agency consumers, who either are insured and referred by physical healthcare networks to New Center CMHS for mental health services or are uninsured and receiving care at New Center CMHS — both physical healthcare services from the physician on site and mental health services from on-site therapists. The nurse/case manager identifies high users of emergency room services for physical and mental health concerns to facilitate treatment modifications that will reduce those numbers.

Both staff positions maintain integrated continuity between mental health and substance abuse and physical health services.

First-quarter project data — for October 2008 through December 2008 — indicate that consumers served through the integrated care initiative were diagnosed with key physical health ailments and substance abuse at the following rates:

- Severe mental illness: 70%.
- Depression: 85%.
- Anxiety: 55%.
- Substance abuse: 75%.
- Obesity: 38%.
- Hypertension: 43%.
- Asthma: 28%.
- Diabetes: 43%.
- Obstructive sleep apnea: 28%.
- Hypothyroidism: 23%.
- Hypertension: 43%.
- Diabetes: 43%.
- Osteoarthritis: 28%.

In addition, patients were diagnosed with mental health issues at the following rates:

- Anxiety: 55%.
- Depression: 85%.
- Severe mental illness: 70%.

To enhance the services available through this integrated care project, New Center CMHS is currently seeking funds through the Michigan Department of Community Health to add a peer-led whole health initiative to this integrated care program. A peer support specialist would offer workshops to consumers as well as to the community at large using a curriculum based on the Personal Action Toward Health evidence-based program.

North Range Moves from Colocation to Full Integration

Wayne Maxwell, Executive Director, North Range Behavioral Health, Greeley, Colorado / wayne(maxell@northrange.org

North Range Behavioral Health collaborates with Sunrise Community Health Center to co-deliver physical and behavioral health services in a single setting.

Coordination of care is facilitated by assigning a Behavioral Health Consultant as a member of the healthcare team and co-managing behavioral health concerns with the clinic-based medical providers. Traditional outpatient mental health services are also available in the primary care clinic. The BHC also facilitates “warm referrals” to NRBH’s extensive outpatient and day-treatment services when necessary.

NRBH provides integrated services at both a family clinic and a children’s clinic. NRBH has been co-located at the children’s
At Pathways, Colocation Helps Providers Coordinate Care

Linda Grgurich, Vice President, Western Region, Pathways Community Behavioral Healthcare, Clinton, MO / lgrgurich@pbhc.org

It is great having my two providers in the same building because they talk with each other at the time of the problem rather than me having to wait until I see my provider for psych meds and/or my therapist,” said Jackie, a 48-year-old woman living in rural Missouri who has been diagnosed with major depression and diabetes. When the behavioral health therapist met with Jackie, she asked Jackie’s primary care practitioner to step across the hall to discuss Jackie’s symptoms. As a result, the PCP made a change in Jackie’s psychotropic medication that resulted in an improved quality of life for the patient.

How often does that kind of coordinated care happen? It usually doesn’t, unless the client is receiving services from a community mental health center and a Federally Qualified Health Center that have partnered together.

Pathways Community Behavioral Healthcare is a large community mental health center specializing in accessible behavioral health services in more than 30 rural locations across mid-Missouri. Katy Trail Community Health Center is a young FQHC providing services in two rural communities. PBHC and KTHC offer integrated services in the cities of Sedalia and Warsaw. In Warsaw, PBHC modified its behavioral health offices (with help from grant dollars) to include a primary care practice. In Sedalia, PBHC placed a behavioral health clinic in the KTHC office.

This colocation has encouraged cross-referrals among agencies and some shared resources, including the opportunity to develop psychiatric consultation relationships for the PCP, which greatly aids in the appropriate prescribing of psychotropic meds. In addition, relationships have developed among the PCP and a children’s specialist and a substance abuse counselor.

The agencies face some challenges; for instance, the centers have two separate receptionists who do not substitute for one another, and having two separate information systems creates some difficulties. Language, communication, patient flow, space utilization, information technology, and potential for growth represent areas of further collaboration.

Ravenswood: Bringing Behavioralists into an FQHC

Elena Jiménez Tindall, Assistant to the CEO/ Program Manager, Behavioral Health Services Program, South County Community Health Center, Palo Alto, CA / ETindall@RavenswoodFHC.org

Ravenswood Family Health Center’s integrated behavioral health team works in tandem with our medical clinic and community to improve the mental health of our clients. Like many other Federally Qualified Health Centers, our clinic serves a predominantly low-income, minority population (45% of the clients in our service area live at or below 200% of the Federal Poverty Level). Our client population is stressed economically and emotionally as a result of surrounding drug- and gang-related violence.

In 2008, with the support of the San Mateo County Department of Behavioral Health and Recovery Programs and California State Proposition 63 funding for mental health expansion, RFHC launched its community-based integrated behavioral health services. This
funding and a financial commitment from Lucile Packard Children's Hospital to provide pediatric social worker support allowed RFHC to hire 2.3 full-time-equivalent behavioralists.

Our behavioral health team provides services in three therapeutic settings. Team members support our clinic's 12 FTE primary care providers and provide wraparound services to our local school district counseling program. They also support the local parolee reentry and recovery programs.

Our behavioral health services, offered on site, are unique in that our full-time program assistant, who has a bachelor's degree in social work, is key to making this team of part-time, bilingual, multicultural behavioralists—a psychologist, a social worker with a master's in social work, consulting pediatric and adult psychiatrists, and a Marriage and Family Therapist intern—work as a unit. We were told that the primary pitfall to avoid when designing an integrated behavioral health practice is hiring part-time behavioralists. However, because of funding limitations and our need for a rich mix of behavioralist providers, we employ part-time staff.

We have found that a well-trained, engaging, and empathetic program assistant conducting the warm handoff can be effective. Our first 6 months of data showed an 80% rate of follow-through to a first appointment when the program assistant conducted the warm hand-off, versus a 20% follow-through rate when the patient was given an appointment by phone.

Our second setting is half a block away, at a neighboring substance abuse recovery nonprofit. Our full-time MFT intern dedicates half of her time off site working with parolees with complicated mental health histories and the other half of her time providing goal-directed mental health services to the RFHC clients in the residential treatment program.

In our third setting, our consulting pediatric psychiatrist devotes one day a week to seeing referred patients from the clinic and consulting to and providing training to our primary care practitioners, community youth workers, and school district interns.

Our next goal is to provide care in the school setting to people whose children receive support from the school district but who are unable to access mental health services for themselves. Currently, RFHC is sponsoring a 6-week parent education program for families of these students.

Our IBH program, delivered in three clinical settings, is a vibrant and effective practice.

South Central Foundation Finds Colocation and Flexibility Critical to Integrated Care

Wendy D. Bradley, LPC, Lead Behavioral Health Consultant Family Medicine, South Central Foundation, Anchorage, AK
wdbradley@SouthcentralFoundation.com

In keeping with its vision of wellness for the whole person, the South Central Foundation formed a team of behavioral health consultants in its primary care center 5 years ago. Customers can receive comprehensive and immediate treatment in the exam room while visiting their primary care provider. The team’s goals are to meet customers “where they are” and to provide immediate services for a wide range of physical, mental, and emotional needs. Behavioral Health Consultants share offices with the providers and case managers, which creates seamless communication and collaboration for patient care.

BHCs are part of primary care and are located in family medicine, women’s health, and pediatrics departments. Currently, 11 BHCs serve about 40 provider teams. BHCs are licensed professional counselors and licensed clinical social workers. SCF is funded by a mix of private insurance, Indian Health Service funds, and grants.

BHCs from SCF have acquired information from several programs, including Cherokee Health Systems and the Air Force Integration Model. We use a variety of resources, such as the Primary Care Evaluation of Mental Disorders for depression, the Pain Patient Profile and Symptom Checklist—90 for chronic pain, the Cognistat Neurobehavioral Cognitive Status Examination for dementia, the Ages and Stages Questionnaires for child development, and the Alcohol Use Disorders Identification Test for substance abuse. We have also developed clinical guidelines for mood disorders, grief, anxiety, chronic pain, attention deficit-hyperactivity disorder, oppositional defiant disorder, and sleep disorders. In addition, we use a combination of handouts and workbooks.

Our BHCs had 7,659 visits in 2008. After BHC visits, we found reductions in emergency room visits by approximately 18%, urgent care visits by 20%, family medicine clinic visits by 11%, and pediatrics visits by 40%. At the same time, visits for behavioral health, complementary medicine, and traditional healing services increased. Provider surveys indicated 92% improved access to behavioral healthcare, a 64% increase in provider job satisfaction, and a 61% increase in appointment efficiency.

Providers have observed that “BHCs have been a wonderful addition; not only has access to behavioral health services been improved, patients are screened for appropriateness of the referral. A definite asset is the ability to have immediate intervention, which not only promotes patient care but also prevents crisis situations. A great asset and much appreciated.” Patients agree and comment, “By seeing my doctor, my dietician, and BHC, I was able to get my diabetes under control, lose weight, and find meaning in my life again.”

At SCF, we’ve learned that for integration to be successful, shared offices are a must. Such an arrangement allows information to be shared easily, and it reminds providers to use BHCs. Also, when customers are seen in the exam room and introduced by their providers, it makes for a seamless transition. Stick to short, solution-focused visits.

Too many scheduled visits can make the BHC unavailable for consults. Trying to be too rigid in therapeutic approaches will not work. Flexibility is key. Newly hired clinicians who have a lot of experience may find it difficult to change how they work.
Thresholds Finds that Patients Respond Better to Holistic Care

**Kristin Davis, PhD, Assistant Research Director, Thresholds Institute; Emily Brigell, MS, RN, Director of Integrated Healthcare, Institute for Health Care Innovation, University of Illinois at Chicago; Ann Hruby, MA, Coordinator of Integrated Healthcare, Thresholds, Inc., Chicago, IL kdavis@thresholds.org**

Thresholds, a large psychosocial rehabilitation center in Chicago, serves 7,000 patients annually. For the past 10 years, it has offered physical healthcare to its members through a partnership with Integrated Health Care, part of the University of Illinois at Chicago’s Mile Square Health Center, a Federally Qualified Health Center.

Each of the three IHC clinics serves different regions of the Chicago metropolitan area. One of the clinics serves one of Thresholds’ most important subpopulations, women suffering from mental illness and their children. The clinic provides preventative care for women and their children, ensuring that the children are up to date with immunizations and that they receive annual physicals. All three IHC clinics are staffed by advanced practice nurses who are faculty with the UIC College of Nursing. An advisory committee composed of leadership from Thresholds and IHC provides a vehicle for ongoing collaboration.

The partnership between Thresholds and the UIC nurses began 10 years ago with a small demonstration project that placed a one-exam-room clinic in a program on the south side of Chicago. The clinic was originally open for 4 hours a week but demand was so great that it added another exam room and now operates 40 hours a week. As one long-time staff member put it, “We started as a little storefront, mom-and-pop operation.” Since the clinic has been open, exam rooms have been added, and the clinic’s scope of care has expanded to meet the changing needs of the consumers it serves.

Clinic staff has learned many lessons about effective approaches to healthcare and healthcare system design over the past 10 years. Perhaps the most important lesson is that holistic care makes sense. When asked how using the clinics and working with the nurses has changed her perspective, one Thresholds staff member put it well: “For many trained as mental health providers, it is easy to find ourselves focusing on what we perceive to be the ‘mental health’ issues our members present, when in fact it is far more productive to approach treatment more holistically by understanding symptoms within the context of the whole person. We need to move away from compartmentalizing symptoms and toward providing effective integrative health services.”

Addressing the physical health conditions of people with serious mental illness is the foundation for recovery-oriented services. Patients like the idea of holistic care more than they do mental health services because it seems more “normal.” At the systemic level, coordination among physical and mental healthcare providers is fundamental to success, and it takes support at upper levels. It therefore requires buy-in throughout the hierarchies of both systems. Steering committees that work bilaterally and regularly hear concerns from frontline staff work best.

Thresholds also found that a jointly funded coordinator to span the two systems on the ground was crucial to ensuring high levels of integration, problem solving around new issues that invariably arise, and conducting ongoing cross-training.

UBHC Provides Medical Care to Uninsured and Underinsured

**Shula Minsky, Director of Quality Improvement, University Behavioral Healthcare, Piscataway, NJ / minsky@umdnj.edu**

University Behavioral Healthcare is a major provider of comprehensive mental health services to people suffering from severe and persistent mental illness who also have multiple physical health problems and face difficulties in obtaining physical healthcare. The difficulties are owing to multiple factors — limited financial resources and insurance coverage for people with SPMI; the scarcity of providers who accept Medicaid; and the difficulty people with SPMI may have navigating the complex healthcare system, given illness-related cognitive and motivational deficits. Although some charity and public clinics could provide physical healthcare to UBHC patients, the clinics typically are overwhelmed and have long waits for service, because they serve several other neglected populations as well as the mentally ill.

In 2008, UBHC received an anonymous donation earmarked for improving physical healthcare services for people with SPMI. Using these funds, UBHC developed a collaboration with the St. John’s Health Clinic (part of the Catholic Charities system), which serves uninsured, immigrant, and poor populations in New Brunswick, N.J. This collaborative effort, named the Yaffa-Rose Project, hired a full-time physician assistant and a medical assistant and opened for business in September 2008. The project began by targeting UBHC clients who had no insurance or had difficulty accessing medical care in a timely fashion.

By the end of January 2009, UBHC had referred about 165 new patients to the Y-R Project. The projected number of clients to be served each year is 350. To track patients and services, we designed several Microsoft Access tools. These databases included one to track the number and program of origin of UBHC patients referred to the Y-R Project and another, a program evaluation database used at the Y-R Project, to track all appointments as well as pertinent health information, such as diagnosis, test results, body mass index, blood pressure, diet, smoking, and emergency room visits.

A noteworthy outcome observed to date is a reduction in the number of ER direct referrals from UBHC. One problem we have encountered and addressed involved scheduling, which needed to be streamlined.

The donors visited both sites recently and were impressed by the dedication and level of service provided by the physician assistant at the Y-R Project and by the enthusiasm and appreciation expressed by professional staff at UBHC. New initiatives planned include a system to assist clients in need of dental care and an expansion of the project to a second site in Newark.
Verde Valley Consumers View Behavioral Health System as Primary Source of Healthcare

Robert D. Cartia, MBA, MA, Chief Executive Officer, Verde Valley Guidance Clinic, Inc., Cottonwood, AZ / robertc@vvgclinic.org

In April 2009, the Verde Valley Guidance Clinic, a private, nonprofit community behavioral health organization that has served the Verde Valley/Sedona area of north central Arizona since 1965, intends to open a full-service integrated care program that will colocate primary care physicians and behavioral healthcare medical staff. A variety of factors, beginning with the surgeon general’s report in 1999 and subsequent studies (including the tragedy of significantly shorter lifespans for people with serious mental illness), resonated with the management and staff of the clinic and served as a call to action. The project intends to provide services to adults with serious mental illness who are enrolled in both the behavioral health system and the Arizona Health Care Cost Containment System (Medicaid).

The clinic conducted an exhaustive review of the literature on integrated care models that might fit our specific situation. Our clinic’s perception is that SMI clients enrolled in the behavioral health system tend to be more connected with that system, with which they interact frequently, than with the primary care system, with which they interact on an as-needed basis. Consumers therefore tend to view the behavioral health system as their primary system of healthcare. As a result, the idea to colocate physicians at the clinic became a critical core value for successfully integrating services.

The clinic developed a relationship with a local physicians’ group, which enthusiastically agreed to staff a primary care office in the clinic’s new building. This group of physicians had input into the floor plan and medical office needs. Because of this collaboration, SMI consumers will receive psychiatric and medical care at the same location — and neither service will be “watered down.” Program sustainability is enhanced, because the physicians’ group bills for its services separately from behavioral health services.

The clinic has constructed a 14,000-square-foot, two-story facility specifically to meet the needs of this project. On one side of the bottom floor is a fully functional primary care office that includes three exam rooms, a doctors’ office, a triage room, a lab draw room, and a supply room. Behavioral health psychiatric staff offices are housed on the other side of the first floor. In addition, for member convenience, a full retail pharmacy will be adjacent to the waiting room. In this model, communication barriers related to space and distance are eliminated. We are establishing protocols for doctor-to-doctor communication to maintain the highest level of collaboration and information sharing.

Another important feature of the project is electronic health information sharing. The clinic is working with the primary care physicians to provide direct electronic input into the client’s behavioral health electronic medical record and for the primary care physicians to have access to minimal data sets of behavioral health information (primarily medical) so they can efficiently and safely provide care. The primary care physicians will also use Netsmart Technologies’ InfoScriber, which is the clinic’s current e-prescribing module.

Walnut Street CHC Focuses on Staffing and Infrastructure to Build Behavioral Health Services

G. Johnson Koilpillai, MD, Medical Director, Walnut Street Community Health Center, Hagerstown, MD / gkoilpillai@wchsys.org

In 2006, Walnut Street Community Health Center, a Federally Qualified Health Center delivering comprehensive primary care to the residents of downtown Hagerstown, Maryland, proposed a project to the Maryland Community Health Resources Commission to integrate behavioral health services into the primary care setting. The commission accepted WSCHC’s proposal and provided a $339,125 grant for the Integrated Primary Care Program, a 3-year program that began in February 2007.

Today, behavioral health services coexist with primary care services at the same location. Service providers use the biopsychosocial model of disease and treatment to enhance the quality of patient care. To maintain a truly integrated program, the IPCP targets only patients who are already established in the family practice and who are referred for behavioral health services by their medical provider. This referral process is thought to improve communication among all the providers and to maintain a more comprehensive approach to care. During the grant period, the IPCP is open to patients who are uninsured or have either Medicare or Medicaid.

The infrastructure of the IPCP was put in place through resources from behavioral health services consultants, local behavioral health services agencies, and the local mental health association. For Year 1, the goal of the program was to offer 40 therapy session hours per week, provided by a certified licensed clinical social worker, and 4 hours of psychiatric care per week. Behavioral health service providers were to get assistance from one full-time behavioral health services assistant. In 2007, 153 patients made a total of 573 behavioral health services visits. For Year 2, recruitment issues prevented the program from reaching its goal of employing two LSW-Cs. Because the demand for medication management was great, in Year 2, the WSCHC directly employed a psychiatrist, who provided 16 hours per
IPCP is now fully staffed after using local newspaper, shows were the largest barriers the center faced. The IPCP has grown tremendously since its inception, and the patients of the WSCHC have benefited greatly. The IPCP is now fully staffed after using local newspaper, behavioral health journal, and online ads. The WSCHC has implemented a new no-show policy as well as innovative scheduling approaches tailored for patients who are invested in their treatment. These measures should reduce the behavioral health services no-show rate, which is roughly 25% to 30%. To date, attendance for group therapy sessions has been poor, and this remains a work in progress.

The future of the IPCP looks promising and exciting. A second LCSW-C joined the IPCP in January 2009. This addition will help the center meet the growing demand for the program. And later this year, the entire center, including the behavioral health services program, will be converting to electronic medical records. Customized behavioral health services templates come with the EMR software. EMR will further improve provider communication and continuity of patient care. Finally, it is intended that the program will be self-sufficient through billable services after the grant period.

Washtenaw’s Integrated Health Programming Unifies Community Partners to Avoid Care Fragmentation

John Shovels, LMSW, ACSW, Program Administrator and Brandie Hagaman, MPH, CSTS, Integrated Health Supervisor — Washtenaw Community Support and Treatment Services, Ypsilanti, MI with contributions from Elizabeth Spring RN, BSN, MS, M3P

Early Intervention Program / shovels@ewashtenaw.org

The integration of physical and behavioral healthcare has been referred to as the “reunification of the body and mind.” It is about bringing together fragmented systems to improve both access to care and health outcomes. In Washtenaw County, Michigan, our mission is to unify our entire community around the central issue of healthcare integration. We have worked to accomplish this mission by focusing on partnership development with healthcare and nonhealthcare partners alike.

In 2000, the Washtenaw Community Health Organization was created to serve as a behavioral health system with the primary objective of integrating physical healthcare for vulnerable citizens of Washtenaw County. From this vision, a model of care has emerged that consists of partnerships with primary care providers, housing shelter programs, public housing communities, and others who share the common belief that access to healthcare is central to their organization’s mission. In Washtenaw County, we call this discovery and commitment to a common mission a “community of interest” — in this case, an integrated healthcare community of interest.

Within this community of interest are many integrated health programming elements and initiatives. Our primary model of healthcare integration is represented by our comprehensive integrated health sites. This comprehensive model was developed when the WCHO, the local community mental health provider (Community Support and Treatment Services), and a nonprofit safety net primary care clinic joined forces by embedding a full-time mental health professional and 4 hours per week of psychiatric consultation and treatment service time within the clinic. This staffing arrangement provides the primary care clinic an opportunity to improve its treatment of patients who need mental health intervention without fragmenting their care. In each of our five comprehensive sites, we have replicated this staffing model with great success, serving people of all ages who have mental illnesses at various degrees of severity.

Prevention and early intervention are a natural blend of primary care and psychiatric services, because in many cases, physical and mental health issues are inextricably linked. Through this model of care, signs of potential mental health and physical health issues can be recognized and treated in their early stages. Our partnership involving the treatment of physical and mental health issues, which has prevention at its core, provides a holistic approach to health and wellness that recognizes all components of a person’s well-being, including social, mental, physical, and environmental factors.

Commitments to the shared vision, partnership collaboration, and guidance from the leadership of the WCHO and other national partners have been the drivers of our continuous program improvement.

An important lesson learned on our journey is perseverance. Bringing two different healthcare cultures together is a complex task and should not be underestimated. It requires compromise from both partners, along with a willingness to learn from each other and use that learning to expand on innovative ways of providing service.

Despite the challenges, our integrated health initiatives have had a positive impact on many lives in our community.
Physical Health Screenings for the Mentally Ill: Key Health Indicators

Joseph Parks, MD, Chair, NASMHPD Medical Directors Council and Director, Comprehensive Psychiatric Services, Missouri Department of Mental Health; Alan Radke, MD, State Medical Director, Minnesota Department of Human Services; Noel Mazade, PhD, Executive Director, NASMHPD Research Institute

As a follow-up to the groundbreaking finding by the National Association of State Mental Health Programs Directors Research Institute that persons with mental illness live 25 fewer years than the general public\(^1\), the medical directors in state mental health agencies are focused on gaining a more thorough understanding of the causes and remedial action that must be taken to address this tragedy. Annually, more than 6 million persons are served in services financially supported by state mental health agencies.

The NASMHPD Medical Directors Council has produced a report that focused on morbidity of chronic and untreated health conditions among persons with serious mental illness\(^2\). The report focuses on specific medical screens recommended for this population of persons with complex medical conditions\(^3\). The report recommends that consumers in the public mental health system be screened for the following:

In addition to implementing a standard set of health indicators to inform clinical care, NASMHPD Medical Directors and the NASMHPD Research Institute (NRI) are recommending the adoption of proven population surveillance tools currently in use within the field of public health and applying these tools to mental health surveillance. Using questions from BRFSS, the world’s largest ongoing telephone health survey system, states could assess the health status of consumers and provide important comparisons with the general population. The data would also provide an overall assessment of how state mental health and health systems are doing in addressing these problems.

The report provides recommendations for how NASMHPD should engage public health and healthcare leadership to reduce the early mortality of people with serious mental illnesses. Members of the NASMHPD Medical Directors Council are also leaders in their state mental health authorities and can take this opportunity to engage medical leadership in state Public Health and Medicaid authorities to promote integration of health and mental health issues in state level health policy, planning, and reimbursement.

Currently, the NRI is assuming the lead to seek funding that will launch implementation of a multi-state effort to implement these screens in selected sites. Particular emphasis will be placed on inculcating healthcare technologies in the sites. NRI and the NASMHPD Medical Directors will use the data to examine the interrelationships among state mental health, public health, and the Medicaid state agency and then disseminate the findings to improve coordinated funding, policy, regulation, eligibility determination, and consensus on evidence based practices in the health arena.

This technical report supports a vision with many initiatives and partners, to improve how the general healthcare and mental health systems collaborate to integrate care and fight this epidemic of premature death and its contributing causes.

The NASMHPD Medical Directors Council conducts its work under the auspices of the National Association of State Mental Health Program Directors. Authorized by the Board of Directors in 1995, the Council’s membership includes medical directors from state mental health authorities from across the country engaged in identifying clinical best practices for people with mental illnesses; improving state psychiatric hospital administration, appropriately utilizing new psychotropic medications; and exploring the use of treatment algorithms, among many others.

The NASMHPD Research Institute is a non-profit corporation devoted to issues of the public mental health system. Established in 1987 as a national organization resource to provide leadership and support in the areas of analysis, evaluation, and research, NRI facilitates the application of research findings to management of state mental health programs.

**Health Indicators**

1. Personal History of Diabetes, Hypertension, Cardiovascular Disease
2. Family History of Diabetes, Hypertension, Cardiovascular Disease
3. Weight/Height/Body Mass Index (BMI)
4. Blood Pressure
5. Blood Glucose or HbA1C
6. Lipid Profile
7. Tobacco Use/History
8. Substance Use/History
9. Medication History/Current Medication List, with Dosages
10. Social Supports

**Process Indicators**

1. Screening and monitoring of health risk and conditions in mental health settings
2. Access to and utilization of primary care services (medical and dental)

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**References**


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People with serious mental illnesses have the highest mortality rates of any subpopulation in the U.S. public health system — obviously something must be done — and it must be done now and by their behavioral healthcare providers. Building evidence-based practices such as psychoeducation and health education into routine practice has been proven to be effective. Adapting such measures for people who are recovering from severe, persistent psychiatric disorders is challenging but implementation brings great rewards — clients are empowered and inspired to choose a healthier lifestyle, optimize their health and wellness, understand and manage their psychiatric disorder, and make choices that reduce relapse and facilitate recovery. Team Solutions and Solutions for Wellness put these goals within reach for consumers and providers across the United States.

More than 700 behavioral health organizations across all 50 states have used Team Solutions and Solutions for Wellness to increase their array of evidence-based services and improve treatment. Team Solutions and Solution for Wellness workbooks have been translated into 16 languages and used in 27 countries around the world. Specifically created for behavioral health providers, this library of psychoeducation workbooks is easy to implement (you can prepare for sessions in a few minutes), is easy to understand (fourth- to fifth-grade reading level), and can be used by the entire treatment team. The workbooks enable providers to help consumers understand and manage their illness, promote recovery, and improve their health and wellness.

**TEAM SOLUTIONS**

Team Solutions is an illness management and recovery-oriented library of ten psychoeducation workbooks that address severe mental illnesses and the many challenges that people recovering from serious mental illnesses face in their everyday life.
lives. Topics include understanding one's illness, managing stress and problems, recognizing and responding to relapse, and substance use. Team Solutions offers information in small, manageable sections, with an interactive format and a tone that is hopeful, encouraging, and empowering.

**SOLUTIONS FOR WELLNESS**

Solutions for Wellness is a set of two workbooks that incorporates physical health and wellness into the recovery process. The goal is to help change many of the lifestyle factors that contribute to the high morbidity and mortality rates in people with SMI. Taking a small steps approach, these workbooks encourage consumers to gradually make healthier choices to improve their personal health and wellness.

Team Solutions and Solutions for Wellness are used by mental health professionals and paraprofessionals in individual and group sessions. They have been disseminated and implemented in a variety of settings, including outpatient, inpatient, CSU, day treatment, clubhouse, case management, Assertive Community Treatment, and residential treatment settings. All the materials include brief facilitator's notes for quick session preparation and describe simple, measurable outcomes that can help you document the success of your sessions and promote your work. Although a number of psychoeducational materials are available, only Team Solutions and Solutions for Wellness pull together the best available research and present it in such an easy-to-use format. No intensive training or advanced clinical skills are required to use the workbooks.

**GETTING STARTED**

These materials have been used for more than 11 years by all members of the treatment team. Nurses use them as handouts to supplement verbal instructions routinely provided during injections, lab work, and medication monitoring. Case managers and ACT teams use the workbooks to help consumers learn and practice effective problem solving, relapse reduction, and stress management skills. Therapists use them to help consumers learn and practice recovery lifestyle habits to optimize recovery and reduce their risk of relapse. Day programs enrich their services with a full curriculum approach to enable quick and easy data collection and outcome reporting. Prescribers select and hand out specific pages to augment the messages they typically want patients to take away from their brief sessions. Peer support specialists use the workbooks to facilitate educational support groups for a wide range of peers.

The most common obstacle is making the process too hard. You don’t have to read or study the workbooks to use them. You don’t even need to create an elaborate implementation plan. Because there's no fidelity scale and the materials are modular, you can use them flexibly. You can truly just jump right in and get started today to improve complete wellness and to measure consumer outcomes.

**Team Solutions and Solutions for Wellness workbooks can be downloaded at www.treatmentteam.com.**

The website includes Spanish-language versions of the materials. Team Solutions and Solutions for Wellness were developed by a group of renowned experts and supported by Eli Lilly and Company.

Patricia Scheifler is the Director of Partnership for Recovery, a consulting firm specializing in providing, developing, and enhancing services for people who are recovering from serious mental illness. Patricia has more than 20 years of direct practice and administrative experience across the treatment continuum and specializes in recovery-oriented treatment of persons with severe and persistent mental illness. She has presented over 300 workshops across the country and has co-authored numerous books.

**NEW EDITIONS, NEW FEATURES**

The new editions of Team Solutions and Solutions for Wellness include enhanced materials for consumers and improved ease of use for facilitators:

- The materials are divided into shorter sections, so each section can be completed in a 1-hour session.
- There is a greater emphasis on stages of change, motivation, and engagement strategies.
- Personal practice options and small healthy steps are included to promote review, utilization, exploration, sharing, and discussion of knowledge and skills between sessions.
- Relative uniform measurable objectives are provided for each session to make inclusion in treatment plans and progress notes quick and easy.
- A pre- and post topic assessment provides several easy-to-use outcome measures for each session, and the results can be quickly documented in progress notes.
- Information has been updated to reflect current guidelines and evidence-based interventions.
- The materials do not focus on a single diagnosis or disorder.
- A new workbook specifically addresses substance use issues in a psychoeducational workbook format.
- Additional skill-building strategies are included.
- Each session's Facilitator's Guide and Pre/Post Topic Assessment precede the session's participant handout, rather than being segregated into separate binders.

**Team Solutions and Solutions for Wellness**

are resources to help the behavioral health treatment team empower and inspire patients with psychiatric illnesses to choose a healthier lifestyle, manage their psychiatric disorder, and make choices that reduce relapse and facilitate recovery.
Wellness

Tobacco use is potentially the most modifiable risk factor for decreasing the excess mortality and morbidity persons with mental illnesses face (NASMHP, 2006; U.S. Department of Health and Human Services, 2004). Behavioral health systems have a tremendous opportunity, by integrating smoking cessation into integrated health and wellness initiatives, to assist consumers to live longer, healthier lives. We know that people with mental illnesses can successfully quit using tobacco (Evins et al., 2005; George et al., 2002), and there are low-burden burden means of successfully assisting interested mental health consumers quit. With brief training, behavioral health providers have the ability to successfully intervene. Moreover, stopping tobacco use does not negatively affect either mental health or substance abuse treatment, and may actually enhance other treatments (Prochaska et al., 2004).

A DEADLY EPIDEMIC
Persons with mental illnesses die up to 25 years earlier and suffer increased medical comorbidity when compared to the general population (Brown, Inskip, & Barraclough, 2000; Colton & Manderscheid, 2006; Joukamaa et al., 2001). Tobacco use causes and/or exacerbates medical comorbidities such as cardiovascular disease. Persons with mental illnesses and substance abuse disorders use over 30% of cigarettes and comprises 44% of the entire U.S. tobacco market (Grant et al., 2004; Lasser et al., 2000). Nationally, tobacco use prevalence among persons with mental illnesses is over 40% (Lasser et al., 2000), twice that of the general population. Although exact numbers are unknown, perhaps as many as 200,000 of the 435,000 annual deaths from smoking in the U.S. occur among persons with mental illnesses and substance abuse disorders (Schroeder, 2007; NASMHPD, 2006; Williams & Ziedonis, 2004). Smokers with mental illnesses also have more psychiatric symptoms, increased hospitalizations, and require higher doses of psychiatric medications (Dalack & Glassman, 1992; Desai, Seabolt, & Jann, 2001; Goff, Henderson, & Amico, 1992; Williams & Ziedonis, 2004; Ziedonis et al., 1994).

WHAT IS THE CAUSE?
Neurobiological, psychological, social, and societal variables are all associated with the high tobacco use prevalence among persons with mental illnesses. For instance, tobacco use is a coping strategy for anxiety and boredom (Goldberg, Moll, & Washington, 1996; Gurpegui et al., 2007; Morris et al., in press; Smith, 1996). Although becoming less accepted, many behavioral health institutions also continue to utilize smoking privileges as a behavioral intervention (NASMHPD, 2006). It is true that nicotine (not tobacco) provides some temporary benefit to persons with mental illnesses such as schizophrenia. Nicotine may improve sensory processing and concentration, and offer temporary relief from some medication side-effects (Desai et al., 2001; Forchuk et al., 2002; Ziedonis, Williams, & Smelson, 2003), but the cost is steep. The potential benefits are transitory, while the long term cost is often disease and early death.

Smoking Cessation Along the Road to Recovery

Chad D. Morris, PhD, Director, Behavioral Health and Wellness Program

An analysis of data from the National Comorbidity Study, a nationally representative survey of psychiatric disorders in the United States, found that 41% of people with a psychiatric disorder smoke, about twice the rate (22.5%) seen in those without psychiatric diagnoses. People with psychiatric disorders consume 44.3% of all cigarettes smoked in this country. The high rate of smoking is an important factor in increased rates of physical illness and mortality in people with psychiatric disorders.
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- **David Mee-Lee, MD**  
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  A physician and a board-certified psychiatrist, Dr. Mee-Lee has worked for more than 25 years developing and promoting innovative behavioral health treatment that emphasizes clinical integrity, high quality, and cost-consciousness. In addition to being both a workshop trainer-teacher and a consultant, he is a prominent researcher and author in the field of addictions and mental health. A native of Australia, Dr. Mee-Lee is an expert in dual diagnosis—co-occurring substance use and mental disorders.

- **Elana Gil, PhD**  
  Integrated Approaches for the Treatment of Abused Children  
  Dr. Gil is director of Clinical Services for Childhelp, Inc., in Fairfax, Va., where she is developing a child abuse and neglect treatment program to provide specialized services to children and their families. She is founder and coordinator of an abused children’s treatment program in Northern Virginia, a Registered Play Therapy Supervisor, a Registered Art Therapist, and a licensed Marriage, Family, and Child Counselor. She was an adjunct faculty member at Virginia Tech for more than 10 years. Dr. Gil is bilingual and bicultural, originally from Guayaquil, Ecuador.

**WE LOOK FORWARD TO SEEING YOU IN WASHINGTON, D.C.!**

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BEHAVIORAL HEALTH AS PART OF THE SOLUTION

Behavioral health clinics are a natural setting in which to offer healthy alternatives to tobacco use. While few behavioral health providers currently ask patients about smoking or advise them to quit (Himelhoch & Daumit, 2003), mental health consumers are just as motivated to quit as the general population. Treatment works for these individuals (Addington et al., 1998; Baker et al., 2006; Lasser et al., 2000), and there are simple means for assisting consumers reach their recovery goals.

The Smoking Cessation for Person with Mental Illness- Toolkit for Mental Health Providers (Morris et al., 2009) is a resource for a broad continuum of mental health providers, including direct mental health and substance abuse providers and administrators. The toolkit contains a variety of information and step-by-step instruction regarding means of assessing readiness to quit, possible treatments, strategies for reducing relapse, and national resources. Providers are given pragmatic steps that take less than five minutes, which will effectively assist many mental health consumers quit.

The toolkit also offers guidance for those sites, such as integrated health clinics, able to offer additional cessation services. Rather than developing stand-alone cessation services, individual or group tobacco cessation treatment is easily built into existing wellness initiatives. Tobacco cessation is an essential part of healthy living along with stress relief strategies, relationship building, nutrition, regular rest, and exercise. With some additional training, clinicians can deliver effective health messages, provide psychosocial or behavioral interventions like cognitive behavioral therapy (CBT), and refer to appropriate tobacco cessation medications. Mental health consumers need to quit, want to quit, and can quit tobacco use. Tobacco cessation is a key component of many individuals’ recovery, and behavioral health and primary care providers are ideally positioned to help.

Stopping tobacco use does not negatively affect either mental health or substance abuse treatment, and may actually enhance other treatments.

Chad Morris, PhD, is an Associate Professor at the University of Colorado Denver, Department of Psychiatry, and Director of the Behavioral Health & Wellness Program. Dr. Morris is the principal investigator of multiple studies exploring the effectiveness of psychosocial and pharmacologic tobacco cessation strategies for both youth and adults. He is Past-President of the Colorado Psychological Association, and a licensed psychologist.

REFERENCES


DID YOU KNOW?

Obesity-related illnesses, like diabetes, are an epidemic within an epidemic among the mentally ill. For example, about 13% of schizophrenic adults in their 50s have received a diabetes diagnosis, compared with 8% of the general population of the same age.
The integration of behavioral health and primary care and the expansion of health information technology are two issues that are gaining increased momentum, especially in the context of national dialogue on economic recovery and healthcare reform. Both are critical to heal many of the ills of our troubled healthcare system. I view these issues as being very much intertwined, and it will be difficult to improve the system unless we take a holistic view of how we provide treatment and share data.

**INTEGRATE OR NOT?**

Sharing data is at the heart of the problem, whether primary care and behavioral health services are provided at a single site or relationships and referral mechanisms are established to provide them at separate facilities. The latter is a much more difficult and, it seems, inefficient approach, because many studies have shown that drop-out rates from a referral to treatment are as high as 50 percent. Integrated behavioral health and primary care can be provided in a primary care setting or in a behavioral health setting.

Some core components of integrated care seem to surface again and again in discussions on this subject. In an October 2008 meeting at Morehouse University sponsored by the Health Resources Services Administration, the Substance Abuse and Mental Health Services Administration, and other federal partners and supported by the Carter Foundation, a large number of federal agencies, along with private, for-profit, and nonprofit providers, discussed primary care and behavioral health integration. Discussion around which models are most effective, which payment structures support those models, and other factors will continue; however, until all providers are on a level playing field, it will be difficult to determine the optimum system in which to provide integrated behavioral health and primary care. What I see as the core components are identified in the figure below. Those components include colocation, communication and collaboration among the primary care and behavioral health providers, shared problem lists, shared treatment plans, shared medication lists and lab results, joint decision making, and communication across systems.

The patient sits in the middle, and it really does not matter whether his or her healthcare home is in a primary care setting or behavioral healthcare setting. Where the patient needs to be treated depends on the severity of his or her illness at that particular time. The two systems have great opportunity to work together to improve patient care as well as share expertise, staff, and best practices to improve the quality of care provided to our patients.

**PATIENT TRACKING**

So how do we best serve patients, assuming that we do have provider organizations that wish to work together in collaborative partnerships? I do not think collaboration can be accomplished without the use of health information technology. Even at a basic level, keeping a disease registry to track shared patients and ensuring that needed and scheduled services are received requires some level of HIT. There can be a large percentage of shared patients between health centers and community behavioral health centers given that there are

- More than 1,200 health centers
- In more than 7,000 locations
- Serving more than 18 million people, of whom
  - 7 million are uninsured (1 out of every 7 uninsured patients in the country)
  - 6.4 million receive Medicaid (1 out of every 8 Medicaid patients)
  - 1.4 million have Medicare
- 12.7 million are below the Federal Poverty Level, and

Think outside your own practice or organization. Ask yourself, “If I were receiving data from someone else and wanted to provide good-quality care to my patient, what would I need?” or, “What would another provider to whom I am referring my patient need to provide good-quality care?” Think of the core components of information sharing and how we make that work.
16.5 million are below 200 percent of the poverty level (1 in every 3 people below the poverty level); and that

One in every four health center patients are minority and below the poverty level; and

More than 1 million health center patients are homeless.

If we use the National Council’s Four-Quadrant Model, it seems clear that to more effectively identify, treat, and track patients in the most appropriate quadrant and provide the most effective healthcare, providers will need HIT to gather appropriate clinical decision support to justify maintenance in a specific quadrant, to communicate effectively as the patient moves from quadrant to quadrant during the course of his or her illness, to track patients through the quadrants, and to carry out care management activities.

**EHR REQUIREMENTS AND GAPS**

So, what systems and structures are in place now to make this happen? Unfortunately, I do not see many examples of them in the current marketplace. In my current position I wear two hats, director of HIT (I help health centers implement electronic health records and other HITs) and senior advisor on behavioral health, with a focus on helping health centers provide integrated primary and behavioral healthcare, either within their own organization or in partnership with community behavioral health centers. I am always looking for systems that can provide the necessary integration to meet the needs of primary healthcare providers and community behavioral healthcare providers. Unfortunately, the perfect system is not out there. I recently reviewed an article in Behavioral Healthcare that took a detailed look at IT products and services for behavioral health providers. None of the products reviewed would provide the integration required to allow providers to meet the core components identified above.

Products must also meet additional requirements to fit the definition of a fully functional EHR. The most frequent components quoted as being required for a fully functional EHR include having computerized systems for

- Tracking patient demographics, problem lists, and medications
- Recording clinical notes, including medical history and follow-up
- Ordering prescriptions

Sending prescriptions electronically (not by fax)
- Ordering laboratory and radiology tests
- Sending orders electronically
- Viewing laboratory and imaging results
- Receiving electronic images
- Warnings about drug interactions or contraindications
- Warnings about out-of-range tests levels
- Reminders regarding guideline-based interventions or screening

The language in the American Recovery and Reinvestment Act, in addition to most of the above requirements, defines a qualified EHR as being able to exchange electronic health information with and integrate such information with other sources. We need to add sharing treatment plans for behavioral health centers to that requirement, because they are different from a “problem list.” The National Council lobbied extensively — and successfully — to have behavioral healthcare included in the ARRA and to have community behavioral health centers included as eligible providers so that they would have access to HIT funds under ARRA. This was a significant accomplishment.

I estimate that there are five or six major EHR vendors for ambulatory healthcare, and none provides a product that can meet the needs of primary care and behavioral healthcare “off the shelf.” Some health centers, however, have formed partnerships with behavioral health centers and developed specific templates that do meet the needs of both the primary care and the behavioral healthcare providers. The Alliance of Chicago comes to mind as an example; however, that entity did need to work together over a period of time to identify needs and develop EHR templates that would adequately address the behavioral health centers’ needs. Collaboration is key and will be key going forward.

Community health centers have a unique model of collaboration called health center controlled networks. An HCCN is a group of three or more health centers with a governing board that is 51% controlled by health centers that come together to share resources. They often share administrative resources and performance improvement staff and act on joint performance improvement projects, and some share human resources and other functions. The most visible area of sharing, however, is in the area of HIT. One center usually becomes the hub, or a new organization is formed to provide the backbone for the HIT infrastructure required for all the health centers in that network. Approximately 50 such collaborations are in operation across the country. These arrangements provide considerable savings through economies of scale that would not be available to a health center implementing an EHR on its own. Savings are also realized from decreases in implementation errors, reduced time spent “reinventing the wheel,” reductions in total implementation time, and reductions in lost productivity during the implementation. Money is saved on servers, back-up devices, and emergency and recovery equipment, and collaborations have discounts on provider licensing fees.

The benefit from joint quality improvement initiatives...
cannot be overemphasized. Many of HCNs are able and willing, as was the Alliance, to enter into partnerships and work with behavioral health centers to meet their EHR needs and requirements.

**DEFINING OUR NEEDS**

If such a gap in behavioral health EHRs exists, then where do we start to ensure that those gaps are filled? The place to start is with the Certification Commission for Health Information Technology. This organization sets the requirements for interoperability for EHRs and tests them to ensure that when they are marketed as interoperable, they in fact are. In 2009, CCHIT will begin to address the standards for behavioral health EHRs. Go to their website, www.cchit.org, to review the specifications. Make comments and let them know what does and does not work and what your needs as a behavioral health clinician, administrator, or patient are. If EHRs are to meet the requirements of integrated care, clinicians, administrators, and patients all need to share information in a secure and confidential manner.

Clinicians may feel that this task is overwhelming; you would become bleary-eyed reviewing a list of specifications. I still get bleary-eyed at times; however, this is why we must develop partnerships with other providers who don’t become overwhelmed with reviewing specifications and who can provide reasonable explanations of what these things mean. Because I am a clinician with an IT systems background, much of what I do involves reviewing specifications. When you review specifications, think outside your own practice or organization. Ask yourself, “If I were receiving data from someone else and wanted to provide good-quality care to my patient, what would I need?” or, “What would another provider to whom I am referring my patient need to provide good-quality care?” Think of the core components and how we make that work.

Be aware of the emerging technology and the National Health Information Network. This network of networks ties various healthcare providers together, including hospitals, laboratories, behavioral health centers, emergency rooms, community health centers, pharmacies, radiology centers, nursing homes, and so on. The goal is to have the right information to the provider at the point of care so that he or she can make the best decision for the patient at the time (e.g., “Maybe I don’t need to order this test for the patient for the third time, because I have the result from yesterday in hand” or “Maybe I will order a different medication, because now that I actually know what medications the patient is on, I can avoid a contraindication or adverse medication event”).

Another area to begin to focus on is identifying the “value case” for sharing the data and the mechanisms that make this most efficient. The National eHealth Collaborative (www.nationalehealth.org) will be placing a call for value cases in the next several weeks, and I cannot think of a better value case than community health centers and community behavioral health centers identifying the information and processes they need to easily pass data among each other. This process not only would benefit centers that have systems in operation now but also would set the stage so that future adopters of EHRs would have ready-made templates and processes in place to make sharing patient data an easy and uniform process.

**PATIENT PRIVACY ISSUES**

We should try not to let privacy and confidentiality issues stop us from moving forward to provide quality care. We need to work through some challenges, and some laws need to be changed, but we should not allow “perfect” to get in the way of “good.” We can address many issues with patient education and informed consent at the time of service and by ensuring that we honor the request of patients who opt out of sharing their information. Many behavioral health organizations and community health centers that currently routinely share patients have modified their consent forms to include each organization, and they make this known to patients. Few patients are opting out.

Be transparent; there is nothing to hide. Provide the patient education. Give patients the opportunity to expect communication, collaboration, shared treatment plans, and joint decision making from their providers. It’s what I expect for me and my family! I think it should be what our patients expect as well, but nothing will change unless we make the effort to educate them about the benefits of HIT and shared information to improve quality care.

The goal is to have the right information to the provider at the point of care so that he or she can **make the best decision for the patient at the time** – “Maybe I don’t need to order this test for the patient for the third time, because I have the result from yesterday in hand” or “... now that I actually know what medications the patient is on, I can avoid a contraindication or adverse medication event.”
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EHRs Improve Care and Increase Revenue in Integrated Settings

Virna Little, LCSW-r, PsyD, Vice President for Psychosocial Services, Institute for Family Health

The Institute for Family Health is a freestanding Federally Qualified Community Health Center network dedicated to developing innovative ways to provide primary health services to medically underserved populations based on the family practice model of care. Founded in 1983, the institute operates 16 full-time health centers and 9 part-time centers in Manhattan, the Bronx, and the Mid-Hudson Valley of New York State. All centers provide a full range of primary medical care and mental health services.

In 2002, the institute implemented an electronic health record and practice management system in all of its practices, becoming the first freestanding ambulatory care network in New York and one of only a few nationally to have a fully integrated EHR system. Since 2003, the institute has been completely “paperless,” and all chart notes, clinical data, and patient information are stored within the EHR system. The full integration of the EHR system presents unparalleled opportunities for assessment, data collection, and monitoring to promote quality improvement. It has also significantly improved the integration of care provided to patients who access both medical and mental health services.

IMPROVING CLINICAL CARE

The implementation of an EHR system is a huge developmental milestone for any organization, but it offers unique opportunities for those who are creating or practicing integrated models of care. Although it was originally designed for medical healthcare delivery, the EHR is ideal for an integrated setting that includes behavioral healthcare. Through the ongoing advancement of both EHRs and integrated care systems, most EHR models are now compatible with behavioral healthcare. The creation of behavioral health user groups to share tools and development strategies, as well as the development of electronic intake and assessment tools within the EHR, is increasing both efficiency and ease for behavioral health providers.

Using assessment measures in the EHR creates quantifiable ways to communicate behavioral health information to primary care providers. At the institute, the results of such tools as the Patient Health Questionnaire depression screening tool or the Generalized Anxiety Disorder Assessment are entered in the EHR as a lab value, which allows mental health providers to track patient success in treatment. “Flagging” these results in the EHR alerts other interdisciplinary care team members to the patient’s results. The sharing of such information among disciplines not only is critical to an integrated setting but also is a core component for quality care.

STREAMLINED FINANCIAL MANAGEMENT

Implementation of the EHR at the institute has positively enhanced management’s ability to supervise providers and programs, measure outcomes, monitor quality and revenue, and extract data for proposals and reports. In an integrated care model, it is imperative that, in addition to the medical record itself, the EHR encompass registration, billing, and reporting systems. This structure promotes a more
The EHR permits patients to be seen at any institute location, because their entire chart can be accessed from any institute center. Providers can use the EHR to review patient records, create and send provider messages, and manage patients from any organization location. Records can also be accessed remotely through a virtual private network, thereby enabling providers who are on call to retrieve records in an emergency.

**IMPROVING DATA COLLECTION**

Another valuable use of the EHR for the institute has been the ability to extract data and create reports that have enabled managers to better understand program utilization. Productivity data that can be broken down by center, program, or provider have been a useful tool for individual provider evaluations and understanding program viability. The ability to extract data on a specific service delivery, medication, or diagnosis has given a comprehensive picture of the patient population and its service utilization. Grant proposals and reports to funders are based on accurate data extracted from the system for specific time periods and can be sorted to meet the requirements of each proposal. In a time of fiscal hardship, the capability to compete for funding is critical; an EHR can provide numerical substantiation and the ability to record and track services provided for a particular initiative.

The institute has developed a unique field within patient electronic charts for documenting all special grant programs and services; options enable customized reports for funders and management. This field enables clinicians to document enrollment and services provided during a visit. For example, patients seen in a Ryan White HIV program might have a note that states, “RW escort visit.” At the end of a reporting period, a report can be generated that counts all the RW escort visits. This process documents specific program services without generating paper tracking logs, thereby decreasing the staff time spent gathering data and creating reports.

**MAXIMIZING REVENUES**

The EHR can also be a valuable tool for generating revenues. It can help attract new patients who are interested in the benefits of an EHR, and it permits the tracking of referral sources or patient zip codes. These uses can allow for a better understanding of new patient flow and support marketing efforts or strategic planning. EHRs can lead to opportunities to obtain grants for quality improvement projects or research that requires intensive data tracking and monitoring. Most important, the EHR can help decrease payment denials and maximize billing revenue. The Institute for Family Health, like many integrated organizations, struggles with the complexity of billing with multiple state and private payers and the need for authorizations. To obtain behavioral health payments, providers often must complete outpatient treatment reports. An EHR with a financial system can remind providers when OTR reports are due or authorizations expire.

The EHR can be programmed to flag visits that might be denied by payers for missing or incorrect information, so the paperwork can be corrected prior to being sent out for payment. The institute has been able to dramatically increase payments for mental health services and to provide denial and collection information to managers to better manage service delivery and recoup costs.

**IMPLEMENTATION CHALLENGES**

Legitimate concern exists about the future of integrated care models if health organizations transition to EHRs without the inclusion of behavioral health. Instead of resisting integrated charts and the use of a computer to document therapeutic care, behavioral health managers need to view EHR implementation as an enormous opportunity to promote improved quality of care. Although many analysts view EHRs as the “medicalization” of mental health services, EHRs can actually aid in the success of a mental health program while protecting the sanctity of a mental health session.

The implementation of an EHR is not without difficulty, of course. EHRs are in a state of perpetual development and require ongoing attention, provider training, and resources. The ability to master an electronic system and to think the way an EHR system thinks can be difficult for people who do not regularly use computers. The implementation of an EHR system may influence hiring decisions toward people who are able to adapt to computerized documentation.

These difficulties, however, can be overcome with proper planning; they should not be used to prevent the investment in and ultimate success of an EHR within an integrated health system. The advancement and tracking of outcomes, along with the expansion of quality improvement, research, and funding opportunities made possible with an EHR, can revolutionize a behavioral healthcare delivery system and mainstream integrated care models.

DID YOU KNOW? ➤

A Bazelon Center for Mental Health Law report, “Get it together: how to integrate physical and mental health care for people with serious mental disorders” points out that persons with serious mental illnesses

- Have high rates of comorbid medical problems
- Are twice as likely to have multiple medical disorders
- 42% had at least one chronic physical illness severe enough to limit daily functioning
- The detection of physical health problems is poor

Virna Little, PsyD, LCSW, SAP is Vice President for Psychosocial Services at the Institute for Family Health in New York, New York. She has worked in the field of healthcare and behavioral health for more than 20 years. Little has been with the institute for 13 years and assists organizations that are implementing integrated models of care.
Ensuring Patient Safety through Medication Management

Charles Klein, PhD, Vice President, Clinical Services and e-Prescribing Operations, Netsmart Technologies

Lack of knowledge about patients’ medication at transition points of care such as admission, transfer, and discharge is a key source of adverse events. Prescribers who can access critical information about their patients’ current and past medications from pharmacy benefit managers and community pharmacies are better informed about patients’ potential medication issues and can improve safety and quality.

The integration of behavioral and primary care is a strong, emerging trend that will continue to grow, especially in light of the recently adopted mental health parity legislation, reports revealing high rates of morbidity and mortality among persons with serious mental illness, and general convergence trends in healthcare.

One of the most significant patient safety factors associated with this trend toward integration is the need for correct reconciliation of a patient’s medications and medication history. The Institute of Safe Medication Practice estimates that 50 percent of medication errors and 20 percent of adverse medical events could be eliminated with proper medication reconciliation. The Massachusetts Coalition for the Prevention of Medical Errors believes that the lack of knowledge about patients’ medication at transition points of care (e.g., admission, transfer, discharge) is a key source of adverse events.

In many cases, there is also the risk of polypharmacy — overlapping medications prescribed by multiple providers. Exacerbating the risk of polypharmacy are the differing nature of medications between primary and behavioral healthcare and the fact that people who are severely mentally ill often take multiple classes of medications.

The Joint Commission on the Accreditation of Hospital Organizations, the entity that accredits and certifies more than 15,000 healthcare organizations and programs in the United States, has as a goal to “accurately and completely reconcile medications across the continuum of care.” A subset of that goal instructs organizations to develop a process for obtaining and documenting a complete list of the patient’s current medications upon admission to the organization. Part of this process involves comparing the medications provided by the organization with those on the patient’s medication list. Another part involves communicating the complete list of the patient’s medications to the next provider of service when the patient is referred or transferred to another setting, service, provider, or level of care within or outside the organization.

Continued on page 58
Behavioral Health Benchmarking:
- Clinical Measures
- Operational Measures
- Financial Measures

Regional and National Benchmarking:
- Benchmarking partnerships with state and national entities

Best Practices:
- Unique and innovative “process benchmarking” model

Performance/Outcomes Management:
- Strategy-driven performance management process helps transform data into information

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E-Prescribing

Electronic prescribing and effective medication management can facilitate this sharing of information between primary care and behavioral health providers, including consideration of the unique and differing medication requirements in behavioral health. The Pharmacy Health Information Exchange Network, operated by SureScripts-RxHub, offers certification in transmitting prescriptions electronically. It further provides certification of the ability of pharmacies to send and of providers to receive medication data for a given patient, regardless of who prescribed the medications or where they were prescribed. Pharmacy software systems, prescribing software systems, and electronic medical records can be certified for this functionality.

With patient consent, SureScripts-RxHub provides patient medication history information across providers through electronic prescribing and electronic health records that are certified for the medication history service. The service is made possible by SureScripts-RxHub’s ability to securely access and aggregate patient medication history data from community pharmacies and pharmacy benefit managers. Prescribers who can access critical information about their patients’ current and past medications from pharmacy benefit managers and community pharmacies are better informed about patients’ potential medication issues and can improve safety and quality.

If you are considering implementing an e-prescribing system, note that not all medications may be available for review. For example, if a patient refuses to allow a pharmacy to share his or her data, the information cannot be sent. And if a patient refuses to allow a provider to view the data, the information cannot be received. In addition, federal laws prohibit some medication information from being shared, and some states have passed laws limiting the data that can be shared.

E-prescribing and medication management will play an increasing role in the integration of behavioral health and primary care, boosted by financial incentives such as those in recent Medicare legislation and anticipated Medicaid incentives. By using the technology available through e-prescribing and electronic health records, and by asking your consumers and their caregivers about medications, you will be in a much better position to know how they are being treated across the continuum of care and can provide the safest possible care.

Founded by the pharmacy industry in 2001, SureScripts® operates the Pharmacy Health Information Exchange™, which facilitates the secure electronic transmission of prescription information between physicians and pharmacists and provides access to lifesaving information about patients during emergencies or routine care. Working collaboratively with health plans, health systems, technology vendors, and health policy leaders, SureScripts is committed to improving the safety, efficiency, and quality of the prescribing process.

The National Council for Community Behavioral Healthcare has partnered with Netsmart Technologies to bring e-prescribing solutions to members through InfoScriber—a SureScripts Certified Solution™. InfoScriber is a secure, Web-based prescribing and medication management system that can be operated stand alone or integrated with existing practice management and clinical systems.

Learn more at www.TheNationalCouncil.org (Click on Resources and Services and E-Prescribing).

Charles Klein has more than 18 years experience in the behavioral health field directing inpatient and outpatient child, adolescent, and adult programs as well as consulting in areas such as clinical documentation, performance improvement, and organizational development. He has developed and implemented clinical outcomes measurement systems and directed the start-up of many behavioral health day treatment programs for persons with serious and persistent mental illnesses. At Netsmart Technologies, Klein works in the area of clinical services, participating in customer workflow issues, clinical gap analyses, and prescription and medication management processes.

VOICES

“Mental health has been late to the dance in terms of looking at the connections between mental health and physical health. It may be moot what you’re doing for mental health needs if people are dying so early from physical causes.”

Bob Glover, Director of NASMHPD, in TIME Magazine, December 3, 2008
“So much more needs to be done”

—Dr. Paul Janssen

That’s why we continue to define ourselves by Dr. Paul Janssen’s vision. To keep going beyond medication to discover new, real-life solutions that change the way the world looks at mental health.

It can be patient advocacy, educational programs, new treatments, or community outreach—when it comes to enabling every person to have a healthy mind, **WE WILL** never stop doing more.
Resources for Healthcare Collaboration

NATIONAL COUNCIL CONFERENCE
The 39th National Council Conference in San Antonio, Texas, April 6–8, 2009 features a robust Health Promotion track that brings together best practices from provider organizations and experts in primary care and behavioral health integration. We cover the gamut, from financing models to dealing with cultural challenges. Whether you're just getting into integration or you're further down the road, this is where you’ll find new directions and ideas. The Health Promotion track also features prevention, early intervention, and consumer health and wellness.

Topics include:
>> Mental Health First Aid Instructor Certification
>> National Council’s Behavioral Health and Primary Care Boot Camp
>> Depression Management in Community Behavioral Health: Could It Improve Outcomes?
>> Healthcare Homes: The Building Blocks of Healthcare Reform
>> When Behavioral Health and Primary Care Cultures Don’t Align
>> Can We Prevent Schizophrenia?
>> Disease Management for Serious Mental Illness: Team Solutions
>> Helping Staff and Consumers Quit Smoking

Handouts will be available at www.TheNationalCouncil.org/Conference.

NATIONAL REGISTRY
Across the country, organizations are operating integrated, collaborative, and colocated behavioral health and primary care services. Help us find out who’s doing what and how they are doing it. The National Integrated Health Sites Registry hosted by Washtenaw Community Health Organization and the University of Michigan and supported by the National Council for Community Behavioral Healthcare and 15 foundations from across the country.

Registering with this national resource helps you
>> Gain access to a full online listing of sites across the country doing collaborative/integrated care.
>> Receive support from others in developing the services you need.

>> Create linkages to programs like yours where you can get immediate consultation on emerging problems.
>> Participate in research to turn integrated health into an evidence-based practice.

www.ewashtenaw.org/government/departments/wcho/INTEGRATED HEALTH PRACTICE-BASED RESEARCH NETWORK
The Washtenaw Community Health Organization and the University of Michigan Department of Psychiatry recently joined seven community- and hospital-based primary care clinics to form “The Integrated Health Practice-Based Research Network.” This PBRN is a first of its kind, focusing on the integration of primary care and mental health/substance use disorders treatment services for “public patients” (Medicaid, indigent and underserved or uninsured populations). The mission is to improve the health of persons with, or at risk for, severe mental and physical health conditions through cross-site collaboration and research that identifies evidence-based and cost-effective approaches to fully integrated care.

PBRNs have proven to be a powerful tool that has helped clinicians and researchers to learn together
how best to investigate new practice interventions and ways of bringing about organizational change. An example is the primary care Practice-Based Research Network, developed and supported by the Administration for Healthcare Research and Quality to engage clinicians in quality improvement and research activities. Central to the mission of all PBPRNs is the goal to involve practicing clinicians in asking and answering clinical and organizational questions critical to healthcare quality improvement.

To learn more and join the Integrated Health PBPRN, contact Jeff Capobianco, Washtenaw Community Health Organization at capobia@washtenaw.org

BOOKS

Raising the Bar: Moving Toward Integration of Healthcare, published by the National Council for Community Behavioral Healthcare and authored by Donna Sabourin, MA, LLP and Kathleen Reynolds, LMSW, ACSW, is the classic guide to primary care and behavioral health integration, and reflects successes in implementing integrated healthcare for consumers of publicly funded behavioral health and primary care services.

This book offers an inside look at Washtenaw Community Health Organization’s journey in integrating behavioral health and primary care services. This collaborative effort harnessed support from many different stakeholders to create successful, thriving services that offer better care for consumers.

This publication will serve as a guide for your integration efforts. It presents an overview of research that supports the case for primary care and behavioral health integration, the financial implications of undertaking this type of project, and how to overcome identified barriers. Appendices provide survey samples, work plan tools, and model agreements to help you launch a similar initiative in your community.

https://store.thenationalcouncil.org/

REPORTS


This report from the Hogg Foundation for Mental Health summarizes various approaches to integration and what is known about their effectiveness, describes integrated programs in Texas and nationally, and identifies resources to help with developing and implementing integrated care systems.

www.hogg.utexas.edu/programs_RLS15.html

Obesity Reduction & Prevention Strategies for Individuals with Serious Mental Illness

This National Association of State Mental Health Program Directors report makes specific recommendations that, when implemented, should substantially reduce the weight and improve the overall health of a population with SMI.

www.nasmhpd.org/publicationsmeddir.cfm

Integration of Mental Health/Substance Abuse and Primary Care

This report from the Agency for Healthcare Research and Quality describes models of integrated care used in the United States; assess how integration of mental health services into primary care settings, or primary health care into specialty outpatient settings impacts patient outcomes; and describe barriers to sustainable programs, use of health information technology, and reimbursement structures of integrated care programs within the United States.

www.ahrq.gov/clinic/tp/mhsapctp.htm

Morbidity and Mortality in People with Serious Mental Illness

This report from the National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council reveals that persons with mental illnesses die 25 years younger than the general population, largely due to chronic medical conditions. The findings clearly point to the need for increased public funding and support to give mental health centers the capacity to identify physical illnesses and ensure that patients have access to lifesaving treatments.


Get It Together: How to Integrate Physical and Mental Health Care for People with Serious Mental Disorders

This Bazelon Center for Mental Health Law report examines model programs for improving integration and coordination of behavioral health and primary health services for adults and children with serious mental disorders who rely on the public mental health system for their care. It summarizes findings of a series of studies and offers recommendations for policymakers.

www.bazelon.org/publications/index.htm

EDUCATION

The Department of Family Medicine and Community Health, University of Massachusetts Medical School, offers a Certificate Program in Primary Care Behavioral Health for licensed mental health professionals who want to learn to work as primary care behavioral health providers. Schedules for fall and spring 2009-2010 are now available.

www.integratedprimarycare.com

Essential Learning offers customized course libraries on healthcare, behavioral health, and corporate compliance for community behavioral health centers and community health centers. Courses meet Joint Commission standards and offer continuing education for nurses and clinical staff.

www.essentiallearning.com

2009 WORLD MENTAL HEALTH DAY, OCTOBER 10

Theme — Mental Health in Primary Care: Enhancing Treatment and Promoting Mental Health

The release in September 2008 of Integrating Mental Health Into Primary Care: A Global Perspective by the World Health Organization and the World Organization of Family Doctors signaled a major step in fostering a global effort to integrate mental health into primary care. The 2009 World Mental Health Day global awareness campaign will address the continuing need to “make mental health issues a global priority” and will emphasize the all too often neglected fact that mental health is an integral element of every person’s health and well-being. Campaign materials will assist the grassroots – patients and consumers, family members and caregivers, and advocacy organizations around the world to plan their local and national WMHDay activities for October 10.

One of the primary advocacy concerns to be addressed by this year’s campaign is the danger that adequate and effective diagnosis, treatment, and recovery of people living with mental illnesses will not receive a parity-level priority within the general and primary healthcare system.

WMHDay 2009 will also highlight the opportunities and the challenges that integrating mental health services into the primary healthcare delivery system presents for people living with mental disorders and poor mental health, to their families and caregivers, and to healthcare professionals.

The World Federation for Mental Health established WMHDay in 1992 and coordinates and promotes its annual commemoration on October 10. It is the only annual global awareness campaign to focus attention on specific aspects of mental health and mental disorders and is now celebrated in more than 100 countries through public awareness and education events.

Organizations that want to receive a 2009 WMHDay campaign materials packet should contact Deborah Maguire, Director, Global Awareness and Information Services, World Federation for Mental Health at dmaguire@wfhm.com.

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The e-Prescribing partner of the National Council for Community Behavioral Healthcare, Netsmart’s InfoScriber e-Prescribing solution is designed specifically for the unique requirements of behavioral health. With InfoScriber, you can reduce medical errors, improve efficiencies and take advantage of the new Medicaid/Medicare incentives for electronic prescribing.

Netsmart is the leading provider of electronic health record, practice management, e-Prescribing, e-Learning and connected care technologies to the largest community of behavioral health providers.

The mission of the National Council for Community Behavioral Healthcare is to champion opportunities and advance its members’ ability to deliver proactive and holistic healthcare services.
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- Have no prescription drug coverage (public or private)
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Families of six or more and residents of Alaska and Hawaii should contact Together Rx Access at 800-250-2839 for household income information.

To order a supply of Together Rx Access quick start savings cards, visit togetherrxaccessonline.com/order.

† Each cardholder’s savings depend on such factors as the particular drug purchased, amount purchased, and the pharmacy where purchased. Participating companies independently set the level of savings offered and the products included in the Program. Those decisions are subject to change.

‡ Visit TogetherRxAccess.com for the most current list of brand-name medicines and products.

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