Increasing health care integration in the rural community mental health setting: A Program planning and evaluation study

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Individuals with severe and persistent mental illness have greatly reduced life expectancies in comparison with the general population, with much of the excess mortality attributable to medical conditions. Yet evidenced shows that people with SMI are less likely to received standard care for medical conditions. Integrated care, or the process of addressing physical and mental health concerns together, has been shown to increase quality of care of patients, as well as reducing long-term health costs. Increasing integration had been identified as a priority goal for a rural Oregon coastal mental health center, (CMHC) yet no formal integration programs were in place.

THE CLINICAL PROBLEM

To increase integration of behavioral health and physical health services in the county for the highest-risk clients of the CMHC by:

1). Assessing the current state of integration among the CMHC and local health partners to identify current strengths and opportunities for improvement.

2). To propose a program design for increased formal integration processes between the CMHC and local health systems.

AIMS

- 70% of clients are served by Medicaid
- 9% of the ~700 clients had 4 or more chronic medical conditions, 17% of active clients had 2 or more ED visits in the last 6 months, and 7% of clients had a 15% or greater probability of being hospitalized in the next 6 months

SETTING & POPULATION

The program evaluation project was completed at a community mental health center located on the rural Oregon Coast.

METHODS

This project followed the methods set by the CDC’s Program Planning and Evaluation Framework:

1). Engaging stakeholders: Identified and met with primary persons involved in the program.
2). Describe the program: Created a model to describe the intended program inputs and outcomes.
3). Focus the evaluation design: Assessed the biggest issues while using resources as efficiently as possible. Completed an estimated budget, workplan, and program logistics.
4). Gather credible evidence: Reviewed available knowledge and evidence for proposed program.
5). Justify conclusions: Linked stakeholders standards with the available evidence through analysis/synthesis and application to the specific community.
6). Ensure use and share lessons learned: Ensured appropriate design, preparation, feedback and dissemination so CBH can use program design and evaluation to move towards their goals of increased integration. (CDC, 1999).

RESULTS

1). Numerous meetings with stakeholders (CCO, Primary Care, and other local leaders) regarding potential integration needs.

2). Local survey of medical care partners in the county regarding currently challenges and opportunities to increase integration.

3). Program development of a “Nurse Case Manager” position, including logic models, budget, job description, and work plan for implementation

4). Literature review of the evidence for similar program designs.

5). Sharing of the program and evidence and analysis of application to the specific county.

6). Project planned to apply for grant funding for potential implementation in late 2021.

DISCUSSION & LEARNING

- Limits to organizational energy; must take into consideration other projects and priorities.
- In smaller, rural organizations, staffing changes can greatly impact organizational capacity.
- Progress and change is a slow process: patience, patience, patience.
- Do not let great be the enemy of good: small steps are better than no steps!
**Program Name**

“Nurse Care Manager” program

**Program Goals**

To increase healthcare integration between community behavioral health and local physical health services

**INPUTS (Resources)**

- **Staff**: (an RN to serve as a care manager/liaison)
- **Time from stakeholders in co-developing program**
- **Funding**: (financial support for personnel and non-personnel costs)
- **Data**: (monthly population health data from CCO regarding high risk members)

**OUTPUTS (Activities)**

- **Registry of high risk individuals with co-morbid psychiatric and physical health conditions**
- **Formalized care coordination for high risk individuals including patient education, self-management support, provider communication, and linkages to community resources.**

**OUTCOMES (Short Term)**

- **Strengthening bidirectional communication between CMHC and physical health entities in county.**
- **Registry of high risk individuals with co-morbid psychiatric and physical health conditions**

**OUTCOMES (Long Term)**

- **Improved health outcomes for program members (indicated by reduced ER visits, reduced ACG hospitalization risk scores).**
- **Improved perception of health as indicated by members (SF-12 scores)**
- **Reduced long-term costs per improved health management.**
- **Program design replicable for use in other rural counties**