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

The California Endowment  
Health Aging-Emerging Issues  
April 21, 2014  

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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?

The Plan

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

The Four Quadrant Clinical Integration Model

Quadrant II

BH  ↑  PH  ↓

- BH Case Manager w/ responsibility for coordination w/ PCP
- PCP (with standard screening tools and BH practice guidelines)
- Specialty BH
- Residential BH
- Crisis/ER
- Behavioral Health IP
- Other community supports

Quadrant IV

BH  ↑  PH  ↑

- PCP (with standard screening tools and BH practice guidelines)
- BH Case Manager w/ responsibility for coordination w/ PCP and Disease Mgr
- Care/Disease Manager
- Specialty medical/surgical
- Specialty BH
- Residential BH
- Crisis/ER
- BH and medical/surgical IP
- Other community supports

Stable SMI would be served in either setting. Plan for and deliver services based upon the needs of the individual, consumer choice and the specifics of the community and collaboration.

Quadrant I

BH  ↓  PH  ↓

- PCP (with standard screening tools and BH practice guidelines)
- PCP-based BH*

Quadrant III

BH  ↓  PH  ↑

- PCP (with standard screening tools and BH practice guidelines)
- Care/Disease Manager
- Specialty medical/surgical
- PCP-based BH (or in specific specialties)*
- ER
- Medical/surgical IP
- SNF/home based care
- Other community supports

*PCP-based BH provider might work for the PCP organization, a specialty BH provider, or as an individual practitioner, is competent in both MH and SA assessment and treatment.

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

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