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Wellness & Recovery Toolkit

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I N T R O D U C T I O N

Case Study

John is a 59-year-old man who lives in a group home in Maine. He is tall, wears glasses, and sports a beard. He is shy and gentle with a good sense of humor. Three days a week, he attends a Clubhouse where he goes to the morning house meeting and then helps out in the café or snack bar. On Wednesday night, he attends choir practice at his church where he has made “a lot of friends.” He has a girlfriend at the group home where he lives who “really cheers me up.” He has been attending the Clubhouse for 10 years. He has several mental health diagnoses—clinical depression, bipolar disorder, and obsessive-compulsive disorder (OCD). He has had diabetes for a number of years, is on insulin and has his blood sugar checked daily at the facility where he lives. He recently started using a cane to compensate for a balance disorder, which, prior to using the cane, caused him to fall a lot. He rates his current health as very good and says a new medication for his depression has resulted in him feeling physically and mentally well for the past month. Because of his balance problem, he finds it difficult to exercise. He says he would like to have a salaried job, but because of his health conditions, “I can’t do a lot of things that I used to be able to do.” John does not have a driver’s license. His parents are deceased, and he has some family about an hour away who used to visit him at Christmastime. However, John said he hasn’t seen them for a long time.

(Names and other identifying information have been changed.)

Making the Case

Nationally and in Maine, people with diagnoses of Serious Mental Illness (SMI) die 25 years sooner than people who do not have diagnoses of SMI. They die of chronic diseases and not from their mental illnesses. People with diagnoses of SMI tend to live with more than one other chronic health condition, like diabetes and cardiovascular disease or chronic pulmonary disease (COPD) and arthritis. They also die from vaccine-preventable infectious diseases like the flu and pneumonia.[1]

Maine data shows that:

- 65.4 percent of MaineCare members under age 65, with a diagnosis of SMI, had five or more medical conditions; this compares to 24 percent for MaineCare members with no diagnosis of serious mental illness[2]
- 25 percent have been diagnosed with diabetes[3]
- 37 percent have pre-diabetes or metabolic syndrome[4]

As in the general public, cardiovascular disease causes most of the deaths in the SMI population. There are more deaths from heart disease than from suicide.[5] In Maine, people with SMI ages 18–65 are three times more likely to have coronary artery disease than those without SMI.[6] People with SMI get coronary artery disease at a younger age than those without a mental illness. They are also at greater risk of developing vascular disease because of their high rates of diabetes. Unlike the general population, coronary artery disease rates for men and women with a diagnosis of SMI are equal. In the general population, men have higher rates.

Many people with SMI also have higher rates of behaviors that put their health at risk. When compared to the general public, people with mental illness smoke more, are more overweight or obese, and exercise less. These factors are known to increase the likelihood of developing diabetes, heart disease, high blood pressure and other chronic health conditions.

Maine data shows that:

- 51.9 percent of people age 18–64 with SMI are obese
- 46.9 percent smoke[7]

In a public health framework, people with SMI would be considered a vulnerable, or health disparity, population. The problem would look like this:

Stigma also plays a role in preventing people with SMI from getting the health care they need. Some providers may be reluctant to treat them or may find the time it takes to deal with their more complex health needs too great. By collaborating with primary care, mental health agencies can help reduce stigma for their clients and find primary care physicians who are willing to partner with them.

“We continue to see people show up at the Emergency Department or primary care office and their complaints are dismissed as psychosomatic because they have a mental illness.”

THERE IS HOPE

Many of the health conditions that are associated with death in the United States and premature death in mental health consumers can be prevented and managed with positive health habits. If a person has already developed a chronic disease like diabetes, medication and ongoing monitoring from a trusted health care provider is critical. The level of disability from that chronic disease can be reduced with changes in nutrition, exercise, and other health habits.

THE MAINE MODEL

Six community-based mental health agencies in Maine participated in a three-year project funded by the Maine Health Access Foundation (MeHAF) through a grant to the Maine Department of Health and Human Services (DHHS) Office of Quality Improvement (OQI). They are:

- Common Ties Mental Health Services in Lewiston
- Crisis and Counseling Services in Augusta
- Kennebec Behavioral Health in Augusta
- MaineGeneral HealthReach ACT Team in Augusta
- Motivational Services in Augusta
- Tri-County Mental Health Services in Lewiston

In a fairly short amount of time and with limited funds, these mental health agencies have made tremendous

strides in the following areas:

- Adopting a health screen for consumers with SMI
- Collecting data on consumers' health, exercise, health risk behavior, and relationship to primary care
- Supporting consumers in developing a long-term relationship with a welcoming primary care practice
- Training the mental health workforce on the health status and needs of consumers
- Collaborating with community resources such as the Cooperative Extension Service, Healthy Maine Partnerships, and food pantries
- Setting up diabetes education for staff
- Setting up diabetes education for consumers
- Adapting diabetes education and support models to better fit people with SMI

GIVING YOU SOME TOOLS IN YOUR TOOL BOX

This is a toolkit to help mental health agencies integrate health into their service settings. It addresses the following topics:

- How to bring health and wellness into agency culture
- How to use a health screen to assess people's health status
- How to involve and empower consumers in their health care
- How to link with community resources

It is divided into sections depending on your role within a mental health agency:

- Direct care staff
- Consumers
- Administration

Finally, there is a list of some Maine and national resources and websites.

D I R E C T C A R E

This section is for staff working directly with consumers. You may be:

- A case manager
- A nurse
- A community integration worker
- A clinical director
- An ACT team member
- Nurse practitioner or psychiatrist

- A direct support worker

No matter what your role is, you can play an important part in integrating health into the mental health setting. For many consumers, you are the trusted other. Consumers may be more comfortable with you and at your agency than they are at a primary care doctor's office.

FORM YOUR TEAM

Once you have decided that improving health and wellness within your agency is an important goal, form your team and give it a name. You can be the Health and Wellness team. Or the Integrated Care Leadership team. Giving your team a name will help pull people together and give them a sense of purpose and direction.

"We've found that if we support our employee health and wellness, it creates a huge impact on employee attitude, which in turn supports the clients."

WHO IS ON THE TEAM?

Your team doesn't have to be as large as a football team. Five or six people can do great things!

It is important to have support from your administration in achieving your health and wellness goals. It is important to have consumers involved in your team. It is important to involve staff who works with consumers.

Teams in Maine that have done this work have had the following people on their teams:

- Consumers
- Case managers
- ACT team director
- Clinical director
- Psychiatric nurse practitioner
- Registered nurses
- Peer recovery center director
- Executive director

GETTING STARTED

Once you have your team formed, get together and brainstorm what it is you want to do about health and wellness goals. Come up with a vision. Set some goals. Start small.

Some examples of activities your teams could work on:

Educate staff about the health status of consumers and some of the health risks that they face.

> **Example:** Invite your medical director to talk about the rates of diabetes among people with SMI and the side effects of certain medications that cause weight gain and put people at higher risk for getting diabetes.

Start a health and wellness group for consumers.

Example: Meet with a local diabetes educator and develop a series of classes for consumers about healthy eating, nutrition, and physical activity.

Identify local community resources that may help you achieve your health and wellness goals.

Example: Find out where the closest Healthy Maine Partnership (HMP) is and what activities they offer. Most HMPs are eager to collaborate with mental health agencies in their service areas.

IMPLEMENTING A HEALTH SCREEN

When integrating health into mental health care, it is useful to have a concrete tool to assess consumers' health status and health risk behavior. Using a health screen can be a useful way to achieve this goal.

"Using the screen helped us to focus on consumers' health and to bring up sometimes difficult topics."

WHY HAVE A HEALTH SCREEN AT A MENTAL HEALTH AGENCY?

Having a health screen in place can make it easier for you to see where there are gaps in care for consumers. For example, if someone hasn't seen a primary care doctor in a year, it is a sign that they are not very well connected to their primary care doctor and may not be getting good preventive care. If they have diabetes, but haven't had a hemoglobin A1c test done at least twice a year, then consumers may not be getting quality care for their diabetes.

A health screen can also give you a way to bring up health topics with consumers or sensitive subjects like exercise or smoking and support them in taking positive steps toward improving their own health.

If health and wellness goals are documented in the Individual Support Plan (ISP) and in the case notes, MaineCare will reimburse for community support services that help the consumer reach health and wellness goals. One example: taking a consumer to a meeting with a diabetes educator and sitting in on the meeting with the consumer.

Consumers receiving certain atypical antipsychotic medications are at high risk of developing diabetes, so monitoring for weight gain or changes in glucose or lipid metabolism may guide changes in choice of medication.

Many consumers rely on their mental health agency and trust the staff there. It is sometimes easier for you to work with consumers on health issues than it is for staff at a doctor's office. You may want to use the screen to work more closely with the primary care doctor providing care for the consumer you are working with. Examples: you could go with the consumer to primary care visits or coordinate with the care manager in the doctor's office.

The goal of the screen is not to replace primary care in the consumer's life, but to strengthen that relationship, to identify gaps, and to identify goals that the consumer may want to work on, like reducing smoking, exercising more or developing better diabetes self-management skills.

If consumers are not having their physical health needs met, Maine surveys show that they are also more likely to be unhappy with mental health services they receive and have poorer overall health and psychiatric functioning. Treating the health needs of people with SMI will also result in better mental health care.[8]

"It's how you present it to people. If you present it as one more piece of paper, then consumers and staff won't buy in. The expectation should be full implementation."

PUTTING THE PIECES TOGETHER

What elements do you want to include in a health screen?

There are several simple, measureable items, called direct measures, that are important to include in a health screen.

They are:

- Body Mass Index (BMI) from height and weight
- Blood pressure
- Results of lipid and glucose screens
- Medication lists

Doctors recommend that BMI be less than 25 and that blood pressure go no higher than 130/80.

"The health screen helped remind everyone on the team that we were looking at the whole person."

DIABETES

Because so many people with SMI also have diabetes, the health screen examples in this toolkit include sections on quality care for diabetes. People who already have a diagnosis of diabetes should have the following checks done:

- Hemoglobin A1c test done at least **2 times per year** if the person is stable and **4 times per year** if the diabetes is not controlled
- Cholesterol testing at least **once a year**
- A foot exam **once a year**
- A dilated eye exam **once a year**

Given the high rates of prediabetes among people on antipsychotic medications, the following metabolic screenings are recommended by the American Diabetic Association and the American Psychiatric Association **when medications begin, after 12 weeks** and then **once a year:**

- BMI
- Blood pressure
- Fasting lipids
- Fasting glucose of hemoglobin A1c

HEALTH ASSESSMENT QUESTIONS INCLUDE:

It is fairly simple to get an idea of what health conditions consumers may have or what health risk behaviors they may want to work on simply by asking a question or having consumers complete a series of questions. This is called self-report.

Health Assessment Questions include:

- Have you ever been told that you have cardiovascular disease?
- Have you ever been told that you have high blood cholesterol?
- Have you ever been told that you have high blood pressure?

HEALTH RISK QUESTIONS:

- Do you smoke cigarettes?
- Do you exercise?
- For women, do you have two or more drinks per day?
- For men, do you have three or more drinks per day?

WHO SHOULD DO THE HEALTH SCREEN?

Through your team, you can work to see who in the agency is best suited to administer, or carry out, the screen. Some consumers can fill out a paper questionnaire with little or no staff support. If you have nurses on staff, they could work with consumers on the screen and calculate the BMI and blood pressure. If case managers are working with consumers on the screen, they can work with consumers answering the self-report questions and then work with nursing staff, medication management, or primary care to get information like blood pressure and lipid screens. Some mental health clinics may purchase blood pressure cuffs that work automatically and scales so that with appropriate training, even administrative support staff can measure blood pressure, or height and weight.

“One individual, once we started having discussions, became very motivated and started participating in all health and wellness activities. She lost 60 pounds in a year.”

ROLLING WITH RESISTANCE

Taking the health screen should be voluntary on the part of consumers. For consumers who wonder why, it may help to discuss with them how important their physical well-being is to their day-to-day functioning and recovery from their mental illness. If a consumer still doesn't want to work on the health screen, you could agree to put it aside and return to work on it another day. Sometimes just bringing up the topic is enough to get people thinking about their health and things they want to address. The next time you ask, you may be surprised at the answer. It also helps when health evaluations become a routine part of the initial evaluation and yearly update. The screen can then be understood as part of something the mental health center does to deliver high quality mental health care.

TWO HEALTH SCREEN EXAMPLES

The screens in this toolkit were both used by mental health agencies in Maine who were working on integrating health into their settings. One screen is shorter and more focused on certain key measures. One is longer and more comprehensive. The screen you pick depends on what your team has decided your goals are.

The first health screen was developed by the Maine Department of Health and Human Services' Office of Quality Improvement and Office of Adult Mental Health Services. The second screen was developed by Tri-County Mental Health Services. Both seek to assess health, see if a consumer is linked to primary care, and identify health risk behavior.

MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health and Wellness Screen

Date of Screening _____

DIRECT MEASURES

Name_____ Age _____ Gender _____

Height _____ Weight _____ BMI _____

Blood Pressure _____ Lipid Screen Date_____

Obtained Medication List Yes No

Who is prescribing psychotropic medication? _____

DIABETES

Diabetes Yes No

A1c within the past year Yes No A1c within the past 6 months Yes No

Dilated eye exam within past year Yes No Foot exam within the past year Yes No

CONSUMER SELF-REPORT

1. Have you ever been told by your doctor or other health professional that you have? (Check all that apply)

Angina or coronary heart disease

Heart attack or myocardial infarction

Stroke High blood cholesterol

High blood pressure or hypertension

2. Do you now smoke cigarettes? (Please check one)

Every day Some days Not at all

3. During the past month, did you participate in any physical activities or exercises such as running, aerobics, basketball or other sports, gardening or walking for exercise? Yes No

4. On the days when you drink alcohol, about how many drinks do you drink on average? (One drink is one can or bottle of beer or wine cooler, one glass of wine, one cocktail or one shot of liquor.)

Average number of drinks per day _____

5. How would you describe the condition of your teeth: (Please check one)

Excellent Very good Good

Fair Poor

6. How long has it been since you had your teeth cleaned by a dentist or dental hygienist?

Number of months_____

Number of years _____

7. How would you say your general health is?(Please check one)

Excellent Very good Good

Fair Poor

8. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good? Number of days

9. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

Number of days _____

10. During the past 30 days, about how many days did poor physical or mental health keep you from doing usual activities, such as self-care, school, or recreation? Number of days

USUAL SOURCES OF CARE

Who is your primary care provider? _____

How often in the past 12 months have you seen your primary care provider? _____

How many times have you visited the Emergency Room in the last 12 months? _____

Tri-County Adult Mental & Physical Health Survey

Date of Screening _____

Name_____

Age _____ Gender Male Female Other

Height _____ Weight _____ BMI _____ Waist Circumference _____

Blood Pressure _____ Pulse _____ Recent Blood Sugar _____

1. Do you have a Primary Care Physician? (Check one):

Yes No

If you answered yes, please provide your doctor's name:

_____

2. How many times a year do you see your Primary Care Physician? (Check one)

None One Two Three Four or more

3. During the last month, how much have your personal or emotional problems interfered with your usual activities with friends, relatives, and neighbors? (Check one)

Not at all Very little Somewhat
Quite a lot All the time

4. During the last month, how often did you feel nervous or anxious? (Check one)

Not at all Very little Somewhat
Quite a lot All the time

5. During the last month, how often did you feel fearful or worried? (Check one)

Not at all Very little Somewhat
Quite a lot All the time

6. During the last month, how often did you feel stressed or overwhelmed? (Check one)

Not at all Very little Somewhat
Quite a lot All the time

7. During the last month, how often did you feel depressed or sad? (Check one)

Not at all Very little Somewhat
Quite a lot All the time

8. During the last month, how would you rate your sleep quality overall? (Check one)

Very bad Fairly bad Average
Fairly good Very good

9. During the last month, how was your appetite?
(Check one)
Very bad Fairly bad Average
Fairly good Very good

10. Do you smoke cigarettes? (Check one) Yes No

11. Thinking of an average day this past month, how many servings of alcohol did you have in a typical day?
One serving is a can of beer, glass of wine, or a shot of hard liquor. (Check one)
None 1-2 servings 3-4 servings
5-6 servings 7 or more servings

12. In general, how is your overall physical health?
(Check one)
Excellent Very good Good Fair Poor

13. Compared to one year ago, how would you rate your health in general? (Check one)
Much better now than a year ago
Somewhat better now than a year ago
About the same as one year ago
Somewhat worse now than one year ago
Much worse now than one year ago

14. During the last month, how has your physical health interfered with your usual activities, like visiting friends/relatives, walking, climbing stairs, cleaning? (Check one) Not at all Very little Somewhat
Quite a lot All the time

15. During the last month, how often did you lift or carry your own groceries? (Check one)
Not at all Very little Somewhat
Quite a lot All the time

16. During the last month, how often did you climb flights of stairs? (Check one)
Not at all Very little Somewhat
Quite a lot All the time

17. During the last month, how often did you have difficulty bending or kneeling? (Check one)
Not at all Very little Somewhat
Quite a lot All the time

18. During the last month, how often did you have difficulty walking from place to place? (Check one)
Not at all Very little Somewhat
Quite a lot All the time

19. Within the last month, have you experienced any of the following? (Check all that apply)
Frequent urination Excessive thirst
Extreme hunger Unusual weight loss
Increased fatigue Irritability
Blurry vision

20. Do you have family members with diabetes?

(Check one): Yes No

21. Have you recently had labs (blood work) done?
(Check one) Yes No

22. Do you currently take any of the following medication listed? (Check all that apply)

Clozapine/Clozaril	Olanzapine/Zyprexa
Quetiapine/Seroquel	Asenapine/Saphris
Risperidone/Risperdal	Sulpiride/Meresa
Amisulpride/Solian	Remoxipride
Aripiprazole/Abilify	Perospirone/Lullan
Melperonel/Buronil	LLoperidone/Fanapt
Paliperidone/Invega	Sertindole/Serdolect
Ziprasidone/Geodon	

23. Have you ever been told by your medical doctor or any other medical professional that you have any of the following? (Check all that apply)

Heart Disease	Heart Attack
Stroke	High Blood Pressure
High Cholesterol	Diabetes
Asthma	Arthritis
Epilepsy	Seizures
Liver Disease	Overweight
HIV	Underweight

If you **checked Diabetes** in question 23, please answer the following questions. If you **did not check Diabetes,** you are done with the survey.

24. How many times a year do you see a doctor for your Diabetes? (Check one)
None One Two Three Four or more

25. Do you know what your last A1c level was? A1c level is blood work completed at a lab that provides information about your average glucose level over a three-month period. (Check one) Yes No

If you answered yes, what was your level: _____

26. If you are taking any medications listed in question 22, have you had a recent lipid done? Yes No

27. How many times throughout the day do you check your glucose level using your portable monitor? (Check one)
None One Two Three Four or more

28. When was your last foot exam? (Check one)
Never Within 3 months Within 6 months
Within 12 months 12 months plus

29. When was your last eye exam? (Check one)
Never Within 3 months Within 6 months
Within 12 months 12 months plus

Please see Appendix 1 for a list of the sources Tri-County Mental Health Services consulted with in preparing this screen.

A THIRD HEALTH SCREEN OPTION: KEEPMEWELL

The Maine Center for Disease Control and Prevention developed the online **KeepMEWell** health assessment tool. The **KeepMEWell** screen is designed to help Maine residents assess their risk for chronic disease, improve their health through education, and link them to local resources and supports that can help them decrease their risk of chronic disease. You can access the screen at: **www.keepmewell.org.**

The screen is for people 18 and older.

WHAT DOES THE SCREEN DO?

After answering a series of health questions, you will get three reports:

1. **A scorecard:** a summary of your risk for chronic disease
2. **My Report:** feedback and links to trusted health information websites that will help you take action to lower your risk for chronic disease
3. **Local Community Supports and Programs:** Based on the results of the assessment, you will receive a customized report from **KeepMEWell** listing local resources that can help you take action with health risks that are identified

Within your agency, you could use **KeepMEWell** in several ways:

- Have staff work on the screen with consumers
- Print out the reports and incorporate some of the goals into the Individual Support Plan (ISP)
- Distribute free information about **KeepMEWell** (available from the Maine CDC) and encourage consumers to do the screen at home
- Have the screen be a topic at a social club event
- Have the screen be a topic at a health and wellness group for consumers

WHAT NEXT?

Once you have selected a health screen, or developed one of your own based on components of these examples, it is a good idea to identify a sub group, or target population, of people within your agency to test the screen on.

Agencies that have done this work in Maine have first tested the screen on the following target populations:

- ACT teams
- People in residential settings
- Clients of case managers
- Clients of medication management unit
- Clubhouse members

PLAN-DO-STUDY-ACT

After you have picked the group of people you want to screen and identified the staff you want to do it, it is useful to have a tool to see how that change worked or didn't work. We can borrow a work sheet often used in health care settings called the Plan-Do-Study-Act Worksheet for Testing Change developed by the Institute for Health Care Improvement. (Please see worksheet on the next page).

THE LESSON OF LOW LYING FRUIT

Feeling good about early accomplishments and victories is very important. Even after staff education and consumer education, any change in workflow or in practice can feel quite overwhelming. By testing your screen first on a small defined population, and using the Plan-Do-Study-Act worksheet, you can best test change and learn from it without becoming overwhelmed by it.

The Plan-Do-Study-Act tool helps teams to be clear on their goals, to test change, and to learn from it.

The Plan-Do-Study-Act (PDSA) Worksheet is a useful tool for documenting a test of change. The **PDSA cycle** is shorthand for testing a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act).

Teams can then spread the new practice use of the change, such as the health screen, to broader populations. For example, an agency that started with its ACT team members may want to then more on using the screen on all Community Integration clients. The Plan-Do-Study-Act worksheet is useful in helping your team test out the use of a health screen. Or any other health and wellness change you may want to test at your agency.

PLAN DO STUDY ACT WORKSHEET

AIM – Overall goal you wish to achieve

Every goal will require multiple smaller tests of change

Describe your first (or next) test of change:

Person responsible

When to be done

Where to be done

PLAN

List the tasks needed to set up this test of change:

Person responsible

When to be done

Where to be done

Predict what will happen when the test is carried out

Measures to determine if prediction succeeds

DO

Describe what actually happened when you ran the test

STUDY

Describe the measured results and how they compared to the predictions

ACT

Describe what modifications to the plan will be made for the next cycle from what you learned

Source: Plan Do Study Act Worksheet for Testing Change, Institute for Health Care Improvement

REGISTRY

Once you have used the health screen for your target population, you will have a series of completed individual screens. It is useful to take this individual information and gather it together into a whole or aggregate. This is called a registry. By doing this, you can see how the people you serve are doing as a group. You can use this information to make decisions about interventions you may want to try. For example, if you see that many consumers at your agency are smoking, you may want to contact your local HMP and find out about smoking cessation programs in your area.

The registry template on the next page is based on the Maine Department of Health and Human Services' screen. It is created by using a simple Excel program. You can set a date each month to enter data. This can also be useful to keep your project on track. If you have a month where no one has been screened, you may want to investigate why.

INCENTIVES

We all respond to rewards. We all know that resources are tight in these hard fiscal times. But if funds can be identified to buy gym memberships, aerobic water classes, and food portion kits, these can be useful in creating excitement and buy-in for the wellness measures as well as institutionalizing wellness measures.

Make it fun. Provide healthy snacks at a wellness group meeting. Celebrate successes no matter how small. Consumers who have participated in health and wellness efforts have also said they felt empowered when getting positive reinforcement from their primary care doctor for better managing their blood sugar. Consumers who participated in diabetes support group sessions received a Hannaford gift card at the conclusion of the groups. Consumers who attended the Living Well training on how to better manage their chronic diseases said they felt great when they developed an Action Plan to address a health condition that they had been meaning

to work on.

Integrating Health into Mental Health Systems of Care

Health Screen Registry Template

Date:

Pilot site:

Program:

Number in target program:

DIRECT MEASURES

Number of people screened

Number of BMIs > 25

Blood pressure: Number of people with BP > 130/80

Lipid: Number of lipid screens

Med lists: Number of medication lists obtained

CONSUMER SELF-REPORT

Number of people who have been told that they have cardiovascular disease (angina or coronary heart disease, heart attack or myocardial infarction, stroke)

Number of people who have been told they have high blood cholesterol

Report on the number of people who have been told that they have high blood pressure

Number of people who smoke cigarettes

Number of people who participate in any physical activities or exercise

Number of women who have two or more drinks per day

Number of men who have three or more drinks per day

DIABETES

Number of people who have been told that they have diabetes

Number of people with diabetes who have had A1cs done within the past year

Number of people with diabetes who have had A1cs done within the past 6 months

Number of people with diabetes who have had foot exams within the past year

Number of people who have had dilated eye exams within the past year

USUAL SOURCES OF CARE

Number of people who have primary care provider

Number of people who have seen PCP in the past 12 months

Number of people who have visited the ER in the past 12 months

OUTCOMES

Number of people who said that within the last 30 days, poor physical or mental health kept them from doing usual activities such as self-care, school, or recreation for >14 days

C O N S U M E R S

If you have a diagnosis of Serious Mental Illness (SMI), you are more at risk to have other health conditions such as diabetes or cardiovascular disease. You are also at risk of dying sooner than people who do not have mental illness. Just as having a mental illness is not your fault, getting another chronic disease is not your fault. Sometimes the medications you take to help treat your mental illness have side effects like weight gain that put you more at risk for getting diabetes and cardiovascular disease. Just having a mental illness causes certain metabolic changes in your body that make it more likely for you to develop diabetes or cardiovascular disease.

The good news is that there are certain things you can control that can improve your health, lower your health risk and result in you feeling better.

The agency where you receive services is working to improve overall health care. You can participate in the effort in several ways:

- **Take a health screen**
  - Taking a health screen is voluntary. Doing this will help you know where you stand and what goals you may want to set to get healthier
- **Join the health and wellness team at your agency**
  - Brainstorm ideas for improving your agency's health and wellness culture
- **Start a consumer health and wellness group**
  - Identify topics you would like to learn about, like fast food choices or avoiding complications of diabetes
  - Invite guest speakers to a meeting

- Identify community resources that you feel may be helpful in achieving your goals

Consumers at a mental health agency in Maine developed the following wellness log to help them keep track of some healthy behaviors they said they wanted to work on. One log is a general wellness log and one is for diabetes. One is large font for those with vision problems.

WELLNESS LOG

NAME:

DATE:

GOAL(S) FOR THIS WEEK:

SUNDAY

Healthy Food Choices:
YES NO

Activity Done:

MONDAY

Healthy Food Choices:
YES NO

Activity Done:

TUESDAY

Healthy Food Choices:
YES NO

Activity Done:

WEDNESDAY

Healthy Food Choices:
YES NO

Activity Done:

THURSDAY

Healthy Food Choices:
YES NO

Activity Done:

FRIDAY

Healthy Food Choices:
YES NO

Activity Done:

SATURDAY

Healthy Food Choices:
YES NO

Activity Done:

Challenges I Faced:

Developed by consumers at the Capitol Clubhouse, a program of Kennebec Behavioral Health. Use permitted with credit to source.

WELLNESS LOG

DIABETIC

NAME:

DATE:

GOAL(S) FOR THIS WEEK:

SUNDAY

Healthy Food Choices:
YES NO

Activity Done:

MONDAY

Healthy Food Choices:
YES NO

Activity Done:

TUESDAY

Healthy Food Choices:
YES NO

Activity Done:

WEDNESDAY

Healthy Food Choices:
YES NO

Activity Done:

THURSDAY

Healthy Food Choices:
YES NO

Activity Done:

FRIDAY

Healthy Food Choices:
YES NO

Activity Done:

SATURDAY

Healthy Food Choices:
YES NO

Activity Done:

Challenges I Faced:

Healthy Choices:

1 small apple

½ cup ice cream
½ cup canned fruit

1 bag popcorn
1 slice bread
½ cup peas

1 small banana
½ cup corn
½ cup potatoes

2 small cookies
⅓ cup rice
⅓ cup pasta

6 saltine crackers
1 cup milk
1 6-inch tortilla

½ cup orange juice
¾ ounce pretzels
2 taco shells

Developed by consumers at the Capitol Clubhouse, a program of Kennebec Behavioral Health. Use permitted with credit to source.

LARGE PRINT WELLNESS LOG

NAME:

DATE:

GOAL(S) FOR THIS WEEK:

MONDAY
TUESDAY
WEDNESDAY
THURSDAY
FRIDAY
SATURDAY

SUNDAY
CHALLENGES I FACED:

Developed by consumers at the Capitol Clubhouse, a program of Kennebec Behavioral Health. Use permitted with credit to source.

A D M I N I S T R A T I O N

GEARING UP FOR CHANGE

Mental health agencies in Maine provide a unique service and provide this service well. In the eyes of consumers, staff at the mental health agency is frequently the "trusted other" in consumers' lives. Mental health agencies do not have to become primary care practices in order to integrate health and wellness into their routines and work on improved outcomes for their consumers. Rather, they can continue to provide the services that they do well and link with primary care and public health community resources, so that the people they serve can benefit from their services in a holistic way. Maine surveys show that people who report being more physically well are also more satisfied with their mental health services.[9]

Support from your organization's board of directors and key administrators will go a long way toward successful integration of health into your mental health system of care. In gearing up for change, you may want to consider the following:

- Invite someone from Maine who has been working on integrating health into mental health systems to address your board of directors on the need for such work. The speaker could discuss the "dying 25 years too soon" statistic or could give a presentation on the rates of chronic disease among people with a diagnosis of SMI. Representatives from Maine DHHS, from another mental health center, or from a foundation funding this work could fill this role. A consumer could also discuss her health care experiences.
- Your worksite wellness plan. Many organizations and the health insurance plan that they choose have worksite wellness programs. Many of the activities that are effective in worksite wellness programs can also be adapted for the consumers you serve. The staff heading your worksite wellness efforts can also be a useful resource for your consumer-directed efforts. By modeling its own health and wellness commitment, staff is more likely to support consumers in similar activities.
- Maine's primary care community, patient-centered medical home pilots, and a variety of health care systems are increasingly interested in partnering with the mental health system to provide screening for common mental illnesses, consultation, and brief interventions integrated into the primary care system. If your agency already has partnerships with specific primary care providers or is part of a larger hospital system, these partnerships can be leveraged to bring education programs, consultation, or even medical personnel to the mental health agency.
- Maine's public health system has a community face, the Healthy Maine Partnerships, who are a local

resource for activities related to chronic disease care, such as diabetes self-management education programs and for activities promoting healthy eating and physical activity. Many of these organizations, as well as the Public Health District Coordinating Councils, are eager to partner with local mental health agencies, as local experts on mental health, as referral resources, and as participants in their own boards and programs.

- Take an organizational readiness test to determine where you are on the integration spectrum. One example of such a tool is the Site Self Assessment (SSA) Survey that the Maine Health Access Foundation has used for its Integration Initiative grantees. The form has been adapted from similar formats used to assess primary care for management of chronic diseases.
    -

The SSA is not a pass/fail test, but rather an effort to see where your organization is and where you would like to go. It is a tool to help you first define your vision so you can then articulate goals and outcomes. The best way to complete this form is to ask team members to complete it and then get together in a group meeting to discuss and reach consensus on the scoring.

The SSA can be found in Appendix 2.

SUPPORTING THE CHANGE

Once the groundwork has been laid and you have buy-in from your board and staff, it's time to send the message that the administration will support the work of a health and wellness team. This team should have representation from throughout the agency so that the work can be adequately supported and that the consumers' experience at the agency will be well represented. Team composition should consist of:

- Administrator
- Medical staff representative:
    - Registered Nurse, Medical Management Director, Psychiatric Nurse Practitioner
- Consumers
- Case managers

USING THE DATA

If your agency, as part of its integration efforts, has decided to implement a health screen, you may be wondering what to do with the data collected from that screen. In addition to being a valuable tool to discuss health issues with consumers, the screen data can be used to take a look at:

- Quality of consumers' relationship to primary care
- Prevalence of chronic conditions
- Performance on quality measures:
    - If a consumer has diabetes, are they having the recommended tests in the recommended time frame?

POWER IN NUMBERS

Another benefit of using a health screen on a clearly defined population, or group of people, is that it can be a wake-up call on their health status. This can lead to change at the mirco level, or within the agency, or the macro level, state or national policy, and can even influence things like reimbursement from the federal and state governments.

For example, if you look at the aggregated or "grouped" health screen information below from Tri-County Mental Health Services in Lewiston, you can see that 55 of the 88 people who were screened, smoke, for an overall percentage of 68.7 percent. This confirms national and Maine data on the large number of people with a diagnosis of mental illness who smoke. It could also indicate the need for an intervention program, such as smoking cessation, or partnership with the state DHHS Center for Disease Control and Prevention/Chronic Disease Division. You can also see that most consumers seem to be linked to a primary care practice, with 76 of them visiting their provider within the past 12 months.

MOTIVATING STAFF AND CONSUMERS

Change is hard for all of us, particularly when we are talking about changing something as core to us as how we eat. Or what we snack on. Or when we realize we need to start exercising after having spent the winter as a couch potato.

Agencies in Maine that implemented a health screen for consumers of mental health services learned that it would not do any good to force consumers to take the health screen if they didn't want to. So, they would put it aside and agree to tackle it at another time. Teams also felt more confident about talking with people about their diabetes after they had collaborated with the local diabetes education program. Peer support among the agencies involved helped a lot, too. Members shared success stories, problem-solved and planned next steps.

WHAT WAS DONE

Monthly conference calls kept the teams plugged in with each other and with their state partners. A quarterly Learning Collaborative allowed them to work together to understand and face challenges and share success stories. One team shared a story about a member who had lost 70 pounds since joining the health and wellness group. Another team member shared her concern about morbidly obese clients, more than 300 pounds, whose weight was not only affecting their health but also isolating them in their apartments and hindering self care, such as hygiene.

Agencies also worked hard on culture change. Tri-County Mental Health incorporated a Health and Wellness group into its regular services for clients. Kennebec Behavioral Health spread the health and wellness message to its network of social clubs. Motivational Services had a wellness fair for employees. Two agencies, Tri-County and Common Ties, collaborated on a community-wide Diabetes Fair open to their consumers and the general public and held at the Lewiston Public Library.

"We can't ask people to give up everything at once. We can provide information and hope it will support them."

MOTIVATING CONSUMERS AND DIABETES EDUCATION

Given the prevalence of diabetes among people with a diagnosis of Serious Mental Illness, it is important to reach out to diabetes educators at local hospitals to educate first their staff and then to see how to best provide diabetes education to consumers. “Lunch and Learns” about diabetes can be scheduled for both consumers and staff.

After finding a “champion” diabetes educator to work with, diabetes education sessions can be arranged for consumers. A project that tried this in Maine shortened the time frame from the traditional day-long program to several one-hour presentations. Plenty of time was given for consumers to ask questions and process information. One consumer dramatically improved her A1c status during the course of the education sessions. Another missed a couple of sessions because she was hospitalized for a health condition, but returned to finish and reported that the sessions had really helped her and that she had learned more through them than anywhere else. After the diabetes education meetings ended, a monthly diabetes support group was set up. Consumers found it easier to commit to a once-a-month structure than the weekly education sessions.

REACHING OUT

As the diabetes example shows, teams benefitted when they worked with community partners. And the community partners did too: they had support from the mental health agency staff in addressing health needs of the people they were serving. Your agency staff can look to many community resources to meet consumers’ health and wellness needs: diabetes educators, Healthy Maine Partnerships, local food pantries, and the Cooperative Extension Service.

“We are collaborating with our local primary care practices. To develop this integration is our goal. We want to look at the whole person.”

COLLABORATION WITH PRIMARY CARE

Some people with SMI have a difficult time maintaining a good relationship with primary care. Primary care practices may struggle to meet their needs. Sometimes consumers face stigma when they seek primary care or care in the emergency room. Sometimes consumers’ mental illness makes it hard for health care providers to see the true health issue they may be facing.

One nurse practitioner in the MeHAF-grant project had to send a young man experiencing cardiac problems to the emergency room because she could not get him into a primary care doctor for a referral to a cardiologist.

There are several strategies for improving a relationship with primary care:

Collaboration: Reach out to primary care. Write a letter describing what you are doing to address consumers’ health needs and ask if the primary care practice is interested in collaborating on the change. Describe your goals in improving consumers’ overall wellness. Mental health agencies that have tried this have been pleased by the response from primary care practices who were in turn pleased to learn that the mental health agencies

had a health and wellness program in place.

Case Management: Case managers can work with the consumers to complete the health screen, to get information from primary care, and to problem solve issues consumers may be facing in accessing primary care. Health and wellness goals can be incorporated into the Individual Support Plan (ISP) so that agencies can be reimbursed for working with consumers on their health needs.

Health Literacy: It is important for team members to work with consumers to increase their health literacy, to feel empowered enough to ask questions at their doctor's office visit. Case managers or other key staff, such as a registered nurse, can work with consumers to prepare a list of questions to take to the doctor's office.

SPREADING THE WORK AND THE WORD

After assessing where your agency is with its health and wellness program at six-month and 12-month intervals, you may want to consider expanding or "spreading" the screen to a broader population. If you have implemented a health screen, you may want to spread the health screen from the initial target population, an ACT team, to all people getting community integration support. Or if you initially had two case managers working on a health screen with their caseload, you may want to have these case managers work with other case managers who haven't been using the screen.

As people work on a health screen within your agency, they also educate people outside of their agency. By collaborating with primary care, they raise awareness about the health needs of people with SMI. By working with community organizations, they decrease stigma about mental illness and increase awareness of the early mortality of people with a diagnosis of SMI.

ENDNOTES

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[3]Mental Health Statistics Improvement Program (MHSSP) Survey 2010

[4]Mental Health Statistics Improvement Program (MHSSP) Survey 2010

[5]Colton, CW, Maderscheld, RW (2006). Congruencies in increased mortality rates, years of potential life lost and causes of death among public mental health clients in eight states. Prev Chronic Disease. Downloaded from url:http/www.cdc.gov/pcdissues/2006/aprol05 0180.htm

[6]Freeman, E., Yoe, J. (2008). PowerPoint: The poor health status of consumers of mental health care: the interaction of behavioral disorders and chronic disease

[7]Mental Health Statistics Improvement Program (MHSSP) Survey 2010

[8]Mental Health Statistics Improvement Program (MHSSP) Survey 2010

[9]Data Infrastructure Grant, Adult Mental Health & Well-Being Survey, 2010 Adult Survey

Resources

NATIONAL

The **Institute for HealthCare Improvement** is a national organization that is committed to improving patient care. Its website has information on the chronic care model and on the Plan-Do-Study-Act cycle. **www.ihi.org**

The **Substance Abuse and Mental Health Services Administration** has launched the 10x10 campaign, which seeks to reduce mortality for those with mental illness by 10 years within 10 years. Information on their campaign can be found at: **http://www.promoteacceptance.samhsa.gov/10by10/default.aspx**

Minding Our Bodies is a project in Ontario, Canada, whose goal is to increase capacity within the community mental health system to promote active living and healthy eating for people with serious mental illness to support recovery. **http://www.mindingourbodies.ca**

The **SAMHSA-HRSA Center for Integrated Health Solutions,** run by the National Council for Community Behavioral Healthcare under a cooperative agreement from the U.S. Department of Health and Human Services, is funded jointly by the Substance Abuse and Mental Health Services Administration and the Health Resources Services Administration. The CIHS promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings. **http://www.thenationalcouncil.org/cs/center_for_integrated_health_solutions**

RESOURCES IN MAINE

DHHS **Office of Adult Mental Health Services (OAMHS):** The Office of Adult Mental Health Services (OAMHS) is the designated State Public Mental Health Authority for adults. A primary responsibility of the OAMHS is to develop and maintain a comprehensive system of mental health services and supports for persons age 18 and older with severe and persistent mental illness. **http://www.maine.gov/dhhs/mh**

DHHS **Center for Disease Control and Prevention/Diabetes Control and Prevention Program** promotes increased excellence in diabetes care, improved access to diabetes care and a more efficient and effective health care system for people in Maine. **http://www.maine.gov/dhhs/bohdcfh/dcp**

[1]DHHS **Office of Quality Improvement (OQI):** The services and functions of the Office are designed to support and enhance the quality and integrity of services provided to DHHS customers. Quality Improvement Services emphasizes consumer and family involvement, building strong relationships with internal and external stakeholders, and the use of outcome measurements to guide policy and decision-making. **http://www.maine.gov/dhhs/QI**

The **Chronic Disease Self-Management Program,** or **Living Well,** is a workshop given two and a half hours, once a week, for six weeks, in community settings such as senior centers, churches, libraries and hospitals.

People with different chronic health problems attend together. Subjects covered include techniques to deal with problems such as frustration, fatigue, pain and isolation; appropriate exercise for maintaining and improving strength, flexibility, and endurance; appropriate use of medications; communicating effectively with family, friends, and health professionals; nutrition; and how to evaluate new treatments. Program participants demonstrate significant improvements in exercise, cognitive symptom management, communication with physicians, self-reported general health, health distress, fatigue, disability, and social/role activities limitations. **http://www.maine.gov/dhhs/oes/healthychoices/living_well.shtml**

The **Consumer Council System of Maine** is responsible for providing an independent and effective consumer voice into mental health public policy, services, and funding decisions. The CCSM consists entirely of past/present recipients of mental health services (consumer/peers), including all Statewide Consumer Council representatives and paid staff. **http://www.maineccsm.org**

Healthy Maine Partnerships are a collaborative effort of the Maine Department of Health and Human Services, the Maine Center for Disease Control and Prevention, the Maine Office of Substance Abuse, and the Maine Department of Education. The HMPs work to promote health in Maine. **http://www.healthymainepartnerships.org**

The **Maine Health Access Foundation**'s mission is to promote access to quality health care, especially for those who are uninsured and underserved, and improve the health of everyone in Maine. Its three priorities are advancing health reform, promoting family and patient-centered care, and strengthening Maine's Safety Net. Its Integration Initiative seeks to integrate behavioral health and primary care initiatives across the spectrum of care. **www.mehaf.org**

Quality Counts is a regional health care collaborative committed to improving health and health care for the people of Maine. Its goals are to improve health, promote consistent delivery of high quality care, improve access to care, and improve health care costs. **http://www.mainequalitycounts.org**

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Appendix 1

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Appendix 2

INSTRUCTIONS FOR COMPLETING THE INTEGRATION INITIATIVE SITE SELF ASSESSMENT (SSA) SURVEY

This form was adapted from similar formats used to assess primary care for chronic diseases. We would like you to focus on your site's current extent of integration for patient and family-centered primary care, behavioral and mental health care. The purpose of this assessment is to show you your current status along several dimensions of integrated care. Repeat administrations of the SSA form help to show changes your site is making over time.

It is recommended that you obtain input from your team to complete this form, for example, by asking each team member to score it, then discussing the scores in a team meeting, and reaching consensus or taking the average of the individual scores. Please rate your patient care team(s) on the extent to which they currently do each activity for the consumers at your agency. By patient care team, we mean the staff who work together to

manage integrated care for patients. This often, but not always, involves health care providers, behavioral health specialists, and possibly case managers or health educators and front office staff.

IDENTIFYING INFORMATION:

Name of your site:_____ Date:_____

Name of person completing the SSA form:_____

Your job role:_____

Did you discuss these ratings with other members of your team? Yes _____ No _____

Adapted from the PCRS – Developed by the Robert Wood Johnson Foundation Diabetes Initiative, www.diabetesintiative.org; also adapted from the ACIC survey developed by the MacColl Institute for Healthcare Innovation, Group Health Cooperative.

SITE SELF-ASSESSMENT FORM

Using the 1–10 scale in each row, circle (or mark in a color or bold, if completing electronically) one numeric rating for each of the 18 characteristics. *NOTE: There are no right or wrong answers. If some of this wording does not seem appropriate for your project, please suggest alternative wording that would be more applicable, on the form itself or in a separate email.*

I. Integrated Services and Patient and Family-Centeredness *(Highlight one NUMBER for each characteristic)*

CHARACTERISTIC

LEVELS

1. Co-location of treatment for primary care and mental/behavioral health care…

does not exist; consumers go to separate sites for services

is minimal; but some conversations occur among types of providers; established referral partners exist

is partially provided; multiple services are available at same site; some coordination of appointments and services

exists, with one reception area; appointments jointly scheduled; one visit can address multiple needs

2. Emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse)

2. (ALTERNATE: If you are a behavioral or mental health site, respond in terms of medical care needs)…

are not assessed (in this site)

are occasionally assessed; screening/assessment protocols are not standardized or are nonexistent

screening/assessment is integrated into care on a pilot basis; assessment results are documented prior to treatment

screening/assessment tools are integrated into practice pathways to routinely assess MH/BH/PC needs of all patients; standardized screening/assessment protocols are used and documented.

3. Treatment plan(s) for primary care and behavioral/mental health care…

do not exist

exist, but are separate and uncoordinated among providers; occasional sharing of information occurs

Providers have separate plans, but work in consultation; needs for specialty care are served separately

are integrated and accessible to all providers and care manager; patients with high behavioral health needs have specialty services that are coordinated with primary care

4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care…

does not exist in a systematic way

depends on each provider's own use of the evidence; some shared evidence-based approaches occur in individual cases

evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence-based treatment depends on preferences of individual providers

follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently

5. Patient/family involvement in care plan…

does not occur

is passive; clinician or educator directs care with occasional patient/family input

is sometimes included in decisions about integrated care; decisions about treatment are done collaboratively with some patients/families and their provider(s)

is an integral part of the system of care; collaboration occurs among patient/family and team members and takes into account family, work or community barriers and resources

6. Communication with patients about integrated care…

does not occur

occurs sporadically, or only by use of printed material; no tailoring to patient's needs, culture, language, or learning style

occurs as a part of patient visits; team members communicate with patients about integrated care; encourage patients to become active participants in care and decision making; tailoring to patient/family cultures and learning styles is frequent

is a systematic part of site's integration plans; is an integral part of interactions with all patients; team members trained in how to communicate with patients about integrated care

7. Follow-up of assessments, tests, treatment, referrals and other services…

is done at the initiative of the patient/family members

is done sporadically or only at the initiative of individual providers; no system for monitoring extent of follow-up

is monitored by the practice team as a normal part of care delivery; interpretation of assessments and lab tests usually done in response to patient inquiries; minimal outreach to patients who miss appointments

is done by a systematic process that includes monitoring patient utilization; includes interpretation of assessments/lab tests for all patients; is customized to patients' needs, using varied methods; is proactive in outreach to patients who miss appointments

8. Social support (for patients to implement recommended treatment)…

is not addressed

is discussed in general terms, not based on an assessment of patient's individual needs or resources

is encouraged through collaborative exploration of resources available (e.g., significant others, education groups, support groups) to meet individual needs

is part of standard practice, to assess needs, link patients with services and follow up on social support plans using household, community or other resources

9. Linking to Community Resources…

does not occur

is limited to a list or pamphlet of contact information for relevant resources

occurs through a referral system; staff member discusses patient needs, barriers and appropriate resources before making referral

is based on an in-place system for coordinated referrals, referral follow-up and communication among sites, community resource organizations, and patients

II. Practice/Organization (Highlight one NUMBER for each characteristic)

CHARACTERISTIC

LEVELS

1. Organizational leadership for integrated care…

does not exist or shows little interest

is supportive in a general way, but views this initiative as a "special project" rather than a change in usual care

is provided by senior administrators, as one of a number of ongoing quality improvement initiatives; few internal resources supplied (such as staff time for team meetings)

strongly supports care integration as a part of the site's expected change in delivery strategy; provides support and/or resources for team time, staff education, information systems, etc.; integration project leaders viewed as organizational role models

2. Patient care team for implementing integrated care…

does not exist

exists but has little cohesiveness among team members; not central to care delivery

is well defined, each member has defined roles/responsibilities; good communication and cohesiveness among members; members are cross-trained, have complementary skills

is a concept embraced, supported and rewarded by the senior leadership; "teamness" is part of the system culture; case conferences and team meetings are regularly scheduled

3. Providers' engagement with integrated care ("buy-in")…

is minimal

engaged some of the time, but some providers not enthusiastic about integrated care

is moderately consistent, but with some concerns; some providers not fully implementing intended integration components

all or nearly all providers are enthusiastically implementing all components of your site's integrated care

4. Continuity of care between primary care and behavioral/mental health…

does not exist

is not always assured; patients with multiple needs are responsible for their own coordination and follow-up

is achieved for some patients through the use of a care manager or other strategy for coordinating needed care; perhaps for a pilot group of patients only

systems are in place to support continuity of care, to assure all patients are screened, assessed for treatment as needed, treatment scheduled, and follow-up maintained

5. Coordination of referrals and specialists…

does not exist

is sporadic, lacking systematic follow-up, review or incorporation into the patient's plan of care; little specialist contact with primary care team

occurs through teamwork & care management to recommend referrals appropriately; report on referrals sent to primary site; coordination with specialists in adjusting patients' care plans; specialists contribute to planning for integrated care

is accomplished by having systems in place to refer, track incomplete referrals and follow-up with patient and/or specialist to integrate referral into care plan; includes specialists' involvement in primary care team training and quality improvement

6. Data systems/patient records…

are based on paper records only; separate records used by each provider

are shared among providers on an ad hoc basis; multiple records exist for each patient; no aggregate data used to identify trends or gaps

use a data system (paper or EMR) shared among the patient care team, who all have access to the shared medical record, treatment plan and lab/test results; team uses aggregated data to identify trends and launches QI projects to achieve measurable goals

has a full EMR accessible to all providers; team uses a registry or EMR to routinely track key indicators of patient outcomes and integration outcomes; indicators reported regularly to management; team uses data to support a continuous QI process

7. Patient/family input to integration management…

does not occur

occurs on an ad hoc basis; not promoted systematically; patients must take initiative to make suggestions

is solicited through advisory groups, membership on the team, focus groups, surveys, suggestion boxes, etc. for both current services and delivery improvements being considered; patients/families are aware of mechanism for input and are encouraged to participate

is considered an essential part of management's decision-making process; systems are in place to ensure consumer input regarding practice policies and service delivery; evidence shows that management acts on the information

8. Physician, team and staff education and training for integrated care…

does not occur

occurs on a limited basis without routine follow-up or monitoring; methods mostly didactic

is provided for some (e.g. pilot) team members using established and standardized materials, protocols or curricula; includes behavioral change methods such as modeling and practice for role changes; training monitored for staff participation

is supported and incentivized by the site for all providers; continuing education about integration and evidence-based practice is routinely provided to maintain knowledge and skills; job descriptions reflect skills and orientation to care integration

9. Funding sources/resources…

are only from MeHAF grant; no shared resource streams

separate PC/MH/BH funding streams, but all contribute to costs of integrated care; few resources from participating organizations/agencies

separate funding streams, but some sharing of on-site expenses, e.g., for some staffing or infrastructure; available billing codes used for new services; agencies contribute some resources to support change to integration, such as in-kind staff or expenses of provider training

fully integrated funding, with resources shared across providers; maximization of billing for all types of treatment; resources and staffing used flexibly

Adapted from the PCRS – Developed by the Robert Wood Johnson Foundation Diabetes Initiative, www.diabetesintiative.org; also adapted from the ACIC survey developed by the MacColl Institute for Healthcare Innovation, Group Health Cooperative.

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