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RECOVERY TIMES

Healthy People, Healthy Communities. Let's Make It Happen!
State of Connecticut Department of Mental Health and Addiction Services
Thomas A. Kirk, Jr., Ph.D., Commissioner

Emphasis On: Innovative Approaches for Integration of Behavioral & Primary Health Care

BEHAVIORAL AND PRIMARY CARE INTEGRATION AT HILL HEALTH CENTER (HHC)

A principal strategic objective of HHC has been the integration of primary and behavioral health care. HHC staff has reduced barriers to care and maintained engagement by offering behavioral health (BH) services under the same roof as medical services and by providing services in various community locations to reduce transportation barriers. Individuals served are likely to feel more comfortable seeking BH services in a setting which offers other medical services. There may be less stigma associated with entering a medical facility versus a mental health or substance abuse treatment facility.

To further decrease barriers to wholistic engagement, pharmaceuticals are available at reduced cost through HHC which participates in the 340b drug program, "Share the Care." HHC's pharmacy delivers prescriptions to individuals' homes without charge to increase accessibility. The HHC Pharmacy also offers its Pharmacy Fund to low-income, uninsured individuals to help pay for needed prescriptions.

HHC recognizes that many individuals served have behavioral health as well as medical problems. HHC's Seamless Integration Committee, including executive managers, program managers and service providers from across health care sites, meet bi-monthly to reduce barriers to integration and address differences in services delivery models. MH/SA programs which provide outpatient services (Adult Psychiatric Clinic, Grant Street Partnership, Northside Community Outpatient Services, West Haven Counseling Services, Community Health Connection Counseling Services, Child and Family Guidance Clinics, South Central Rehabilitation Center, State Street Counseling Services) are either co-located with a primary care site or have obtained State licenses to provide primary care services in addition to their mental health and substance abuse treatment licenses. This allows for the treatment of co-occurring behavioral health and medical issues at each location, avoiding any division of treatment and inconvenience to individuals who may otherwise need to seek services at multiple agencies. Collaborations are also underway with community behavioral health treatment facilities, such as Crossroads, a residential substance abuse treatment program in New Haven, where HHC will provide primary care to residents. These collaborations will decrease use of emergency services and help to establish primary care relationships.

Since its inception, HHC has provided diverse services across the lifespan. The current service continuum is comprehensive and includes dental, medical and specialty care, substance abuse and mental health treatment at inpatient and outpatient levels of care. Services are office-based, community-based and some are provided in the home. Geriatrics, adults, young adults, adolescents, children and infants are served. There is "no wrong door" to treatment in that an individual may access any service via any service location or type of provider. With increased capacity and increased access, treatment is delivered on the individual's terms, when the individual is most amenable to effective intervention. Individuals, not yet engaged in BH services, are more likely to accept BH treatment if they perceive an existing relationship with the facility and familiar, trusted providers.

For more information, contact Nancy Navarretta, HHC, at 203-503-3356.

COLLABORATIONS TO INTEGATE BEHAVIORAL AND PRIMARY HEALTH SERVICES

StayWell Health Center receives federal funds to operate a healthcare program specifically for homeless populations. StayWell works with individuals who are living on the street, in homeless shelters, doubled-up or precariously placed. Unfortunately, lack of permanent housing is often a barrier to quality, continuous health care services. This is especially the case for harder to access services such as dental, mental health and specialty services.

DMHAS' Western CT Mental Health Network's (WCMHN) Waterbury office has developed a program that increases access and is focused on health outcomes so that this special population can achieve optimal health and sustain it. This allows energies to be focused on acquiring housing, employment and other supports.

StayWell provides primary healthcare on a weekly basis on-site at WCMHN's Waterbury Area Office, and on-site dental cleanings on a monthly basis with follow-up treatment provided at their South End office. Care coordination links individuals with specialty services and women's health, as needed. Flu clinics also are an example of preventive services for individuals served. Following is an example of the program's success:

Jessie, a woman in her mid-50's, has been bounced around between family members while seeking housing for years. When entering the program she was uninsured and linked with the Department of Social Services (DSS) to become covered by Medicaid. She had problems with her knee that made it difficult for her to walk. She was linked to an Orthopedist by the RN case manager, Jackie, who also recognized she lacked transportation for the appointment. Jackie went to the home of Jessie's relative and gave her a bus pass to get to the doctor's office. Jessie was tearful in response. Surgery was eventually performed, physical therapy completed and she is now walking without a cane. She has been referred for a GYN exam and is getting dental care for to replace missing teeth. She has been very appreciative and her dignity is starting to return as evidenced in her improved appearance. Jessie continues to receive regular services at WCMHN – Waterbury Office. Now she is being referred to mental health services so that her affect improves along with her physical condition and she can show off that newly built smile!

For more information on the above, contact Ellen.Brotherton@po.state.ct.us 203-805-5300. For Information on WCMHN, contact Colette.Anderson@po.state.ct.us 203-805-6403.

HARTFORD HEALTH COLLABORATIVE

DMHAS' Capitol Region Mental Health Center (CRMHC) participates in a collaborative of healthcare providers from the city of Hartford, the *Hartford Advisory Council.* CRMHC is represented by its Director of Recovery Services and Community Integration, Carl Shields. Other participants on the Council include executive leaders from St. Francis and Hartford Hospitals, the Burgdorf/Fleet Health Center, and the Hartford Health Department. The Council is chaired by the Director of the Hartford Health Department. The Council generates ideas that contribute to the health of Hartford's residents. Recently, the Council focused its efforts on three major health concerns for Hartford residents: diabetes, depression and hypertension. All three of these illnesses can go undetected over long periods of time. The Council has struggled with ways of outreaching to residents to screen individuals for these illnesses. The City of Hartford is poised to undertake a major initiative to improve the health and wellness of its residents, and CRMHC will be a partner in this effort through participation in this Council.

For more information on the above, contact Carl.Shields@po.state.ct.us or 860-297-0826. For more information on CRMHC, contact Karen.Evertson@po.state.ct.us or 860-297-0903.

INDIVIDUALIZED PRIMARY HEALTH AND WELLNESS APPROACHES

-*Individuals who take psychiatric medications are at higher risk of developing diabetes, cholesterol, and obesity because of medication side effects.* At DMHAS' CT Valley Hospital (CVH), individuals have both a psychiatrist and a medical doctor who take care of them.

-*The medical doctor provides primary medical care as well as preventive care*. CVH medical doctors have developed several preventive care measures, in addition to their annual assessments for diabetes care and high cholesterol treatment. Every year, CVH doctors audit charts to assess how well they are doing with their preventive and therapeutic interventions.

-*All individuals who have high fasting blood sugar are treated for "pre-diabetes" and followed carefully for progression of this problem.* Individuals are counseled to exercise and eat a healthy diet, along with medications, if needed. Individuals treated for diabetes at CVH have an average Hemoglobin A1C value of 4.7, which is well below the national average compared to similar programs.

-*Individuals treated for high cholesterol with a statin medication are also monitored for levels of cholesterol while on the medications.* Up to 94% of these individuals have an acceptable result on their cholesterol medication, which is far higher than the national average for patients on these medicines.

-*Medical doctors at CVH have also developed annual monitors to ensure they are treating their patients according to national guidelines for annual screening.* Individuals are offered annual flu shots, age-specific screenings such as colonoscopy at age 50, mammograms after age 40, and DEXA scans for osteoporosis.

-*CVH doctors audit charts to monitor individual's care, with results presented to CVH administration.* In the past 7 years, these audits have documented the impressive care that individuals have been receiving, with over 90% of individuals receiving appropriate medical and preventive care.

There has also been a *Wellness Initiative* at CVH, including individuals served as well as staff, which has encouraged many more individuals to take part in healthy activities.

For more information, contact Luis.Perez@po.state.ct.us or 860-262-5887.

INTEGRATION OF BEHAVIORAL AND PRIMARY CARE AT DMHAS'

SOUTHEASTERN MENTAL HEALTH AGENCY (SMHA)

SMHA recognizes the importance of integrating primary and behavioral health care. SMHA serves approximately 400 individuals in a community setting in addition to individuals served in 2 short-term residential settings. Aggressive outreach to the community takes place through our mobile crisis intervention services, homeless outreach advocacy team, and expansive collaborative homelessness /supportive housing efforts. Approximately 75% of the population served by SMHA experiences a serious co-morbid medical condition or an identified risk to their general health.

Efforts are underway at SMHA to: 1) Improve access to health services; 2) Assist individuals in recovery with establishing improved relationships with community health/medical providers; 3) Address cultural competence and health disparities for diverse and underserved groups; and 4) Improve overall health & wellness of individuals served. The following efforts are currently being implemented:

- **Healthy Eating Group**-To educate and support healthy food choices.
- **Walking Group**-To increase physical activity and address socialization.
- **Circle of Care**-To ensure that nursing services meet and/or exceed standards of excellence.
- **Brief Care Program Collaboration with United Community & Family Services**-To increase individual access to physicals.
- **Nursing Collaboration with Medical Provider**-To establish relationships with medical providers to ensure medical care is delivered.
- **Participation in Community Care Teams**-To address homelessness issues and promote individual access to services.
- **Multicultural Initiatives**-Collaboration with health and service organizations to make them aware of mental health services.
- **Project Homeless Connect**-A national "best practice" model to provide one-stop health and human services for the homeless.

For more information, contact Stephenie.Guess@po.state.ct.us / 860-859-4645.

INTEGRATION OF BEHAVIORAL AND PRIMARY CARE AT DMHAS' SOUTHWEST CT MENTAL HEALTH SYSTEM (SWCMHS)

There are several initiatives at DMHAS' SWCMHS wherein the objectives are to promote the integration of primary and behavioral health care.

-In Stamford, SWCMHS is engaged in an ongoing planning process that involves Optimus Healthcare and Liberation Programs. The objective is to create open access to all three agencies for individuals with mental health or co-occurring mental health and substance use disorders who also need medical services. This planning process was facilitated by a grant from DMHAS' Office of the Commissioner and a work plan was prepared. Follow-up will now get underway to work on the challenging details.

-In Bridgeport, SWCMHS is participating in the Bridgeport Primary Care Action Group with Bridgeport Hospital, St. Vincent's Hospital, Southwest Community Health Center, Optimus Healthcare, Americares Free Clinics, Fairfield County Medical Association, Bridgeport Child Advocacy Coalition, and the City of Bridgeport Health Department. The group's purpose is to improve access to quality primary care for uninsured populations in the greater Bridgeport area. A sub-group is now looking into issues related to provision of specialty services. Currently, the focus is on assuring follow-up care for persons presenting to hospital Emergency Departments by connecting them with outpatient providers. An additional activity is to develop a resource for providing free or reduced price medications for uninsured persons. As part of this process, SWCMHS is in discussions with other CEOs to help assure that individuals we serve have full access to medical providers.

-In Bridgeport, SWCMHS is working collaboratively with two Federally Qualified Health Centers, Southwest and Optimus, to formalize referral processes to facilitate access and continuing care to individuals served by SWCMHS.

For more information, contact James.Pisciotta@po.state.ct.us or 203-579-7368.

INTEGRATION OF PRIMARY AND BEHAVIORAL CARE AT UNITED SERVICES INC. (USI)

USI is an Enhanced Care Clinic and, as such, has worked to develop formal agreements with local primary care groups in order to maximize the use of outpatient clinical resources. Under these agreements, USI accepts individuals referred from primary care physicians for mental health services, including medication management. USI has developed protocols for regular communication between the agency and physicians, and USI updates the physicians regarding medications prescribed to individuals served. Once individuals are stabilized, USI refers them back to their primary care provider for ongoing medication management, and provides ongoing consultation.

These individuals continue to receive other USI services such as case management or the social club, while freeing up USI's outpatient clinical resources to serve other persons.

For more information, contact USI President/CEO Diane Manning or Clinical Services Division Director Michael Patota at 860-774-2020.

NATIONAL HEALTHCARE QUALITY WEEK

In preparation for National Healthcare Quality Week (Oct 19th-25), the Performance Improvement Managers of DMHAS' CT Valley Hospital (CVH) developed story boards displaying the following three major initiatives that will be conducted over the next 12 months:

1. An examination of the procedures for follow through on medical test and exams, using the Failure Mode and Effect Analysis Methodology.
2. Participation of the Intensive Treatment Unit in the Alternatives to Restraint and Seclusion State Incentive Grant.
3. A collaborative project with the Infection Prevention Committee designed to improve flu vaccination rates for staff and patients. Methods to achieve this goal include stream lining procedures and paper work involved

in the vaccination process and raising awareness of the benefits of flu prevention.

CVH is participating in the Joint Commissions Flu Vaccination Challenge and has set targets for vaccination rates that exceed national bench marks. This last project has been launched to celebrate both National Health Care Quality Week and International Infection Prevention Week which coincide this year. Proclamations issued by Governor Rell recognizing both of these observances were distributed to CVH staff.

In addition to launching these three projects, CVH managers in celebration of National Health Care Quality Week, are sponsoring a recognition program entitled "Are you a star". The goal of this program is to highlight performance improvement efforts that go on every day at the unit, discipline or department level. By highlighting the small projects that often go unnoticed yet have major impact on those we serve, our hope is to help staff gain an understanding of how they contribute to quality in their day to day work, provide recognition instill confidence and develop enthusiasm to participate in additional projects and initiatives. The response to date has been so overwhelming that the recognition program will extend beyond National Health Care Quality Week.

For more information, contact Luis.Perez@po.state.ct.us or 860-262-5887.

PREVENTING SUICIDE AMONG ADOLESCENTS

A goal of the federal Substance Abuse and Mental Health Services Administration-funded CT Youth Suicide Prevention Initiative (CYSPI) is to increase availability and accessibility of mental health treatment for adolescents by assessing them for depression and suicide risk and referring them to individual or group counseling. These services are performed at the St. Francis Hospital and Quirk Middle School's School-Based Health Center in Hartford.

Screening for mental health problems at the Saint Francis clinic site and at Quirk Middle School has been going smoothly. Adolescents who screen positive are offered treatment and are overwhelmingly interested in counseling. Thus far, of the 491 adolescents screened, 73 have been positive.

Efforts are underway to add services at Hartford High so that students who graduate from middle school can receive ongoing services. Recruitment techniques vary at the different sites but those enrolled get similar treatment. Follow up sessions are scheduled for adolescents with positive screens and referrals to outside resources are made according to adolescents' needs. At the Saint Francis site, co-location with primary care allows for easy referrals and enhances follow up care to adolescents.

For more information, contact Dianne.Harnad@po.state.ct.us or 860-418-6828.

PRIMARY HEALTH CARE AT HARTFORD DISPENSARY (HD)

The goal of HD's Primary Care Unit is to provide health services to individuals served by HD. A full dental clinic has been added 2 days per week. In collaboration with the University of Connecticut, the dental clinic is gearing up for CARF accreditation. The dental clinic is doing very well.

During 2002 to 2005, HD introduced Hepatitis A&B vaccination program. This service will be introduced in the front end of the primary care unit. New positions include a nutritionist, an infectious disease specialist and Peter Brown MD, the primary physician who will oversee the Primary Care Unit.

For more information, contact Paul McLaughlin, Hartford Dispensary, at 860-525-2181.

WEIGHT MANAGEMENT GROUP

DMHAS' Western CT Mental Health Network's-Danbury Weight management group meets weekly on Wednesdays from 2:00 to 3:00 pm. The group begins each week with weight monitoring. The first ½ hour of group focuses on peer support with the sharing of personal experiences and articles on nutrition, medication and exercise and the role these play in maintaining, gaining or losing weight. The second ½ hour is spent on a group walk with the group members encouraging each other to participate to reach their personal goals.

This past July group members participated in a two day skill building activity which included a budgeting and shopping exercise to develop a weekly meal plan. The second day was an actual meal preparation demonstration and tasting using the items purchased. The emphasis was on healthy choices and alternatives. The menu planning was a big hit with all and many expressed a desire for more skill groups on the topic.

The group continues to grow and some have experienced either gradual or significant weight loss with others pleased to at least maintain their weight. In September members shared a lunch outing and focused on making healthy choices and enjoyed each others companionship with all expressing a desire to plan another outing.

For more information on the above, contact Wallace.Sugden@po.state.ct.us /203-778-1640. For information on WCMHN, contact Colette.Anderson@po.state.ct.us /203-805-6403.

WORK, HEALTH AND RECOVERY

DMHAS' Capitol Region Mental Health Center's (CRMHC) *Work, Health, and Recovery Events* have become community events that integrate important principles consistent with the DMHAS mission. Many programs from CRMHC participate including the nursing team, pharmacy, nutritionist, and Deaf and Hard of Hearing and Peer Support Teams. The exciting group of other participants include: Hartford Hospital, Charter Oak Health Clinic, New England Assistive Technology (NEAT) Marketplace, CT Clearinghouse, CT Commission on Deaf and Hearing Impaired, Department of Labor Connect-to-Work Bus, Easter Seals, Hartford Public Library, Central CT State University, Hartford Adult Education, and Porter and Chester Institute. Staff and persons in recovery have had mobile mammograms scheduled and completed at CRMHC during the event. Additionally, their blood pressures were taken and blood sugar levels were checked. Participants also received information on the incidence of obesity, cancer, symptoms of stroke, and prevention of illness. Also, many received some of these medical screenings in an on site van which was able to screen and evaluate and refer for other local appointments as needed. The *wellness* focus of these events promotes a new way of thinking for CRMHC staff, persons in recovery, and CRMHC's community partners. As CRMHC integrates the overarching principles of recovery and multiculturalism into the daily practices of employment, it is helpful to remember the impact of physical well being on recovery.

For more information on the above, contact Carl.Shields@po.state.ct.us or 860-297-0826. For more information on CRMHC, contact Karen.Evertson@po.state.ct.us or 860-297-0903.