On the Road to Integrated Care:
A Story from the Front Lines
DMH/DHS Collaboration Programs

The California Endowment
Health Aging-Emerging Issues
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Overview

- Why did we start?
- The Plan
- Mental Health Integration Program
- Marketing
- Challenges
- Accomplishments
- Current Status
- Integration Continuum

Why did we start?

- Break down those silos!
- Consistent with county strategic goals
- MHSA unique funding opportunity
  - Different ways and locations to deliver services
  - Convenience, stigma reduction

Why did we start?

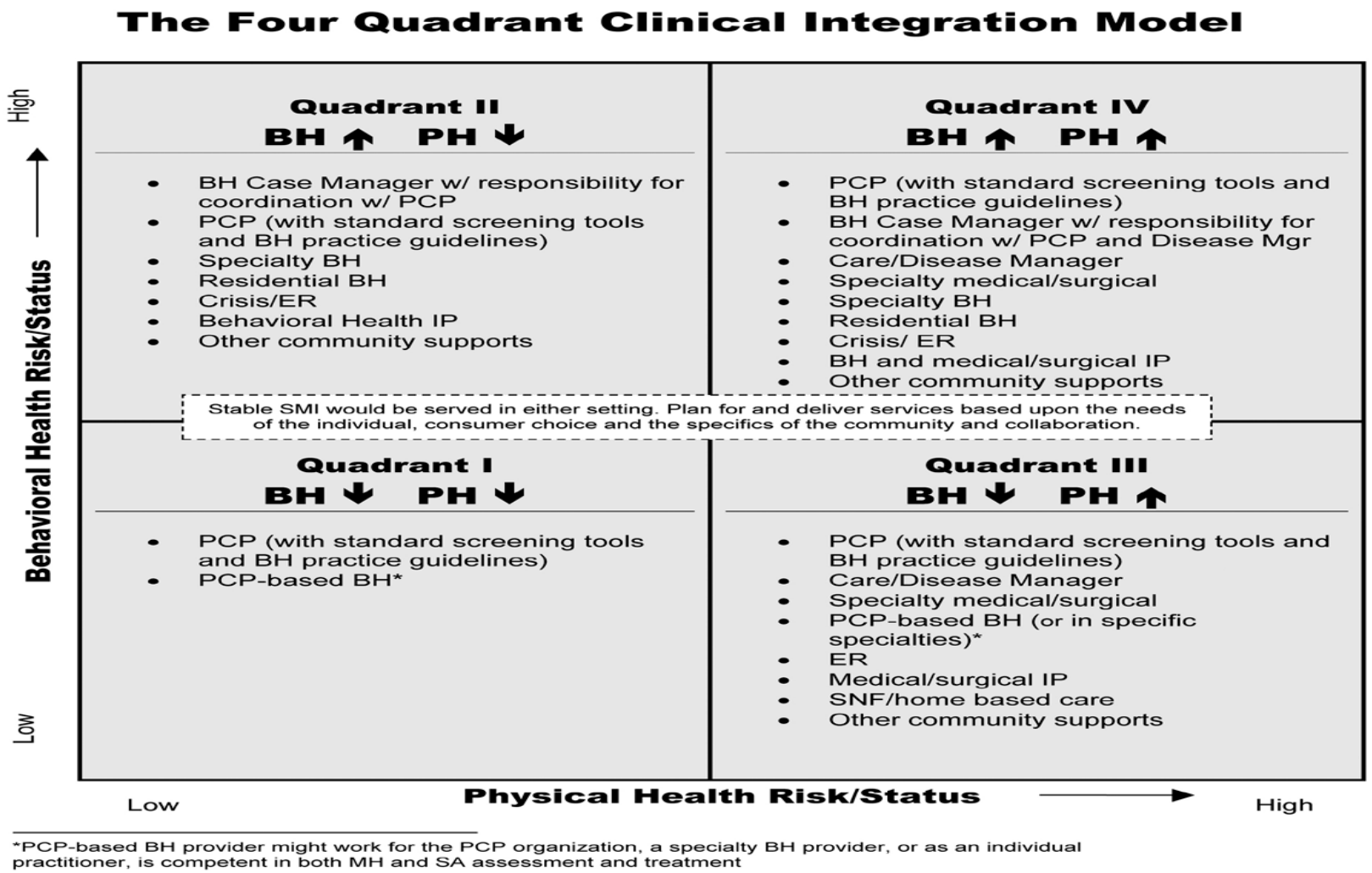
- 45% of suicide victims had contact with primary care providers within 1 month of suicide.[1]
- Older adults had higher rates of contact with primary care providers within 1 month of suicide than younger adults.[1]
- If I screen these patients, then what?

[1] American Journal of Psychiatry. 2002 Jun: 159(6):909-16 Contact with mental health and primary care providers before suicide: a review of the evidence.

The Plan

- Engage DHS - provide mental health services in their facilities
- Determine staffing needs
- Seek funding
- Who would we serve and why?

The Plan



SAMHSA. The Four Quadrant Clinical Integration Model.

The Plan

- How could we meet their needs?
- Designing systems to support off-site operations
- Moving in
- Quarterly meetings

The Plan

- Create Operational Agreement
  - Credentialing
  - Health Clearances
  - Joint Commission
  - HIPAA
  - Medical Records
  - Referral Mechanism
  - Emergencies

The Mental Health Integration Program (MHIP)

- MHIP, aka the IMPACT Model
  - Stepped collaborative care evidence-based model for treatment of depression and anxiety in primary care settings
  - Collaboration between patient, PCP, Care Manager and Consulting Psychiatrist
  - Session-to-session screening (PHQ-9 or GAD-7)
  - Behavioral activation
  - Problem Solving Treatment or Cognitive Behavioral Therapy

MHIP

- MHIP Training
  - Preparatory meetings with providers - how will this effect flow of operations
  - MHIP 2 day trainings
  - Problem Solving Treatment certification
  - Presentations to psychiatrists and webinars for psychiatrists – their new role
  - Webinars for primary care providers – their new role

Marketing

- Time limited service – PEI
- Indirect Consultation model
- Primary care providers as prescribers of psychotropic medications
- Presentations to primary care providers by clinical staff and by consulting psychiatrists

Marketing

- What if there are already mental health staff on site?
- Presentations at joint staff meetings
- Frequent meetings to check on status of co-locations and resolve issues early
- Sharing data on status of referrals during quarterly meetings

Challenges

- Finding champions
- Payment for services rendered at same location
- Staffing
  - Diagnosing done by non-physicians
  - Matching staff to population needs
  - Small teams, personalities and absence of large number of colleagues to diffuse interpersonal challenges

Challenges

- Lack of on-site infrastructure
- Measuring number of visits per day or *how many patients did you see?*
- Variations in PCP willingness to prescribe antidepressants
- Different computer systems across different DHS service areas

Challenges

- Learning how to interact with PCPs
  - Succinct presentations – focus on key information
  - Schedules and finding time to share info
- Increasing awareness – mental health staff and common medical conditions

Accomplishments

- PCPs coming to mental health staff to consult
- Staff satisfaction
- Patient appreciation and improvement
  - “You have a problem, well let’s talk about solutions”.

Accomplishments

DMH/DHS Collaboration Programs
Mental Health Integration Program (MHIP) Outcome Measures
Data Comparison Table for FY 2012-13

Categories	Total Number of Cases	Initial Screening Tool Score (Average)	Final Screening Tool Score (Average)	Percent of pre/post score change	Total Number of Sessions (Average)
DMH-DHS Program Aggregate - Anxiety All Ages Combined *(The Screening Tool is the GAD-7)*	48	12.44	6.52	47.59% Positive Change	7.13
DMH-DHS Program Aggregate - Anxiety Older Adults Population - Ages 55 and up (The Screening Tool is the GAD-7)	14	11.29	4.29	62.00% Positive Change	6.5
DMH-DHS Program Aggregate - Depression All Ages Combined *(The Screening Tool is the PHQ-9)*	151	16.97	7.92	53.33% Positive Change	7.72
DMH-DHS Program Aggregate - Depression Older Adults Population - Ages 55 and up (The Screening Tool is the PHQ-9)	65	15.68	7.48	52.30% Positive Change	7.69

(Data Run Date is: 01.03.14)

Current Status

- Opening up more sites
- MOUs to gain access to DHS systems and share patient level data
- DMH/DHS Collaboration Programs - not full integration but a step in the right direction
- Where are we in the integration continuum?

Integration Continuum

SAMHSA - Standard Framework for Levels of Integrated Healthcare

Coordinated Care

Level 1 — *Minimal Collaboration*

- separate facilities
- separate systems
- communicate rarely, based on a particular provider's need for specific information

Integration Continuum

Coordinated Care

Level 2 — *Basic Collaboration at a Distance*

- separate facilities
- separate systems
- providers view each other as resources and communicate periodically
- communications are typically driven by specific issue

Integration Continuum

Co-Located Care

Level 3 — *Basic Collaboration Onsite*

- co-located
- may/may not share the same practice space
- separate systems
- communication more regular – proximity
- occasional meeting - shared patients
- referral process – likelihood of success related to proximity
- most decisions about care done independently

Integration Continuum

Co-Located Care

Level 4 — *Close Collaboration with Some System Integration*

- beginning of integration of care through some shared systems
- typical model front desk schedules all appointments
- behavioral health provider - access and enters notes in the medical record
- complex patients with multiple healthcare issues drive the need for consultation - done through personal communication
- improved understanding of each other's roles

Integration Continuum

Integrated Care

Level 5 — *Close Collaboration Approaching an Integrated Practice*

- high levels of collaboration
- function as a true team, frequent communication
- team actively seeks system solutions; recognize barriers to integration
- some issues not be readily resolved , like the availability of an integrated medical record
- providers understand different roles of team members, started to change their practice and the structure of care to better achieve patient goals

Integration Continuum

Integrated Care

Level 6 — *Full Collaboration in a Transformed/Merged Practice*

- highest level integration - greatest amount of practice change
- previous system culture(s) blur into a single transformed or merged practice
- providers and patients view the operation as a single health system treating the whole person
- principle of treating the whole person is applied to all patients, not just targeted groups

In conclusion…

Questions?

Thank you for your attention.