New implementation tool helps make integrated primary and behavioral healthcare programs a reality for people with severe mental illness

— by Paul M. Kubek

Portsmouth & Cleveland, OH—There is an increasing awareness in the United States that people with severe mental illness are likely to die 25 years earlier than people in the general population who do not have a mental illness. It’s an alarming statistic that becomes even more startling when you learn that these fatalities occur mainly because of chronic medical conditions—like lung disease, heart disease, obesity, diabetes, and infections—most of which can be prevented, treated, or managed. The illnesses contribute more to premature deaths among people with severe mental illness than suicide.

Many service providers in mental health centers and hospitals have witnessed this reality first hand for years. They have been frustrated by the lack of integration with primary care systems and physicians in their communities and have been eager to do something about

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Development of the new Integrated Treatment Tool has been shaped not only by research but also by the real-world experiences of administrators and practitioners in the community.

Shawnee Mental Health and the CEBP have teamed up in a university-community partnership to create a new instrument called the Integrated Treatment Tool, a 30-item planning and evaluation document which guides an organizational change process that facilitates the integration of primary and behavioral healthcare services. In fact, the collaborators have used the tool to develop and assess primary care facilities and services within Shawnee Mental Health Center, which is located in three communities in southern Ohio. Shawnee serves Lawrence, Scioto, and Adams counties—three of the poorest, most rural Appalachian regions in the state—with a broad range of comprehensive psychiatric services for children and adults. It serves approximately 5,000 people each year.

THE IMPLEMENTATION TOOL
Development of the new Integrated Treatment Tool and the new primary care facilities and services in southern Ohio is funded by a grant that Shawnee Mental Health Center received from SAMHSA's Primary and Behavioral Health Care Integration (PBHCI) Program. The program was established to improve the physical health status of people with mental illness. It awards up to $500,000 per year for up to four years.

Since 2009, the SAMHSA program has awarded grants to 64 organizations, five of which are in Ohio. Shawnee was among the first. It received a supplemental grant from SAMHSA in 2011 to enhance its use of health-information technology, such as electronic medical records and electronic billing. It also received a grant from the Health Foundation of Greater Cincinnati in 2007, which essentially got the whole project started.

The leadership team at Shawnee chose the Center for Evidence-Based Practices at Case Western Reserve University for the integrated healthcare project because of its track record with providing technical assistance (consultation, training, and evaluation) for service innovations. Since 1999, the Case Western Reserve Center—and its two Ohio Coordinating Center of Excellence (CCOE) initiatives—has worked with over 60 community-based organizations and hospitals in Ohio, all state-operated psychiatric hospitals, and multiple sites in other states. The Center provides technical assistance for the following:

- Integrated Dual Disorder Treatment (IDDT)
- Tobacco: Recovery Across the Continuum (TRAC)
- Supported Employment/ Individual Placement and Support (SE/ IPS), the evidence-based practice
- Motivational Interviewing (MI), the evidence-based treatment
Dual Diagnosis Capability in Addiction Treatment (DDCAT)
Dual Diagnosis Capability in Mental Health Treatment (DDCMHT)
Benefits Planning
Integrated Primary & Behavioral Healthcare (IPBH)

Since 1999, the Center has helped Shawnee implement several of these service models and strategies.

Informed by Research & Community Practice
Leadership for the new Integrated Treatment Tool was provided by Debra Hrouda, MSSA, LISW-S, director of quality improvement at the Center for Evidence-Based Practices. Hrouda has almost 30 years of experience as a clinician, administrator, researcher, and evaluator. She has provided leadership for other university-community partnerships, including the development and implementation of “Tobacco: Recovery Across the Continuum” (TRAC), a service model that promotes and supports tobacco cessation among people with severe mental illness. It is an integral part of primary care services.

Hrouda explains that the Integrated Treatment Tool is built with relevant components from TRAC, IDDT, and SE, as well as with components described in research literature and in emerging national standards and guidelines, such as those of the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH). The new tool also includes components identified by the project team during the implementation process itself. Members of the Shawnee management team helped suggest enhancements to and edits of the instrument while they were using it. In other words, the tool has been shaped not only by research but also by the real-world experiences of administrators and practitioners of both primary health and behavioral health in the community. The tool now includes 13 organizational components, 10 treatment components, and 7 care coordination and management components (see Integrated Treatment Tool sidebar).

“This has been a three-year process,” Hrouda says. “The experiences in the field at Shawnee have been incredibly valuable. The team at Shawnee has made this tool that much stronger.”

A Change Tool, Not a Fidelity Scale
According to Hrouda, the Integrated Treatment Tool is structured like and designed to be used like a fidelity scale by implementation committees and teams. However, she emphasizes that the new tool is not a fidelity scale, because it is not a product of an evidence-based practice.

Debra R. Hrouda, MSSA, LISW-S, director of quality improvement at the Center for Evidence-Based Practices
“It’s an organizational change tool,” she says. “It’s a set of clinical and organizational components. It provides guiding principles and a structure. It’s a planning and evaluation document that defines the ideal in integrated care. Right now, there’s no research evidence to show that the combination of ideals will get you the best outcomes. We will be working to develop this knowledge over the next several years. However, it has produced some impressive results already.”

**Ongoing Quality-Improvement Process**

Using the Integrated Treatment Tool typically includes four main activities: conducting an initial needs assessment and baseline assessment; periodically reviewing the progress of implementation (which includes identifying facilitators and barriers to implementation); planning next steps; and revising the formal action plan for continuous quality improvement. Each activity usually has multiple steps, especially the action plan, which is essentially a sophisticated to-do list for ongoing systematic evaluation of what is being accomplished, when it is being accomplished, and by whom.

Since 2009, Hroudah has helped Shawnee’s implementation management team use the new tool to conduct three formal, comprehensive reviews of their evolving integrated services. The most recent review took place in March 2012. Each review has been followed by an implementation report and action plan.

**IMPRESSIONS OUTCOMES**

Among the most important achievements thus far has been the creation of primary care facilities and services that are truly integrated within Shawnee Mental Health Center and its offices in three different counties in southern Ohio (see “Healthcare Home at Shawnee” section on page 6). In addition, there are some emerging statistics. Shawnee reports that in 2007, before the start of this project, more than 40 percent of the people they served did not have a primary care physician and typically sought medical care at emergency rooms. Also, preliminary outcomes suggest that Shawnee’s primary care services are having a positive impact upon consumer health, including the following:

- Losing weight
- Reducing and quitting tobacco use (smoking cessation)
- Lowering blood pressure
- Lowering hemoglobin A1c levels (an indicator used in the management of diabetes)

**START WITH INCREMENTAL CHANGE**

According to Patrick E. Boyle, MSSA, LISW-S, LICDC, director of implementation services at the Center for Evidence-Based Practices, the Substance Abuse and Mental Health Services Administration (SAMHSA) has expressed a lot of interest in the new Integrated Treatment Tool, because it is needed and unique.

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**OHIO HEALTH HOMES**

Leaders of Ohio’s health and human services agencies believe that better care coordination can result in improved health outcomes while spending less of the taxpayer's dollars. Ohio Medicaid has teamed up with the Ohio Department of Mental Health to focus on creating health homes for individuals on Medicaid who have serious and persistent mental illness (SPMI).

**Learn more:**

http://mentalhealth.ohio.gov/what-we-do/protect-and-monitor/medicaid/health-home-committees.shtml
“This tool could have a national impact,” Boyle says. “Researchers and policymakers have been writing about what integrated services should look like. However, they have not been talking about the nuts and bolts, the how-to. This tool gives providers a framework and a guide to implement a very complicated process.”

Boyle explains that the Center for Evidence-Based Practices will use the new Integrated Treatment Tool to help organizations in Ohio and throughout the country begin the process of integrating primary healthcare into services for people with behavioral healthcare issues (e.g., serious mental illness and co-occurring substance use disorders). In fact, members of Shawnee’s management team insisted that the new tool be designed for this purpose—not just for them but for any organization that wishes to do this work. They also wanted it to be flexible, so it could be used with other models of primary care integration.

Boyle adds that if an organization is not able to embed primary care within its behavioral health facilities and services as Shawnee has done, the tool is still relevant and useful, because it helps organizations achieve important incremental goals, which, over time, add up. It’s an approach at the heart of the technical-assistance services provided by the Center for Evidence-Based Practices.

“This stage-wise approach is important,” Boyle says. “It sets a realistic, manageable pace for achieving and sustaining change and improved outcomes over time. It identifies organizational components and clinical services that are most important for the organization to change and grow.”

The success is also built upon the quality of its multi-disciplinary staff, which includes consultant-trainers, evaluators, and researchers from the fields of social work, psychiatry, community mental health, chemical-dependency treatment, and vocational rehabilitation. Staff members have many years of experience as direct-service providers, team leaders, program managers, and administrators. The Center is a partnership between the Mandel School and Department of Psychiatry.

“Our niche is the implementation process,” Ronis says. “There are a lot of people who write articles about implementation from a theoretical perspective. Our consultants and trainers are out there in the community doing it. We are positioning ourselves to be a positive resource in this new era of integrated primary and behavioral healthcare. We are inspired by the opportunities.”

Kola adds that the university-community partnership between Case Western Reserve and Shawnee Mental Health Center exemplifies one of the primary strengths of the Mandel School and Department of Psychiatry. Both are dedicated to applied research and evaluation, developing and disseminating new practice-based knowledge, and educating and training health and behavioral health professionals to be leaders who respond constructively to contemporary challenges.

“The new tool was developed in this tradition,” Kola says. “Although the tool has not been empirically validated, it has face validity because it was created in collaboration with an agency that has been using it now for three years. The collaborators from our Center and from Shawnee were very deliberate and thoughtful and precise about the items they chose to include in the tool. Ultimately, I think this will be an instrument of value to many organizations across the nation that want to put together a top-notch program of integrated care for people with severe mental illness and addictions to alcohol and other drugs.”
HEALTHCARE HOME AT SHAWNEE

Shawnee Mental Health Center is building its primary care facilities and services with the new Integrated Treatment Tool while referencing an outpatient model of care called the person-centered healthcare home. Ideally, this is a single physical location which provides both primary and behavioral healthcare within a single structure, such as a community mental-health center or substance-abuse treatment center. While Shawnee chose to implement this version of the healthcare home, some organizations choose another approach. For instance, they will partner with an external healthcare provider, such as a Federally Qualified Health Center (FQHC) or a local hospital’s outpatient clinic.

We have included below highlights of Shawnee’s integrated healthcare initiative. It includes an outline of the administrative resources, clinical resources and services, and achievements in ongoing organizational change:

**Administrative Resources**
- Certified by Ohio Department of Mental Health (ODMH) as a provider of mental health services
- 2 staff trained in medical coding & billing (ICD & CPT codes)
- In-house billing services
- Applied for and received certification for primary-care reimbursement from Medicaid, Medicare, and various private insurance companies, including Ohio’s Medicaid HMOs
- Accredited by CARF
- Electronic medical records for behavioral healthcare
- Electronic medical records for primary healthcare
- Prescription registry tracking system developed within the electronic medical records system

**Clinical Resources**
- 5 exam rooms in three locations (counties)
- 3 Licensed Practical Nurse (LPN) care managers (one in each county)
- 3 part-time wellness coaches (one for each county)
- 1 supervising physician onsite one-half day each week, who provides direct services in addition to consultation and supervision
- 2 full-time nurse practitioners

**Clinical Services**
- Integrated screening and assessment for
  - Body mass index (BMI)
  - Blood pressure

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Members of the Primary Care Team at Shawnee Mental Health Center

*From left to right:*
- Elizabeth Winters, wellness coach
- Janie Haas, integrated care administrative assistant
- Lisa Poorman, nurse practitioner
- Andrea Ryan, nurse practitioner
- Karen Stidham, nurse care manager

Along the riverfront—Portsmouth, Ohio.
• Glucose
• Cholesterol
• Tobacco use
• Personal and family health history
• Physical fitness history
• Annual assessments (especially for those who are prescribed psychiatric medication)
• Referral letters to physicians (with consumer consent) that describe results from screening and assessment
• Basic primary care
• Immunization clinic for at-risk consumers
• Prescription services via Allscripts, a free web-based prescribing system
• Medical Hotline, an after-hours system for primary care services (to prevent unnecessary emergency room visits)
• Tobacco interventions (smoking cessation)

Peer-Based Wellness Services
• Consumers hired as wellness coaches
• Wellness planning & support (e.g., accompany consumers to doctor appointments)
• Nutrition program

• Fitness programs (e.g., walking club, Wii Fit club)
• Gym memberships
• Vegetable garden developed and managed by consumers

Ongoing Organizational Change
• Reviewing reimbursement rates, claims denials, and other financing practices to help determine the appropriate service mix and number of encounters needed to sustain the services
• Advocating for the State of Ohio to recognize services of wellness coaches and nurse care managers as billable (this occurs in several other states)
• Exploring the feasibility of becoming a Rural Health Clinic and establishing an in-house pharmacy
• Transitioning to a better integrated electronic health record
• Working with the regional extension center to become involved with the statewide health information exchange
We wanted to share some insights directly from the organization that has been using the Integrated Treatment Tool to implement integrated primary and behavioral healthcare in Lawrence, Scioto, and Adams Counties, Ohio, so we asked Executive Director Don Thacker and Integrated Care Project Director Cynthia Holstein at Shawnee Mental Health Center to answer a few questions.

Q: Our readers will be interested in your experiences with the Integrated Treatment Tool, as well as the implementation review process. Why are they useful?

A: The Integrated Treatment Tool and the review process help us focus on areas of our integration that need to be strengthened. This, in turn, enhances care, access to care, and outcomes. The tool and review process help us identify areas that we may not have considered as necessary for a strong program. Examples include written procedures and policies and communication protocols. The review process gives us the opportunity to step back from our daily routines and assess ways to improve. It enables us to actually schedule time to do this.

Q: What has been your biggest lesson learned during implementation of integrated primary and behavioral healthcare services? What was the challenge, how did you respond, what has been the outcome?

A: Simply putting two types of services in one location does not result in integrated care. Each discipline (primary healthcare and behavioral healthcare) has a very distinct culture and different approaches to treatment. For us, putting them together under the same roof resulted in some culture clashes. The practitioners from each discipline did not have an understanding of why the other did things as they did. As a result, we have provided a lot more training to staff members than we anticipated, and we continue to offer training to help merge these two cultures. The goal is to develop a better understanding of each other’s strengths. This is not an overnight event but an ongoing process.

MORE FROM SHAWNEE

Cynthia Holstein, integrated care project director at Shawnee Mental Health Center, published a project update in the magazine of the National Council for Community Behavioral Healthcare in 2010.


- http://www.thenationalcouncil.org/cs/about_us/national_council_magazine
Q: How has implementation enabled clinicians to engage and develop relationships with clients who, in the past, have been difficult to engage?

A: We recognized early that clinicians from both disciplines needed to learn methods of consumer engagement, so we began to offer training sessions on Motivational Interviewing (MI), the evidence-based treatment. We have been implementing this engagement method for several years and are offering group training plus consultation for staff to reinforce skills acquired during the training sessions. Our goal is to grow a group of MI mentors who will be available to help newly hired staff acquire and utilize this effective engagement technique.

Q: What advice would you give to other community-based organizations that want to begin the process of integrating primary and behavioral healthcare services?

A: Check out different models. What might work for one organization may not work for yours. Explore the pros and cons of partnerships with Federally Qualified Health Centers (FQHCs) and the pros and cons of hiring your own primary care staff. Here are two important questions to ask. Would your consumers seek physical healthcare services at your facility? What types of services do your consumers want?

You will also need to determine the type of space needed, as well as equipment, supplies, skill-sets of staff members, billing processes, and more. Also, explore the availability of funding from a charitable foundation. Start with a planning grant to help determine consumer need and desire for these services. Also determine if there is organization-wide support to pursue and support this new integrated service. Use the planning grant to visit other organizations that provide integrated care to learn about their successes and challenges. Should you decide to take the next step, seek several years of foundation funding to help set the program in place. Take the time to find additional funding sources.

Q: What advice would you like to give to other community-based organizations that want to accomplish what you have?

A: Although you can never do enough planning, at some point you just have to go for it. However, your top management must be married to the vision. Integrating care takes a lot of work from all departments (i.e., support staff, clinical staff, billing, administration). It has to become a part of your agency’s mission. We have learned a lot through trial and error. Develop collaborations and partnerships. Reach out to colleges, universities, local gyms, and health departments, among others.
A report from the National Association of State Mental Health Program Directors (NASMHPD) in 2008 has contributed to the growing national attention of health disparities among people with severe mental illness. The report identified major risk factors and medical conditions experienced by people with serious mental illness.

### Risk Factors

The NASMHPD report highlights several common contributors to chronic health conditions and poor health outcomes which can be addressed in an integrated primary and behavioral healthcare setting:

- Tobacco use
- Poor nutrition
- Lack of exercise
- Obesity
- Substance abuse
- Side effects of psychotropic medication (e.g., weight gain, metabolic problems such as high cholesterol and diabetes)
- Poverty
- Social isolation
- Inadequate access to quality medical care (primary and preventative)

### Medical Conditions

The report also emphasizes that chronic health conditions, such as those listed below, contribute more to premature death among people with severe mental illness than suicide:

- Infectious diseases
- Liver disease
- Pulmonary (lung) disease
- Cardiovascular (heart) disease
- Hypertension
- Diabetes
- Dental disorders (a common source for infections, including those that affect the heart)

**Source:**


**Learn more:**

COGNITIVE IMPAIRMENTS & PRIMARY HEALTH

There are many factors that contribute to poor health among people with severe mental illness and substance use disorders, but it is important to consider the impact of symptoms of these disabilities.

Symptoms often inhibit cognition and, thus, a person’s ability to understand health information and how it might apply to his or her personal situation. Also, symptoms often inhibit social cognition and, thus, a person’s ability to engage in meaningful relationships with healthcare professionals, especially during the difficult (often intrusive and sometimes traumatic) processes of screening, assessment, examination, diagnosis, treatment, and rehabilitation. In other words, symptoms often challenge the formation of trusting relationships between patients and healthcare providers—relationships that are necessary for communicating and understanding essential information about illness and health and for discussing, choosing, and participating fully as partners in effective treatment options.

Physicians and nurses who are conscious of and attentive to the potential barriers caused by these impairments (disabilities) are more likely to become partners in healthcare process and help consumers make more informed decisions about their health and wellness. Their abilities to engage patients successfully and develop therapeutic relationships will greatly influence how much or how little the patients will welcome them as healthcare partners.

Primary care services that are integrated within a behavioral healthcare organization—such as a mental health or addiction treatment center—help people participate more actively in the process of maintaining their physical health.

SAMHSA GRANTS

The Primary and Behavioral Health Care Integration (PBHCI) Program was developed in 2009 by the Substance Abuse and Mental Health Services Administration (SAMHSA) with the goal of improving the physical health status of people with mental illness. Since then, SAMHSA has awarded grants to 64 organizations. Grant awards are up to $500,000 per year for up to four years. SAMHSA’s program provides support to communities to coordinate and integrate primary care services into publicly funded, community-based behavioral health settings to achieve the following:

- Improved access to primary care services
- Improved prevention, early identification, and intervention to reduce serious physical illnesses, including chronic diseases
- Increased availability of integrated, holistic care for physical and behavioral disorders
- Better overall health status of clients

Learn more:
http://www.integration.samhsa.gov/about-us/pbhci

NEWS RELEASE

Adults experiencing mental illness have higher rates of certain chronic physical illnesses

According to a recent report by SAMHSA, adults aged 18 and older who had any mental illness, serious mental illness, or major depressive episodes in the past year had increased rates of high blood pressure, asthma, diabetes, heart disease, and stroke. They were also more likely to be treated in emergency rooms and to be hospitalized.

Learn more:
New implementation tool helps make integrated primary and behavioral healthcare programs a reality for people with severe mental illness

Shawnee Mental Health Center in Portsmouth, Ohio has teamed up with the Center for Evidence-Based Practices at Case Western Reserve University to develop one of the first planning and evaluation instruments in the United States that helps organizations integrate primary and behavioral healthcare for people with severe mental illness.

Shawnee is using the new Integrated Treatment Tool to develop and improve primary care facilities and services in its three-county service area. This initiative is funded by the U.S. Substance Abuse and Mental Health Services Administration.

www.centerforebp.case.edu/stories/implementation-tool-for-integrated-primary-and-behavioral-healthcare

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www.centerforebp.case.edu/resources/tools/evidencematters-archive

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