

Placer County's Integration Efforts 2005 to Present

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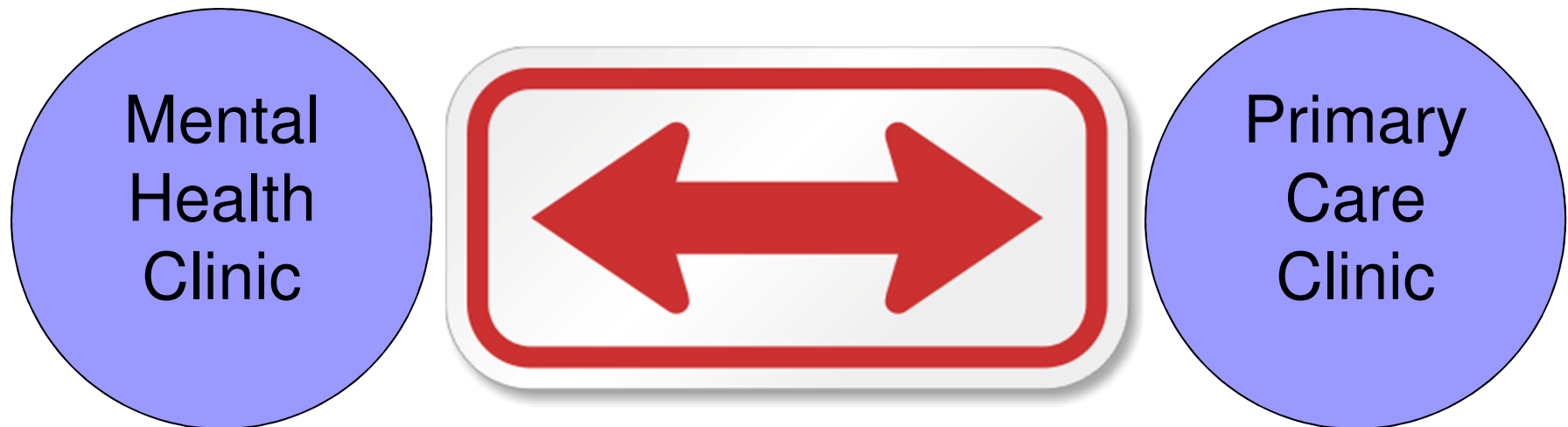
History of Integration Effort

- Effort began in early 2005
- Mental Health used PC clinic for medical care
- Referral by Clinic to ASOC for mental health services
- Established a working relationship



2005

Referrals between MH and PC





Initial barriers

- Challenges with communication between Primary Care and Mental Health
- Concerns about privacy and sharing of information
 - Clinical record issues
- Lack of administrative support
- Culture barrier between systems



Culture Barriers

- Primary care puts the onus of responsibility for accessing care on the patient
- Incompatible management information systems
- What does integration mean?



Strategies to overcome initial barriers

- Change in administration and continued energy from administrators interested in promoting integration
- Administrators worked to establish agreements regarding sharing of patient information and transfer of patients
- Staff trained on HIPAA issues to address confidentiality concerns
- Began to address cultural dissimilarities by co-locating behavioral health providers in clinic
- Development of single clinical record



2008 – 2009: Transition Begins

- Transfer of stable patients to primary care providers
- Psychiatrist 4 hrs/wk at primary care clinic
- Family Practice expands to manage stable behavioral health patients



2008 – 2009: Transition Begins (cont.)

- Established consult service formalized at MH clinic
- 7/1/09 Full time MD Psychiatrist in Clinic
- MFT treating depression at clinic (MHSA)



Case for change

- Budget
 - MH budget crisis
 - Rural Health Clinic had alternative financing strategies
- Insufficient coordination of care
 - Primary Care clinic treating an increased number of patients with severe mental illness
- Literature about mortality and morbidity
 - Patients with SMI and co-morbid medical conditions dying 20-25 years early



Strategy for Change

1. Blow up the system and start over
2. Slowly/methodically change the system
 - Inclusive consensus-building



Model for Improvement

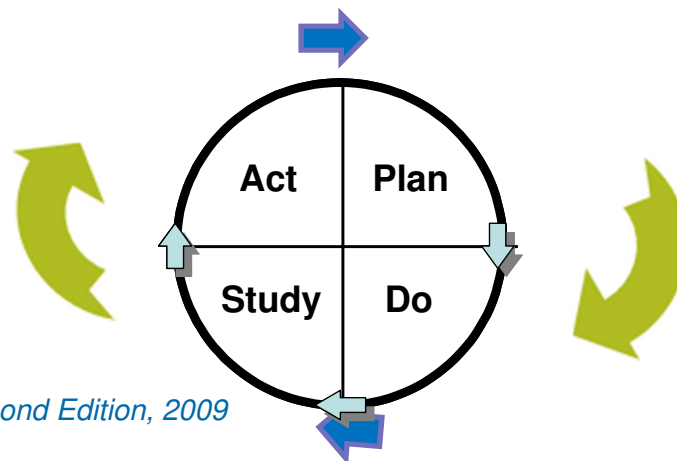
- Began participation with CPCI in 2010, which provided a framework for integration at our site
- Interventions were developed at the systems and clinical levels to further integration process

The Model

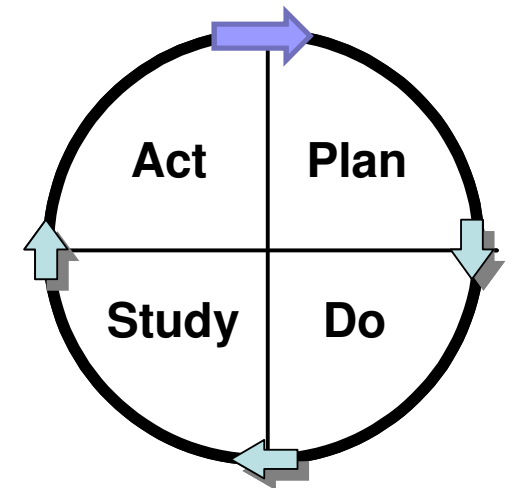
What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in an improvement?



Team:	Cycle Number: _____ Date: ____/____/____
Change or Idea Being Tested	
Objectives for this PDSA Cycle:	
What question(s) do we want to answer with this PDSA cycle?	
Plan <i>Plan to answer questions (test the change): What, Who, When, Where</i> <i>Plan for collection of data needed to answer questions: What, Who, When, Where</i> Predictions (For each question listed above, what will happen when plan is carried out? Discuss theories):	
Do: <i>Carry out the plan; document problems and unexpected observations; collect data and begin analysis.</i>	
Study: <i>Complete analysis of data; what were the answers to the questions in the plan (compare to predictions)? Summarize what was learned.</i>	
Act: <i>Based in the new knowledge, plan for the next cycle.</i>	





Interventions: System level

- Hired MSW (MHSA)
- Psychiatrist, MSW and MFT all located within medical clinic
- Combined medical/MH chart
- RN assigned to work with SMI with comorbidities (CalMend cohort) part time
- “Champion” doctor identified to promote integration & work with MH team



Interventions: System level (cont.)

- Quality assurance of charting, standards of care
- MH assessment and treatment training for PC providers
- Policies and procedures developed to support integration
 - Clerical-level issues addressed through new communication guidelines
- RN assigned to triage, follow-up with psych patients (on a trial basis at present)₁₅



System Outcomes

- PCP providers request support from CalMend team with MH patients or concerns
- Standards of care regarding labs for diabetes, dyslipidemia, AAPs established clinic-wide
 - RNs now able to order labs
- Outcomes sheet in combined chart for CalMend participants



Clinical Interventions: December to present

- Shared care planning with clients, PCP, psychiatrist
- Therapy, case management provided to help SMI improve self-management of physical illnesses
- RN and MSW work 1:1 with clients to improve self-advocacy skills & to help identify strategies to ensure that adequate medical attention is received from PCP



Clinical Interventions:

December to present (cont.)

- Educational groups to promote self-management
 - Nutrition
 - Smoking cessation
- Support groups to promote self-management
 - Walking, weight loss, caregiving, self-esteem



Clinical Interventions:


December to present (cont.)

- Referral for AOD treatment & smoking cessation
- 1:1 consultation with dietician (on hold since Aug. 30), RN, MSW as needed
- Clients actively participating in program activities are encouraged to develop a team mindset



Early Clinical Outcomes

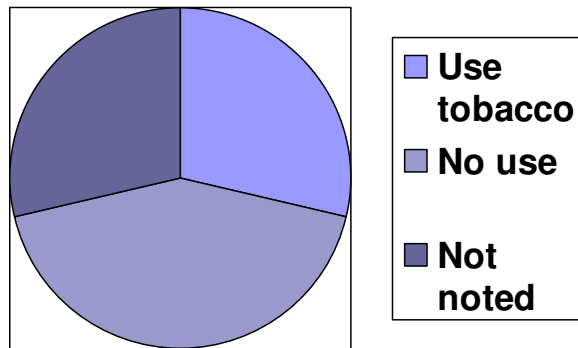
- Improved documentation of tobacco, AOD status
- Improvement in frequency of lab orders
- 1 patient in smoking cessation program quit smoking
- 3 out of 8 patients with AOD problems began attending AOD tx programs



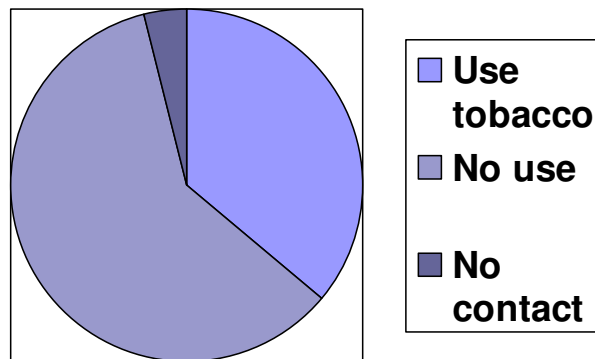
Early Clinical Outcomes (cont.)

- Decrease in average HgA1c & average total cholesterol now within normal range
- Team mindset developed
 - Group decided to share phone numbers
 - 4/30 NAMI walk team— “Gold Country Walkers”

Tobacco: July, 2010 to March, 2011



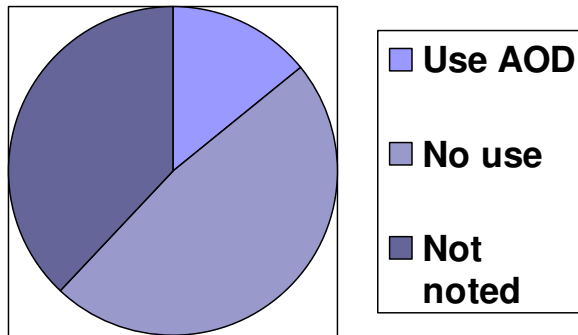
- July '10 (in progress notes)
 - 28.5% of patients use tobacco
 - 43% do not use tobacco
 - **28.5% of patients' tobacco status is not documented**



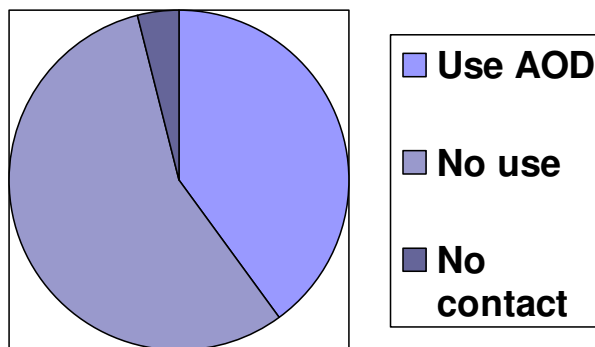
- March '11 (in CalMend notes)
 - 36% of patients use tobacco
 - 60% of patients do not use tobacco
 - 4% have lost contact with CalMend
 - **0% not documented**

N=25 (test group)

AOD: July, 2010 to March, 2011



- July '10 (in progress notes)
 - **14% of patients use AOD**
 - 48% do not use AOD
 - **38% of patients' AOD status is not documented**

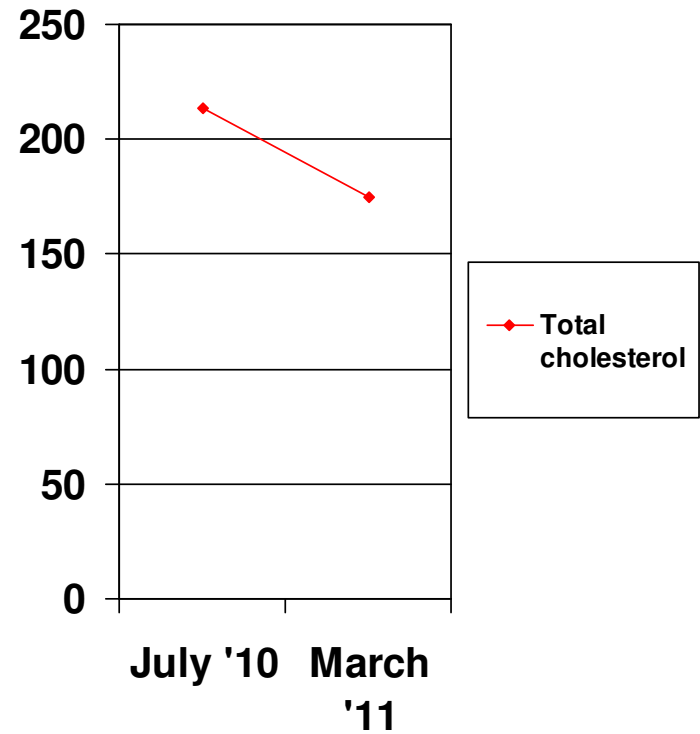
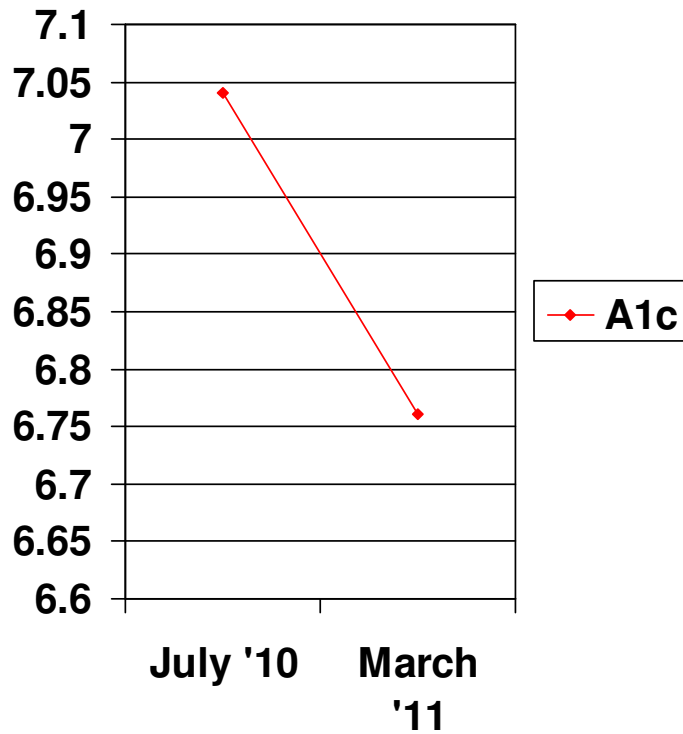


- March '11 (in CalMend notes)
 - **40% of patients use AOD**
 - 56% of patients do not use AOD
 - 4% have lost contact with CalMend
 - **0% not documented**

N=25 (test group)



Average A1c and Total Cholesterol





Impact Stories

“Sherry”

- Referred to CalMend for “relief of depression” and “improvement in ADD symptoms.”
- Initial assessment:
 - Reported 3 concerns that she was “afraid” to tell her doctor about:
 - Started smoking again
 - Bump on neck
 - Incontinence
- CalMend interventions:
 - Helped client make a list of concerns for PCP and encouraged her to talk to PCP
- Results:
 - Sherry talked to PCP and got a referral for bump on neck
 - Bump turned out to be cancerous and was subsequently removed
 - Sherry reports that CalMend “saved my life.”

Lesson: Improving communication between patient and PCP improves health/decreases risk



Impact Stories

“Richard”

- Referred to CalMend to for weight loss support and counseling
- Initial assessment:
 - Weight 330, A1c 7.5, suicidal ideation daily, possible meth abuse
- CalMend interventions:
 - Referred for AOD assessment
 - Coordinated with PCP to change psych medication
 - Brief skills-building therapy
 - Referred to local diabetes education group
- Results:
 - Weight 310, A1c 6.1, reports decrease in suicidal ideation, began participating in AOD tx

Lesson: Case management improves physical health outcomes



Integrated Care

- Treating chronic conditions in primary care
- Specialty mental health available as needed
- Addressing whole person in care program—mental, physical, spiritual, environmental
- All team members must be on board



Future

- LHP—will create expansion of patients
 - More people will be qualified to receive services
 - We will be more prepared to address expansion
- Matching provider with psych patients according to need (PC vs. psychiatrist)
- Plans to train all staff—including clerical—on integration process