Brief History of OLE Health-Napa County Integration

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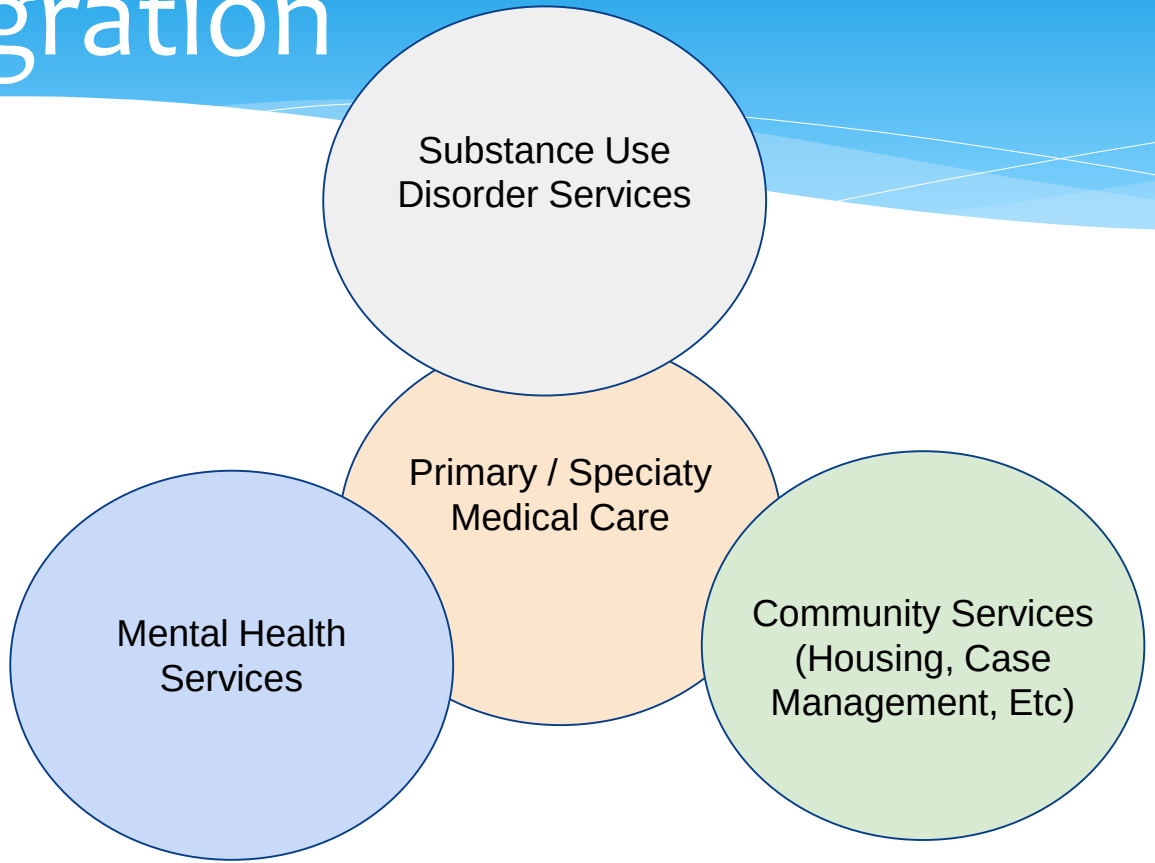
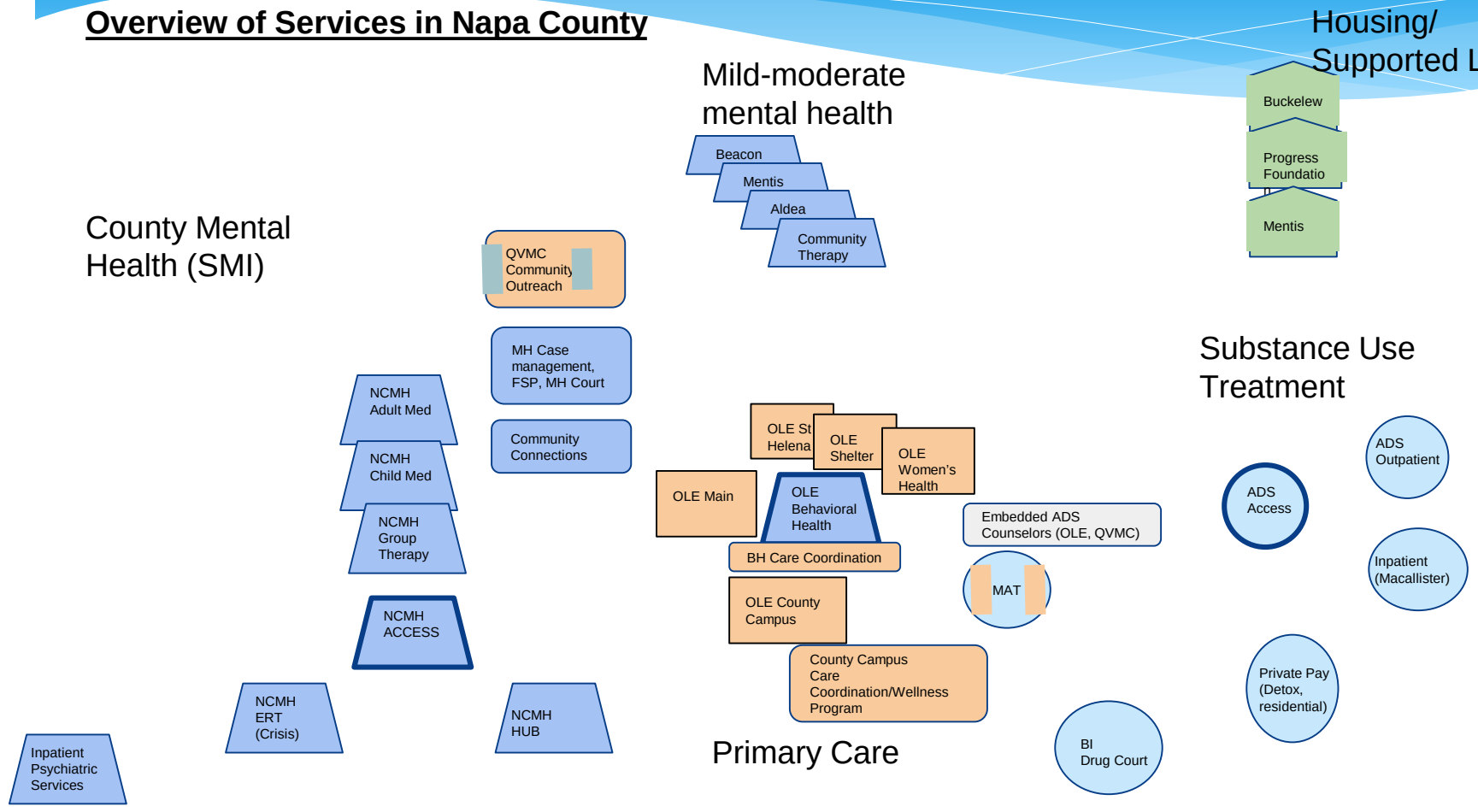
Integration



Overview of Services in Napa County



Integration between OLE Health and Napa County

2007: Lack of access to community psychiatry services increases pressure on FQHCs to treat severe mental illness

2008: Started a process for conceiving a co-located primary care clinic on site with Napa County Mental Health / Alcohol and Drug Services to increase collaboration

Goals:

-Improve access to primary care for patients w/ severe mental health and substance use disorders

-addess health disparities affecting these populations

-help transition patients who are stable on psychiatric regimens back to primary care

-help create a system of coordinated care

Clinic Opens: October 2011

Initiation of co-located primary care clinic on Napa County campus
Structure: PCP physician and NP, clinic manager, front office / MA, pharmacy assistant
-Focus on "Care Coordination group" - select group of up to 30 pts who have SMI and chronic medical illness (diabetes, HTN, obesity)
-RN: weekly medi-set appointments for patients to be monitored closely
-Standards for lab work and follow up for helping track outcomes (BMI, HbA1c, BP, etc)

Aspects of Integration: Mental Health

* Regular contact with psychiatric provider (Psych NP) who was responsible for reviewing cases and referrals to mental health, and coordinating care (labs, plan, etc). Also for informing PCP about concerns with medical conditions that need follow up
* Monthly Multidisciplinary Team Meetings (MDTs) with the entire psychiatry staff and PCP about particularly challenging patients - getting back story, understanding, and developing shared treatment plans
* Developing relationships with case managers - often came with patients to visits to provide more corroborating information about patients
* Medi-sets: RN from MH and RN from PC would collaborate to monitor complex, labile patients

Aspects of Integration: ADS

* Minimal integration at first
* Development of ROI forms that allowed information sharing, especially in light of 42 CFR barriers
* Connection with inpatient ADS treatment facility (Macallister) around access to patients in detox/rehab who need evaluation and treatment of medical and mental health conditions - would come to primary care due to ease of access (as opposed to Mental Health)

Evolution of the Experiment

2014-2015: 100% turnover in the psychiatry clinic (psychiatrists and RN) meant lot of relationships needed to be rebuilt

New MH medical director (Dr. Becky Gladding) with changes:

-Streamlined process for fast-tracked referrals
-Consult psych approach
-Lack of psychiatry resources necessarily meant close collaboration w/ PCP

Structural changes:

- -No medi-sets at NCMH
- -MDTs changed in their scope to being more focused and operated by case managers

ADS Medical Director

Started as Medical Director at the end of 2015
Weekly meetings with treatment team to discuss difficult cases, and provide feedback with primary care providers (within OLE Health system only)
Structured format for ADS physicals to identify health needs and provide better coordination / communication to PCPs regarding substance use disorders
Areas to work on: improved access to SBIRT and intake for those patients in the pre-contemplative stage or for whom SUD identified but not engaging in treatment
More structured access / referrals processes for MAT

Current Status: Mental Health

Dr Gladding left at end of 2015; newly hired Medical Director (Oct 2016) meant that the last 9 months were challenging

Many potential projects on hold

-Fast tracked referrals

-Incorporating stable patients back into primary care

-Medi-sets: How to help complex patients manage medications

Current Status: ADS

Coordination continues to improve
Goal is to expand access to Medication Assisted Treatment
Continue to be challenged by 42 CFR regulations

Piloting MAT Programs

Vivitrol

-Initiated 2013, referrals from ADS/Drug Court for patients who qualify

-Approx 5 patients; 1 patient completed 1 yr of treatment, 2 currently in tx, 2 who started and dropped off (1 of whom is now deceased from OD)

Buprenorphine

-1st patient in late 2014; self-referrals, only certain patients

-Currently: 23 patients total have been treated. Protocols for clinic and home inductions, required referrals for Tx program (County ADS or BH at OLE Health)

Other Aspects of Integration

Personal relationships are the key!

Case Managers:

-Drug court, mental health court, full-service partnership programs, Progress foundation, Collabria care, Community Outreach at QVMC, TAY program

Liaison with Napa County Jail

Napa County Hub

-Individual social workers who work with patients on brief therapy, helping people gain access to assessments, doing home visits

Care Coordination / Wellness Program

Initially started w/ goal of 30 patients…

-Funded through a contract between Napa HHSA from matching federal funds for low income patients in Sept 2013
-Care coordinator responsible for tracking outcome measures, visits, etc.
-Registered Dietician: teaching classes at PEP (now Innovations) - local peer support program for MH clients

Since..

-3 different people have been in role of care coordinator
-Currently we also have a fitness coach, RD/nutrition, behavioral health: classes now being taught by both fitness coach and RD at Innovations as well as with ADS
-Making contacts/connections with ADS program also
-More clear structural outline to program: (1) patient eligibility criteria - 3 different tiers/prioritization of patients, (2) longitudinal structure in 3 phases of treatment

County Campus Wellness Program

Program Eligibility

To be eligible individuals must be established patients of OLE Health County Campus and have willingness and the capacity to make changes in their lifestyle. They must have a SERIOUS AND PERSISTENT MENTAL ILLNESS and/or a SUBSTANCE USE DISORDER and a chronic medical illnesses:

SERIOUS AND PERSISTENT MENTAL ILLNESS

Schizophrenia, Bipolar Illness, Schizoaffective, and Major Depression (depending on level of impairment).

SUBSTANCE USE DISORDER

Variety of substances, individuals involved in recovery

CHRONIC ILLNESS

Prioritizing Patients for Wellness Program

First Priority Patients	Second Priority Patients	Third Priority Patients
Diabetes Heart Disease Fatty Liver Disease BMI over 40	Pre diabetes OR Obesity over 30 with one of the following: -Hypertension -Hyperlipidemia -Sleep Apnea -Chronic Pain Syndrome	Not Obese with one of the following: -COPD and smoking -Fibromyalgia / Chronic Pain Syndrome

Current Results

* **Care Coordination**
  * Currently we have 19 pts in the program
  * 3 – Currently enrolled in ADS.
  * Over the last 6 months 7 patients have withdrawn from the program
  * Most people reported that they “were overwhelmed with responsibilities” and or “not ready” to make changes at the time.
* Data on weight loss:
  * 2/3 of patients had weight loss, with 13% having > 10% wt loss compared to baseline weight

Future Goals

Continuing to build personal relationships in a setting in which there is always a lot of staff turnover is challenging

Building institutional structures between different organizations (with different medical records systems, etc.) is challenging

Measuring outcomes…

-Anecdotally, lot of stories of patients dramatically improving certain health markers by being in the program. However, from a data perspective, we are still waiting to do the analysis (what is our time frame?)

Questions?