Collaborating on mental health

Patient outcomes improved by creative partnership

By Pat Conway, PhD, MSW; Heidi Favet, CHW; and Molly Johnston

Two innovative initiatives in rural Ely, Minn., a mental health clubhouse (Northern Lights Clubhouse) and a community care team, have led to improved health outcomes for patients with complex chronic conditions. The Ely Clinic's Community Care Team (CCT), an interagency group working to meet patient's health and wellness needs through coordination of services with multiple access points, builds on the medical home model implemented at Essentia Health's Ely Clinic. This article describes the development and purpose of the two programs, their relationship with inter-professional health care teams, and the impact of collaboration on health outcomes.

Mental illnesses or mental disorders such as depression, anxiety, schizophrenia, and post-traumatic stress disorder create dilemmas for individuals, families, and communities. Isolation and lack of resources in a remote, rural area add tremendous stress to an already overwhelming experience. Nationally, mental disorders are the most common reason for disability (www.nami.org/factsheets/mentalillness_fact sheet.pdf). In Ely, 17 percent of Essentia Health patients have a diagnosis of anxiety, bipolar disorder, depression, dysthymic disorder, PTSD, and/or schizophrenia; the most common diagnosis is depression.

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The Ely Community Care Team

The CCT was established to ensure that there is no wrong door to meeting health and wellness needs of individuals in the Ely area.

The CCT is affiliated with 21 agencies, which focus on evaluating the whole needs of individuals—not just the needs served by the particular agency—and makes appropriate referrals and follow-up to ensure that all health needs are met. The CCT provides a framework that strengthens limited resources into a solid network of support. The team meets monthly to network, offer case management, and develop tools and systems for collaboration.

Agencies include medical providers, mental health care providers, educators, social service agencies, housing agencies, and community members. CCT care ranges from providing referral information to an individual, to providing care coordination that addresses physical and mental health and psychosocial needs. The care coordinator, a certified community health worker (CHW), is the point person, connecting individuals and families with programs and serving as the communication conduit between providers and patients. The majority of individuals participating in care coordination have one or more mental health diagnoses and/or psychosocial needs.

CHWs come from the communities they serve, building trust and vital relationships. This trusting relationship enables them to be effective links between their own communities and systems of care. This crucial relationship significantly lowers health disparities in Minnesota because CHWs provide access to services, improve the quality and cultural competency of care, create an effective system of chronic disease management, and increase the health knowledge and self sufficiency of an underserved population (www.mnchwalliance.org).

Prior to the formation of the CCT, service providers recognized that no clear process existed to meet the complex psychosocial needs of some patients. This lack of a process led to patient needs going unmet. CHWs were identified as a key component of the solution. CHWs are now housed at Northern Lights Clubhouse (NLC) and the Essentia Health–Ely Clinic, providing care coordination at all levels. Referrals come from all CCT agencies, with most of them coming from Ely Clinic.

Northern Lights Clubhouse

The NLC (www.elynlc.org) is a local initiative that is part of the global Clubhouse International (www.iccd.org) movement, which is included in the U.S. National Registry of Evidenced-Based Practices and Programs. Clubhouse International believes that working is rehabilitative, with a focus on work opportunities within the clubhouse and in the community. The local members and staff work alongside each other to accomplish the work of the clubhouse and learn new skills. NLC goals include decreased social isolation, increased com-

munity connectedness, and supported employment and education goals.

The key to success is an environment of support, acceptance, and commitment to the potential and contributions of each individual regardless of the severity of his or her illness. The clubhouse philosophy values people living with mental illness as contributing members, rather than as patients. Members participate in daytime programming, employment and education support, housing support, psychosocial resource management, and holistic wellness programs.

One member explained, "I am doing a lot better. My mood and cutting are better. I have support I never had before. The clubhouse is my safe haven. It gives me a purpose, something to do during the day. I feel safe and I don't feel judged here."

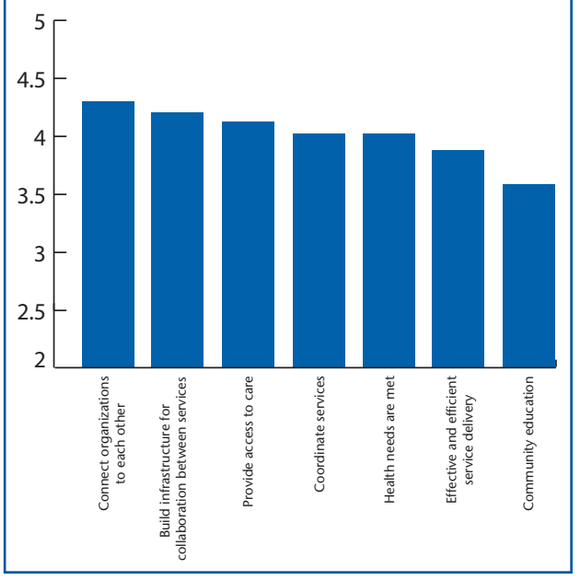
Another NLC member said, "The clubhouse gives me new skills, such as menu planning, shopping, cooking, and American Sign Language, and social opportunities like the weekly coffee club. We also explore holistic wellness opportunities such as yoga, art, and hiking."

Roles for health care providers

Ely primary care providers have played a crucial role in the development of the CCT and NLC through planning, participation, financial contributions, and referrals. Clinic providers and administration joined early conversations about increasing mental health resources for youth and families in the community. Monthly meetings identified problems and explored solutions to create a safety net for individuals who were slipping between the cracks.

Family nurse practitioner Peggy York-Jesme, CNP, a longtime patient advocate, participated in grant writing that led to the formation of the CCT and is an active member. She is also the NLC board chair. "These projects are important because there are not enough options for patients with behavioral health concerns," said York-Jesme. "Helping create solutions is very rewarding to me as a professional, especially in situations that previously left me feeling frustrated and unhelpful."

Figure 1. Results of Fall 2013 survey on success of the Ely CCT



The Essentia Health–Ely Clinic is the fiscal agent for the CCT and houses its leadership. Providers now have a referral source for patients with unmet needs. "It makes sense for our clinic to be a core part of the solution," stated Laurie Hall, clinic and integrated behavioral health administrator. "Our providers see first-hand the challenges created by the limited services for people with mental illness. Because we are on the front line with patients, we

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are in an excellent position to identify individuals' needs and connect them to services."

When the CCT identified the need for increased care coordination, the clinic committed to pilot the CHW role.

"As we transition to the world of accountable care and meeting goals of the Triple Aim, it greatly benefits the patient and the clinic to address the social determinants of health," said Joseph Bianco, MD, division chief of primary care, Essentia Health East Region. "We will never be successful unless we find and build models to address these needs in our patients. The CCT essentially takes us from the model of the health care home to the health care neighborhood."

Impact of the CCT and NLC

The story of a 27-year-old female, diagnosed with bipolar disorder and anxiety, describes the process and impact of the CCT and the collaboration with CHWs and NLC. The young woman, who moved to Ely from out of state, was referred for care coordination to access insurance and other benefits. The strength-based assessment revealed additional needs. Together, the CHW and young woman established a full range of supports and services to meet her needs and goals. Social phobia was a large barrier in helping her access services of the CCT. The CHW personally introduced the woman to the NLC, where a strong rapport and increased level of support quickly developed. This "warm hand-off" helped reduce her anxiety of meeting new people. The young woman attributes participation in the clubhouse as a significant part of her recovery. NLC connected her to an ARMHS (Adult Rehabilitative Mental Health Services) worker, who assisted in skill building in the individual's home setting. In five months, she experienced significant change, becoming a pleasant, smiling individual who has created a plan to stop self-harm.

Evaluation of the Community Care Team

In 2013, CCT organizations participated in an evaluation to identify community needs, make recommendations, and describe interactions between organizations. In response, Essentia Health–Ely Clinic now makes reciprocal referrals with hospice, the nursing and rehabilitation center, the hospital, the free clinic, Head Start, and the community college. Member feedback also informed development of the CCT Strategic Plan.

As part of the Fall 2013 CCT survey, organizations rated their opinion of CCT successes. Connecting organizations to each other, building infrastructure for collaboration between services, providing access to care, coordinating services, and meeting health needs were rated highly (Figure 1 on page 23).

Members commented on the value of the CCT to their clients: "As my contact with new clients increases and I find needs that can be met by this group, I can increase services to my client and improve their issues with the proper sources."

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