

III. INTEGRATION OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES INTO PRIMARY CARE PROGRAM (INTEGRATED CARE PROGRAM)

Issue

Access to affordable mental health care that is integrated into the primary care setting for patients of safety net clinics.

Vision

Preventive, diagnostic and therapeutic services for mental, substance abuse and physical conditions are delivered by a fully integrated team composed of primary care providers, psychosocial therapists and psychiatrists, with readily available consultation with substance abuse counselors.

Future Focus

Execution of two integrated care model programs in the Health District, one at each of the major safety net primary care clinics.

Short Term Implications

Support planning of a care model integrating mental health care and substance use prevention, assessment, treatment, care coordination and referral services into the primary care clinics, positioning our community for two successful implementations of the model in 2005. Assure that the models are evaluated for effectiveness.

Factors Influencing Choice as Health District Priority

Extent of Health Burden to the Community

Mental health conditions are common in the Health District and together they were estimated to account for nearly one-third of the disease burden in the 2001 prioritization analysis. Most mental health conditions are very amenable to treatment but many persons needing mental health services experience barriers to obtaining them in the Health District (see Mental Health Services in the Health District 2005 Strategic Plan). Consequently, inadequate access to mental health services was estimated to be a large contributor to disease burden in the community. Lack of access to mental health services ranked 9th among the risk factors contributing health burden in the Health District. Efforts to improve access to services would be expected to reduce that burden. If all residents had full access to mental health services, used those services when they needed them, and received high quality care, the community could potentially gain 263 years of healthy life annually.

Lack of access to primary care is also a top contributor to disease burden and a priority issue for the Health District. Because mental health and physical health are inextricably linked, access to primary care plays a key role in the delivery of mental health care. There are many factors that

make integration of mental health care into primary health care a logical development. An analysis conducted for the Health District Board in 2003 documents the following evidence (see “The Impact of Mental Health on Health Status and its Relationship to Primary Care”, Health District, 2003):

- The underlying causes of many of the common somatic complaints that patients bring to their primary care physicians are psychosocial. As many as 70% of patient visits are for medical complaints that stem from psychological factors.
- Chronic medical conditions and mental illness or substance use disorders often co-exist in the same patient.
- Many chronic diseases can be prevented or treated in part by engaging patients in behavioral change.
- A substantial proportion of people with psychiatric symptoms present in primary care—of the half that ever seek care, 50% receive their care in the primary care setting. Reasons include easier access and less perceived stigmatization. Patients may have an established relationship of trust with the PCP. They may perceive their symptoms as physical.
- Mental disorders are common among primary care patients. One-quarter of patients seen in the primary care setting have a mental illness. Another 15% have sub-threshold disorders with significant functional impairment. These proportions may be twice as high in clinics that serve low-income and uninsured populations.
- Many people receive their mental health care exclusively from their PCP and prefer it that way. Studies have shown that one-third to one-half of primary care patients will refuse referral to a mental health professional.
- Studies have shown that PCPs commonly misdiagnose mental health problems, missing illnesses in some and over-diagnosing in others. It is estimated that about 50% of patients with mental disorders go undiagnosed in the primary care setting.
- Even when correctly recognized, primary care providers vary in their capacity to effectively treat mental illness.

There is a growing body of evidence that when mental health care is integrated into primary care, the identification and treatment of people with mental disorders improves significantly.

Health District Experience

Since 1996 the Health District has enhanced access to direct mental health services beginning with the Pro Bono Therapist Program. In 1997, therapist referral services were added and in 1999 the Health District began funding outpatient psychiatric services, first through an on-site psychiatric specialty clinic and later, through a voucher for service program. Also since 1996, the Medical Services Program has been delivering primary care services on the Health Van, including mental health assessment and treatment services. Both Mental Health Pro Bono and the Health Van have been a source of consultations and referrals to the other program. In particular, the Health Van has provided interim medication management and prescription refills for Connections clients moving into the community or recently discharged from corrections or an inpatient program and waiting to get into formal psychiatric follow-up care.

In 1999, the District was instrumental in organizing the Community-wide Mental Health And Substance Abuse (MH/SA) planning process (see 2005 Strategic Plan, Community Mental Health and Substance Abuse Partnership). In 2001 the MH/SA Partnership was formed to coordinate an action plan to address the critical issues identified in the planning process. In response to the need identified by the Partnership to assure adequate connections to services, the Health District entered into a partnership with the Larimer Center for Mental Health in 2002 to expand pro bono and therapist referral services and add assessment, crisis intervention, brief therapy services and consumer advocacy (the “Connections Program”). The Integration of Mental Health and Substance Abuse Services into Primary Care Program was conceived, in part, to address two other needs identified by the Partnership: 1) the need for increased capacity for psychiatric services and 2) the need for improved identification, diagnosis and treatment of mental disorders by primary care physicians.

Other Community Services

There are two primary care clinics serving medically underserved populations in the District: Plan de Salud del Valle (Salud), a federally qualified health center, and Family Medicine Center, a family practice clinic and family medicine residency program. Between the two, they serve approximately 9,200 children/adolescents and 9,400 adults. The clinics are currently able to provide adequate capacity for physical health care services, but administrators and physicians from both have expressed increasing concerns about the increase in presentation of mental health issues, including serious mental illnesses in adults (SMI) and serious emotional disturbances in children (SED). Both of the safety net primary care clinics have mental health workers on staff and integrate mental health care with primary care, but capacity is very limited and there are no integrated psychiatric services.

Medically underserved persons with mental disorders have two main options for mental health care outside of the care delivered in the primary care safety net: the Connections Program or Larimer Center for Mental Health. Services at LCMH operate at capacity and often have long waiting times for psychiatric specialty care, particularly for those who don’t qualify for Medicaid. The Health Provider Shortage Area (HPSA) survey conducted by the Health District in 2003 found that the provider to population ratio for psychiatric care to the low-income population was 1:26,500, well below the underserved threshold of 1:20,000. The MH/SA Partnership service mapping project identified access to services for mental health diagnosis and initiation and follow-up of pharmacotherapy as major gaps in services in the District, particularly for low-income populations.

Estimated Unmet Need

A trend towards increasing prevalence of mental disorders was noted in the 2001 Health District Community Health Survey: 20.4% of respondents reported that they were currently suffering from “depression, anxiety, or other mental problems” in 2001, up from 17.6% in 1998. The average adult reported having 4.7 days in the past month when “mental health was not good”. This number was 33% higher among low-income and 77% higher for those in poverty than among those above low-income. The self-reported prevalence of mental health problems from the Health District survey was nearly identical to diagnosable mental disorder prevalence estimates from national epidemiological studies (20.4% vs. 21%). Applying this estimate to our

population, about 32,800 persons suffer from mental disorders in any given year in the Health District, most of whom do not receive care.

Given between one-quarter and one-half of primary care patients have diagnosable mental disorders, we estimate that between 4,800 and 9,600 patients attending Salud and FMC in a year have mental health problems.

Despite the array of effective known treatments, surveys have consistently found that over 50% of persons with mental disorders do not receive treatment, and may needlessly suffer distress, disability, lost productivity, homelessness, over-use of other health care services and in some cases death. In the Health District's 2001 CHS, a striking 28% of uninsured adults indicated they had delayed seeking needed mental health care, compared to 12% of respondents with health insurance.

Health District Plan for Services

Intervention Hypothesis

If the Health District:

- Engages key partners and stakeholders to integrate mental health care systems into two of the primary care safety net clinics,
- Facilitates a planning process,
- Funds the hiring of mental health workers, and
- Plans and funds training programs

Then patients who are cared for in these clinics will receive more timely, appropriate and effective mental health and substance abuse care.

Service Plan

The Health District plans to provide the following mental health and substance abuse primary care services in 2005:

Preliminary Planning Phase

The planning phase initiated in 2004 will be completed with participation of all key partner organizations. Planning activities to be completed in January 2005 include:

- Final draft of implementation plan (goals, objectives, work plan and evaluation plan; budget, accounting and budget management procedures; staffing plan, coordination, training, supervision and communication plans).
- Securing final plan approval with decision makers of all key partners
- Memoranda of Understandings, agreements and contracts signed
- Baseline outcome indicators collected
- Inputs (hire staff, secure space, purchase equipment and supplies) secured
- Development of policies and procedures and supporting documents
- Forms and paperwork processes developed
- Establish oversight/evaluation committee; meetings and reporting systems
- Staff training, internal publicity

Implementation Phase

- Implementation of the Integrated Care Program in the first half of 2005

- Initiate program monitoring, evaluation and feedback phase
- Make initial program improvements in the second half of 2006.

Annual Objectives

Objectives for the program in 2005 will include:

- 1.) Complete the final implementation plan for the Integrated Care Program, including goals, objectives, work plan, budget, evaluation plan, and marketing/communications plan by 4/1/2005.
- 2.) Secure signed letters of approval to the final Integrated Care Program plan with decision-makers of all key partners by 4/29/2005.
- 3.) Begin implementation of the plan by 7/1/2005.
- 4.) Facilitate and monitor progress on the plan by reporting bi-monthly to Steering Committee and Board.

Partners

Key partners include the Family Medicine Center, the Salud Family Clinic Fort Collins, the Larimer Center for Mental Health and Island Grove Regional Treatment Center (Hope Branch). Consumers will participate in planning meetings.

Evaluation Plan: Program Targets

Until the plan has been developed and finalized, the Project will be evaluated on the basis of progress made on accomplishing annual (planning year) objectives. As part of the planning process, Key Partners will agree upon process targets, outcomes, and client satisfaction indicators for the project as part of the evaluation plan.

The Community Mental Health and Substance Abuse Partnership has identified a group of objectives under the RWJ grant for which this project will provide target data. These include:

- Objective C1.f2b: “Consumers will indicate satisfaction with access to and quality of services.”
- Objective C1.p1: “One FTE psychiatrist will be hired.”
- Objective C1.p6: “The integrated primary care mental health project is in place.”
- Objective C1.o2: “More appointment hours will be available for diagnosis, prescriptions and monitoring.”
- Objective C1.o4: “Waiting times for new consumers needing psychiatric services will be reduced.”

Communication Needs/Plan/Outcomes

Staff will work with communications to assure that human services agencies and other referral sources to mental health services are informed about eligibility criteria and services offered once they are available.

Staffing Plan

The Integrated Care Program will be staffed by a 0.1 FTE Community Projects Program Specialist and will be coordinated by the Medical Director. The Executive Director will assist in planning strategy. An integration team composed of psychiatric and therapist mental health workers will be hired beginning in late 2004. Specific staffing for the implementation stage will be determined in the planning stage. Administrative and support staff will provide support services. The total full time equivalency (FTE) for integration services in 2005 will be 7.805. *The detailed staffing plan is found in Appendix E.*

2005 Budget

The 2005 budget for the Integrated Care Program is:

\$759,531	expenditures
<u>\$ 33,000</u>	<u>revenue</u>
\$726,531	net expenditures

The detailed budget is found in Appendix F.