

## **2009 Innovations Awards Program APPLICATION**

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ID # (assigned by CSG): 09-S-08LA

**Please provide the following information, adding space as necessary:**

State: Louisiana

Assign Program Category (applicant): Health and Human Services (Use list at end of application)

1. Program Name  
Behavioral Health and Primary Care Integration Program
2. Administering Agency  
Capital Area Human Services District (CAHSD)
3. Contact Person (Name and Title)  
Jan Kasofsky, Ph.D. Executive Director
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9. Please provide a two-sentence description of the program. The Behavioral Health and Primary Care Integration program provides an innovative approach to integrate behavioral health, primary care, and preventive care in non-traditional settings such as a mobile medical unit, local public health units, and behavioral health clinics. A primary focus of the program is to engage clients who do not typically seek or utilize traditional health services by building a local system of care with medical case management in rural communities.
10. How long has this program been operational (month and year)? Note: the program must be between 9 months and 5 years old on March 2, 2009 to be considered. The program began operations in February 2008. Expansion of services has occurred since this time.
11. Why was the program created? What problem[s] or issue[s] was it designed to address?  
The urgent need for physical healthcare access for seriously mentally ill (SMI) clients seen in public behavioral health settings is well documented. The majority of early deaths in this population have been attributed to the lack of access to physical healthcare for chronic diseases and lifestyle choices. In the public system there is little collaboration between behavioral health specialists and physical health providers, and care is provided within the silo in which it is funded. Typically, the SMI population is engaged in treatment only within

the behavioral health specialty setting. These clients typically access physical health treatment either inappropriately or when emergent in local emergency departments. Preventive care is extremely rare. Similarly, clients seen in Public Health Units who access preventive or primary care for physical health needs often experience poor health outcomes, and may benefit from a cohesive approach to care management and access to behavioral health professionals to provide interventions to address “non-compliance” and assist with follow-up appointments or treatment adherence.

The goal of the Behavioral Health and Primary Care Integration program is to provide community-based integrated preventive, primary and behavioral health services for the un/underinsured adult population delivered through public health units and CAHSD behavioral health clinics in partnership with community providers. This integrated system of care is expected to improve physical health and emotional well-being of the population served with a minimal amount of resource investment.

12. Describe the specific activities and operations of the program in chronological order.

In February 2008, a mobile medical unit began providing primary care services for SMI clients with no medical home at the CAHSD campus. In May 2008, CAHSD implemented a smoke free campus and provided a low barrier tobacco cessation program. CAHSD was awarded grant funding from the American National Red Cross in May 2008 to implement expansion of this program to include additional mobile unit medical services, a voucher system for primary care visits to Federally Qualified Health Centers (FQHC) and prescriptions, and social worker services in rural community-based public health clinics. In July 2008, a physical health screening policy, screening tool and referral process was implemented for the CAHSD behavioral health clinics.

Specific components of the program include:

Medical Screening, Education, and Referral at CAHSD Clinics

A Nurse Practitioner was hired to oversee the behavioral health and primary care integration model for the seven parish region. Literature indicates that many behavioral health patients do not access primary care, resulting in many chronic illnesses undiagnosed, poor health outcomes, and early death. To help address this, a medical screening and referral policy was developed and training of CAHSD clinic staff completed. CAHSD nursing staff provides the health screenings in both mental health and addictive disorders clinics. Clients’ primary care needs are identified and referrals are made to providers as indicated. Patient education and referral resources to address identified needs of clients are in place.

Expansion of Our Lady of the Lake (OLOL) Regional Medical Center Mobile Unit-Primary Care Services

A contract agreement between CAHSD and OLOL was finalized to expand primary care services for CAHSD’s mental health and addictions services clients who have been screened by CAHSD nursing staff and are not being followed by a primary care provider in the community. The mobile unit, staffed by a nurse practitioner, is now coming on site to CAHSD’s largest clinic four times per month to provide primary care services for clients.

Voucher System for Medical Visits to FQHC’s and Prescriptions for Indigent Clients

A contract agreement between CAHSD and the Louisiana Primary Care Association was implemented to reimburse FQHC’s providing primary care services to indigent clients referred by behavioral health clinic staff through a web-based voucher system. A prescription voucher system has been implemented through a contract with the local

Albertson's pharmacy, allowing indigent clients access to medications prescribed by the OLOL mobile unit clinical staff.

#### Social Workers Providing Brief Intervention in Primary Care Settings

Four social worker positions were filled to provide services at the Public Health Units in the region. Processes for referral, brief counseling, client education, and care management have been developed and implemented. A documentation and data collection system has been developed. Social Workers receive referrals from the CAHSD behavioral health clinics and the Public Health Units located in urban and rural communities throughout the region.

13. Why is the program a new and creative approach or method?

This program is unique in that it provides a multifaceted approach to integrate behavioral health, primary care and preventive care in non-traditional settings such as a mobile medical unit, local public health units, and behavioral health clinics. The public health units are primarily located in rural areas where access is a major issue. A primary focus of this program is to identify and engage clients who do not typically seek or utilize traditional health services by building a local system of care with medical case management services. Vouchers are provided to clients to access prescriptions and primary care services. Social workers are uniquely available to receive referrals from both behavioral health providers and public health providers. Services provided by social work staff including brief counseling, education and care management have been a vital component to the success of the program. The program also improves access to primary care for public mental health and addictive disorders clients in the behavioral health setting.

14. What were the program's start-up costs? (Provide details about specific purchases for this program, staffing needs and other financial expenditures, as well as existing materials, technology and staff already in place.)

The program is staffed by a full-time Nurse Practitioner who manages the program, four full-time Social Workers to provide brief intervention services, one full-time Medical Assistant at the behavioral health clinic to coordinate mobile medical services, a part-time Nurse Practitioner and part-time Nurse Assistant to provide primary care services through the mobile unit, and a driver for the mobile unit. Equipment for lab work was purchased for the mobile medical unit (start-up cost of \$5,204.35). Personnel and other expenses such as supplies, printing and vouchers are paid by the American National Red Cross Grant funding. The monthly expense for the program is \$40,407.13 (annual expense: \$484,885.56)

CAHSD provides in-kind resources related to medical screening by nursing staff in the behavioral health clinics, program administration, office space and office supplies, and phone/computer lines. A database was created by CAHSD to track program activities and outcomes. The Louisiana Office of Public Health provides in-kind resources of clinical staff time, administrative support, office space, furniture and phone/computer lines. Educational materials were purchased for use with clients from already published sources. The total "in-kind" expense is estimated to be \$52,800.

15. What are the program’s annual operational costs?

Expense Area	Item	Explanation	Annual Expenditure
Personnel Salary & Fringe	Nurse Practitioner (1 FTE) Social Workers (4 FTE) Medical Assistant (1 FTE) Nurse Practitioner (1 part-time) Nurse Assistant (1 part-time) Driver (1 part-time)	\$37,351.19/mo.	\$448,214.28
Other than Personnel Expenses	Travel, supplies, printing, fuel, educational materials, vouchers for primary care and prescriptions	\$3,055.94/mo.	\$36,671.28
Total		\$40,407.13/mo.	\$484,885.56

16. How is the program funded?

CAHSD has formed a partnership with local parish government and the Louisiana Office of Public Health in the region to gain support for the Behavioral Health and Primary Care Integration Program. The Public Health Units are providing office space, furniture, computer and phone lines for the social worker services at no cost. CAHSD has allocated nursing staff time to complete medical screenings of CAHSD clients to identify needs for referral to the social workers. CAHSD has provided administrative support to develop and manage the program. The American National Red Cross is providing grant funding for the program in the amount of \$480,000. Due to the success of the program, local parish governments are interested in funding social worker positions based in the rural public health units once the American National Red Cross funding has ended. CAHSD will continue to sustain the program through CAHSD funding and community partnerships within its financial constraints.

17. Did this program require the passage of legislation, executive order or regulations? If YES, please indicate the citation number.

No

18. What equipment, technology and software are used to operate and administer this program?

A medical screening tool and referral process was developed along with a database to track activities/outcomes. The FQHC voucher system is managed through an electronic database. The mobile medical unit is equipped for delivery of primary health care services.

19. To the best of your knowledge, did this program originate in your state? If YES, please indicate the innovator’s name, present address, telephone number and e-mail address.

Yes, CAHSD has developed the model of integrated behavioral and primary care services being implemented in its region. This model can be successfully replicated in other communities.

20. Are you aware of similar programs in other states? If YES, which ones and how does this program differ? There are no similar programs in other states. This model represents an

innovative approach to integrate behavioral and primary care needs among the un/underinsured adult population. An abstract of the CAHSD Behavioral Health and Primary Care Integration Program has been accepted for presentation by the National Association of Mental Health Program Directors scheduled for April 15, 2009 in Washington, D.C.

21. Has the program been fully implemented? If NO, what actions remain to be taken?  
Yes, the program is fully operational and provides services in a seven parish region encompassing a population of 642,232 people. The success of this program highlights the importance of collaboration among community providers in the development and implementation of an integrated system of care.
22. Briefly evaluate (pro and con) the program's effectiveness in addressing the defined problem[s] or issue[s]. Provide tangible examples.  
The program components have positively impacted clients who suffer from behavioral health and medical conditions that were chronic, undiagnosed and untreated. Many of the clients served suffer from severe mental illness, trauma, mild/moderate depression, STD's, HIV, hypertension and diabetes. A positive outcome from the medical mobile unit services was the identification and treatment of clients with undiagnosed hypertension, diabetes, and other diseases. With the assistance of the medical social workers in providing care coordination, brief counseling, referral and follow-up, client's quality of life and health outcomes improved. The project was responsible for client's keeping medical appointments and receiving appropriate treatment in a timely fashion. It demonstrates the importance of integration between behavioral health and primary care to address the causes of lower life expectancy for the SMI clients treated in public facilities. The client's self-esteem, their general state of health and outlook on life were positively impacted. Improved functionality and empowerment were commonly reported by clients. Several case studies are included as an appendix to illustrate the effectiveness of the program.

In developing a system of care among the FQHC's to provide primary care services, it has become apparent that fees and services for care are inconsistent across the region. CAHSD is working with the FQHC's to address issues related to access, fees and quality of services to meet the needs of the un/underinsured population. The Louisiana Primary Care Association is supportive of the initiative and remains very committed to enhancing the system of care.

The Behavioral Health and Primary Care Integration program direct care services consisted of primary care for CAHSD clients provided through the Our Lady of the Lake mobile health unit. For the reporting period 2/5/08-11/6/08, the OLOL mobile unit provided primary care services for 86 unique clients with a total number of 231 visits. The demographic data shows that the majority of clients (79%) was age 18-54 years with low income and diagnosed with a serious mental illness. Of the clients served, 62% were Caucasian and 38% African American living in the metropolitan area of the region. The mobile unit served a population that was 58% females and 42% males. The primary client conditions treated by the mobile unit were elevated blood pressure (74%), elevated blood sugar (35%), elevated cholesterol (23%) and gastro-esophageal reflux disorder (16%).

For the period 8/22/08-11/9/08, the social workers in the PHU's provided services to 122 unique clients with a total number of 478 contacts. Of these clients, 83% were ages 18-54 years and 10% had a serious mental illness on referral. Clients were primarily African American (61%) and Caucasian (36%) of low income and 50% lived in rural areas of the region. The major reason for referral to the social worker was related to depression/anxiety

(45%) and elevated blood pressure (39%). There were 31 (28%) clients who received psychosocial therapy, 54 (49%) clients who received education, and 33 (30%) clients who received care management. The major referrals of clients were for medical care (34) and mental health services (18). Of the clients referred to a primary care provider, 85 (77%) kept their appointments. There were more than half of clients (54%) that did not know the last time they had seen a primary care doctor for physical health needs.

There were 38 vouchers for primary care issued to clients and 25 (66%) redeemed totaling \$500. There were a total of 70 patients who received prescription vouchers totaling \$769.97. There were a total of 160 service providers, counselors, and medical staff who received training related to the Behavioral Health and Primary Care Integration Program. There were a total of 48 people who were reached with outreach activities.

A total of 88 people have participated in “Town Hall” meetings for the purpose of creating partnerships in the community and addressing gaps in services. The town meetings were sponsored by the local parish governments and facilitated by CAHSD staff. A total of 431 surveys of the general population of clients receiving services through the regional behavioral health clinics and Public Health Units was conducted in December 2008 to gain additional input from consumers regarding what their identified health care needs are, their access to care, and what services they would like to see put in place in their communities. Information from each Parish’s town meeting and health survey data are being compiled into a report with recommendations for that community. CAHSD will provide technical assistance to communities in the region that are interested in developing interventions to address identified needs of the population.

23. How has the program grown and/or changed since its inception? The program recognizes the importance of SMI client’s having a permanent medical home. Therefore, clients that have been receiving services through the mobile medical unit are being transitioned to a community health clinic for ongoing primary care. To sustain the program, local parish governments are interested in funding Social Worker positions based at the public health units. The components of the model have been implemented as designed and are being improved related to communication of client information among providers and access to primary care services. In one rural community, the local government in partnership with a local hospital is opening a primary care clinic co-located at the same complex as the public health unit and behavioral health facility. The co-location of primary care, preventive care and behavioral health services will enhance the system of care for this community.

24. What limitations or obstacles might other states expect to encounter if they attempt to adopt this program?

The urgent need to increase access to an integrated system of care for behavioral health and primary care is being addressed through this program. Many of our client’s have both behavioral and physical health problems that impact their quality of life resulting in significant morbidity and mortality. Transportation and financial resources are major barriers to access to care in the rural areas. Wrap-around services such as transportation and financial assistance are critical components to improving medical compliance and health outcomes. Follow-up with clients for ongoing care management can be a challenge due to the frequent change in place of residence and sporadic phone service. A strong partnership and effective communication among providers is essential to the success of addressing client’s needs through a coordinated and integrated system of care that promotes a “medical home” for all consumers.

## **Appendix: Behavioral Health and Primary Care Integration Program Case Studies**

**Patient “A”** came to the Personal Health Clinic for STD treatments. She presented as delusional and agitated with grandiosity, loose associations and rambling speech. She also had exhibited recent suicidal behaviors (per her mother). Medical treatment could not be given due to these behaviors. The Sheriff’s Department was contacted and, with family assistance, the patient was taken to Earl K. Long Hospital for assessment and treatment. She was admitted to a psychiatric ward, treated for mental and physical (STD) illnesses and is currently compliant with medications and willing to work with clinic staff to make positive life choices.

**Patient “B”** was referred to the program from the health unit due to possible depression and elevated blood sugar. She had been using herbal remedies to treat her blood sugar for at least 6 months with no major change. Upon referral to a primary care physician (PCP), she was placed on medication and diagnosed with diabetes, hypertension, and a hernia. Since the initial visit to her PCP, her daughter has been diagnosed with elevated blood sugar and the mom is currently receiving health education and care management services. Her blood sugars and hypertension are being managed with medication and diet. She has been referred to a general surgeon for evaluation of her hernia. Her depression has been linked to fatigue and the impact her illnesses were having on her life. As a result of her diagnosis and treatment, this has also improved.

**Patient “C”** is a 30-year-old African-American female referred from the health unit after reporting some depression related to her unplanned pregnancy. She is employed, but in need of permanent housing. In the course of routine testing, she learned she is HIV positive. Services provided to date:

- \*Educational information on HIV and pregnancy and related referrals.
- \*Support with follow-through on pre-natal care.
- \*Formal referral to CAHSD’s Housing Support Team for affordable housing, money management, day care and on-going case management

**“Patient D”** was referred from the Health Unit due to positive screening for tobacco use, substance abuse (alcohol, beer and marijuana use) and a positive STD finding. She also had a positive pregnancy test and was approximately 12 weeks gestation. With the help of the health unit staff, we were able to assist her with a Medicaid application and schedule her prenatal appointment. The patient has been keeping all her prenatal appointments and has been successfully treated for her STD. She reports that she no longer drinks alcohol or smokes marijuana. She also has cut back on the number of cigarettes she smokes per day. The patient has been complimentary of the health unit and social work staff.

## **2009 Innovations Awards Program Program Categories and Subcategories**

Use these as guidelines to determine the appropriate Program Category for your state's submission and list that program category on page one of this application. Choose only one.

### *Infrastructure and Economic Development*

- Business/Commerce
- Economic Development
- Transportation

### *Government Operations*

- Administration
- Elections
- Public Information
- Revenue

### *Health & Human Services*

- Aging
- Children & Families
- Health Services
- Housing
- Human Services

### *Human Resources/Education*

- Education
- Labor
- Management
- Personnel
- Training and Development
- Workforce Development

### *Natural Resources*

- Agriculture
- Energy
- Environment
- Environmental Protection
- Natural Resources
- Parks & Recreation
- Water Resources

### *Public Safety/Corrections*

- Corrections
- Courts
- Criminal Justice
- Drugs
- Emergency Management
- Public Safety

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This application is also available at [www.csg.org](http://www.csg.org), in the Programs section.

**Deadline: March 2, 2009**