OLE HEALTH

Live Life Well

a california health+ center

Integrated Healthcare

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RCHC Integrated Health Learning Collaborative
Session 1

Our Work in the Community

- **93,904** Total Visits in 2014
- **24,534** patients served
- **13,161** patients served in language other than English
- **6,379** patients are agricultural workers or dependents
- **5,371** patients are uninsured
- **8** total sites in Napa County
- **1** site in Solano County

SAMHSA 6 Levels of Integration

Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understanding of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet ill-defined team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth understanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

Integrated Sites

Napa Medical: Pear Tree Lane

- ❑ Warm Handoffs
- ❑ Brief Therapy
- ❑ Psychiatry
- ❑ Co-located services
  - ➢ psychiatry
  - ➢ specialty mental health
  - ➢ Alcohol and Drug Services
  - ➢ Pre-crisis services
- ❑ Comprehensive Perinatal Services Program
- ❑ Groups
- ❑ BH Care Coordination

Integrated Sites

Woman's Health Services: Napa

- ❑WHOs
- ❑Brief Therapy

County Campus: Napa

- ❑WHOs
- ❑Brief Therapy
- ❑Care Coordination
  - ➢ Patients with chronic illness (diabetes, heart disease, obesity and SMI or Addiction)
- ❑Collaboration with County Services
  - ❑Shared patient information
  - ❑OLE Health Provider is ADS Medical Director

Integrated Sites

Homeless Shelter

- ❑Primary Care
- ❑WHOs
- ❑Small amount of brief therapy

St. Helena

- ❑Psychiatry
- ❑Co-located specialty mental health

Fairfield

- ❑WHOs
- ❑Brief Therapy
- ❑Dental
- ❑BH Care Coordination

Snapshot of BH Integration

Screens

PHQ2, GAD2 with each primary care visit (MAs)

PHQ9, GAD7 and Audit-C with each BH visit

WHOs (MFTi)

Brief Therapy (LCSW)

- ❑1-6 sessions
- ❑Mild to Moderate
- ❑Episodes of Care
- ❑Providers use evidence-based modalities: motivational interviewing, problem-solving therapy, CBT

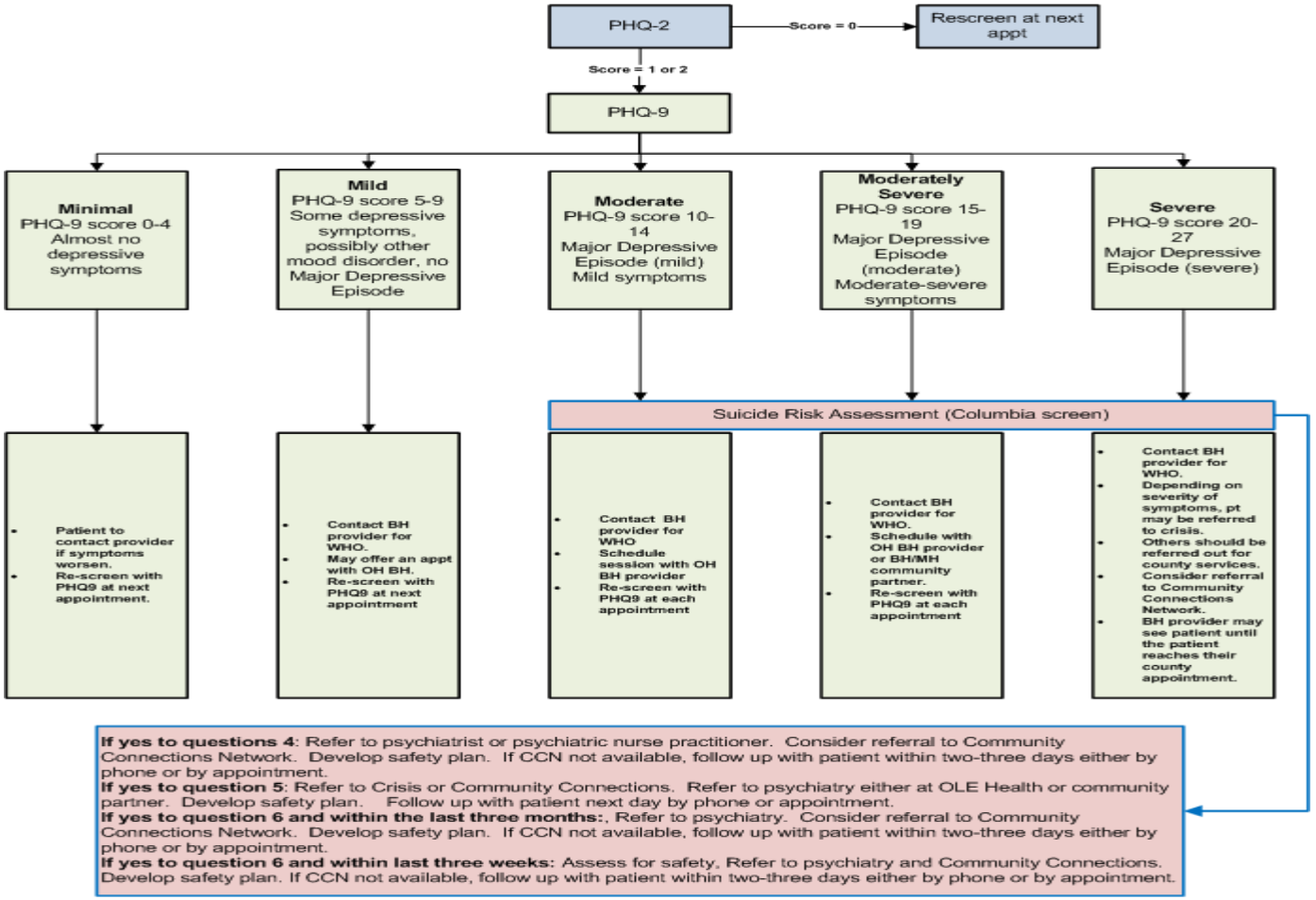
Psychiatry (Psych NP and Co-located psychiatrist)

- ❑Mild to Moderate
- ❑Psychiatrist works as consultant

Specialty MH (Co-located MFT, LCSW)

- ❑Moderate needing longer-term care
- ❑16 – 20 sessions

Screens: PHQ2, GAD2; {PHQ9, GAD7, AUDIT-C}



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Snapshot of BH Integration

- **Groups (MFTi, ACSW)**
  - ❑Depression support groups (Spanish and English)
  - ❑Chronic pain support group
- **SBIRT(Psych NP, Psychiatrist, LCSW)**
- **Utilization Review**
- **Communication**
  - ❑EMR (eClinical Works)
  - ❑Curbside consultations
  - ❑Team meetings
- **Opioid Oversite Committee**
- **Workforce**

Internal Referrals

Behavioral Health Provider

- ❑Most anyone can schedule or refer

Psych Nurse Practitioner

- ❑Provider refers; Most anyone can schedule
- ❑ Med management and therapy

Co-located specialty MH therapist

- ❑Provider refers; Screened by BH Manager prior to scheduling

Groups

- ❑Referral process dependent on group

Psychiatrist

- ❑Provider can refer
- ❑Scheduled by Integrated Care Coordinator

Psychiatric Referral back to PCP

Patient will see the psychiatrist/psych NP until the following occurs:

- ❑ **Patient is stable on medication regime (No medication changes in at least 2 visits)**
- ❑ **There is a clear reduction in symptoms present when referred.**
- ❑ **And/or**
- ❑ **There is a statistically reliable change in PHQ 9 score ≥ 6pts**
- ❑ **There is a statistically reliable change in GAD7 ≥ 4pts**

Recovery is defined as movement to a score below caseness from a score of caseness or above.

Measure	Disorder	Range	Caseness	Statistically Reliable Change
PHQ-9	Depression	0-27	10	≥ 6
GAD-7	Generalized anxiety disorder (and unspecified anxiety problems)	0-21	8	≥ 4

External referrals

Psychiatry

- ❑ Moderate to severe
- ❑ Need longer term care
  - ➢ County Med Clinic
    - ▪ Fast Track

Therapy (Group and Individual)

- ❑ Moderate to severe
- ❑ Mild to moderate but may benefit from longer-term care
  - ➢ County Access
  - ➢ Beacon Programs

Alcohol and Drug

OLE Health/Aldea Collaboration

OLE Health/Aldea Collaboration

- Collaboration with Aldea in Solano County
- Share the same building
- Aldea patients check-in at OLE Health prior to their MH appointment
- Care Coordinator is an Aldea employee
  - Works closely with OLE Health BH provider
  - Performs WHOs
  - Oversees all BH referrals
- Aldea patients (especially foster care children) utilize OLE Health for primary care.
- Administrative Collaboration

BH Integration Initiative

- Partner agencies: Aldea, Mentis, Napa County Health and Human Services and OLE
- Form a Policy Council
- Develop a model of cross-agency integration
- Utilize a care coordinator to:
  - Oversee all outgoing referrals
  - Coordinate care and track outcomes for a defined target population of Patients with Depression and Diabetes
- Implement a mechanism to exchange patient health information electronically
- Form a operational workgroup to oversee care coordinator workflow

Tracking referral data

January-December 2015 (Q1+Q2+Q3+Q4)									
Agency Name	Number of Referrals	RDS	Outcome(s) of Referral(s)						
			Received Services		Did not receive services		No info/Outcome Unknown		Average Wait Time (calendar days)
Aldea	158	1	49	31.0%	109	69.0%	0	0.0%	48
SOAR	9	0	2	22.2%	7	77.8%	0	0.0%	20
Aldea co-located therapist	77	0	48	62.3%	29	37.7%	0	0.0%	32
NCMH Access- Adult Med Clinic	71	4	34	47.9%	37	52.1%	0	0.0%	27
NCMH Access-Adult Therapy	54	0	8	14.8%	46	85.2%	0	0.0%	41
NCMH Children's Unit (Psychiatric Services)	10	0	5	50.0%	5	50.0%	0	0.0%	41
NCMH Children's Unit (Therapy Services)	31	1	8	25.8%	23	74.2%	0	0.0%	45
Alcohol & Drug Services	87	0	9	10.3%	78	89.7%	5	5.7%	8
Community Connection Network	63	1	37	58.7%	26	41.3%	0	0.0%	2
Mentis	292	3	90	30.8%	202	69.2%	0	0.0%	51
Mentis co-located therapist	20	0	11	55.0%	9	45.0%	0	0.0%	16
Mentis Medi-Medi	29	0	3	10.3%	26	89.7%	0	0.0%	71
Total	**901**	**10**	**304**	**33.7%**	**597**	**66.3%**	**5**	**0.6%**	**26**
January-October 2014									
Total	374		44		125	33.40%	200	53.50%	

Tracking referral data

January-December 2015 (Q1+Q2+Q3+Q4)						
Agency Name	Did not receive services	Unable to Contact	Declined Services	Not Eligible	Client Delayed Service	Pending
Aldea	109	21	29	6	0	53
SOAR	7	1	5	0	0	1
Aldea co-located therapist	29	5	6	0	0	18
NCMH Access- Adult Med Clinic	37	4	19	6	0	8
NCMH Access-Adult Therapy	46	5	29	2	0	10
NCMH Children's Unit (Psychiatric Services)	5	2	0	0	0	3
NCMH Children's Unit (Therapy Services)	23	2	11	4	0	6
Alcohol & Drug Services	78	6	62	6	0	4
Community Connection Network	26	9	14	2	0	1
Mentis	202	69	42	5	1	85
Mentis co-located therapist	9	1	3	0	0	5
Mentis Medi-Medi	26	0	16	1	0	9
Total	597	125	236	32	1	203

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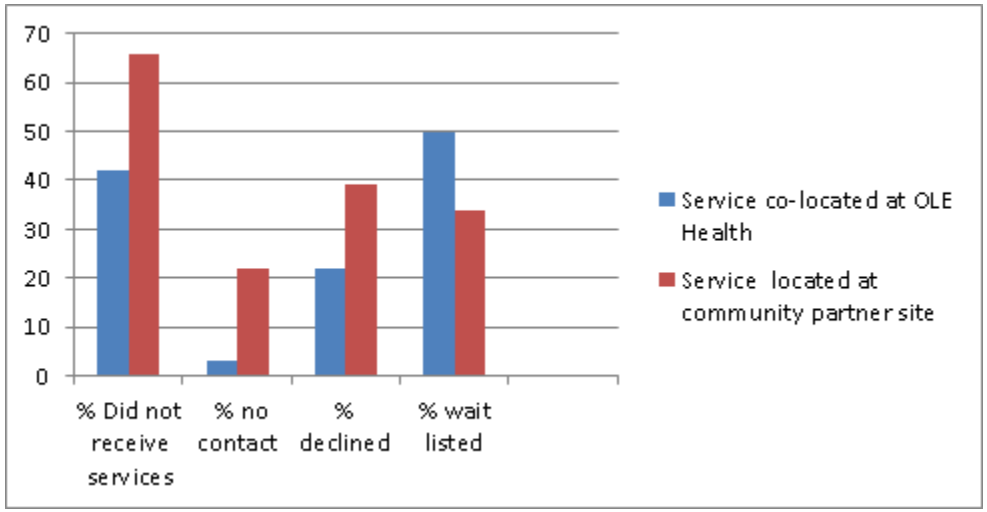
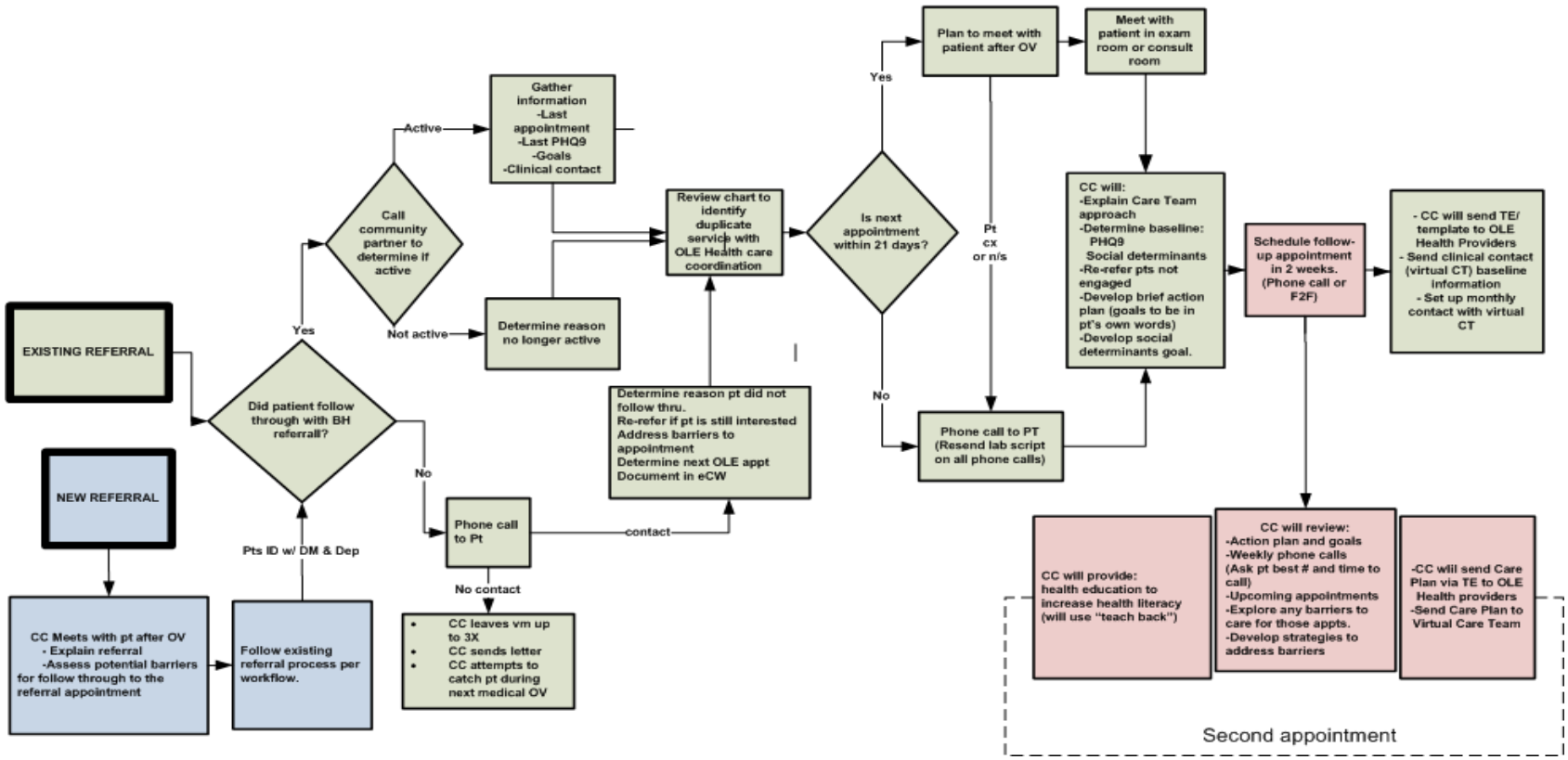
Co-located services vs onsite services



Behavioral Health Care Coordination

BH Care Coordinator workflow



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BH Integration Initiative next steps

- Expand care screening and referral practices to other patient populations
  - Other chronic conditions
  - Children at-risk for diabetes and depression
  - Stable SMI clients that need primary care
- Expand chronic disease focus to "prevention" focus by including smoking cessation; depression screening for adolescents, etc.
- Perform medication reconciliation during care transitions between hospital and primary care home
- Support patient self-management

BH Integration Initiative next steps

- Expand role of hospitals/urgent care for transitions back to primary care home
- Expand the range of outcome measures:
  - Decreased number of inpatient admissions
  - Decreased use of ER visits
  - Improved patient experience scores
  - Enhanced communication with their PCP and/or care coordinator
  - Improved patient understanding of their condition and how to best self manage it
- Establish the business case for the model and enlist additional community partners

Moving Forward with Integration

- Behavioral Health included in chronic disease clinical pathways
  - Currently collaborating with Nutrition
- Team meetings
- Developing medication guidelines
- Training
- Additional groups
- Increased workforce

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Thank You!