Community Health Centers of Lane County

Community Health Centers of Lane County is an FQHC located in Springfield/Eugene, Oregon. Our clinic serves almost 16,000 patients, 650 of whom are actively receiving a combination of behavioral health services. This subset of our patient population is predominately severely and persistently mentally ill. The most common diagnoses are schizophrenia and bi-polar disorder. Many are dually diagnosed with substance abuse disorders. Almost all patients are either uninsured or receive Medicaid or Medicare benefits.

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PARTICIPATION

What motivated your practice site to participate in this initiative?

There were three main motivators to integrate care between primary care and mental health treatment. First, the medical providers identified inadequate processes and staff in place to provide for the mental health needs of our primary care patients. Second, research shows that severely and persistently mentally ill (SPMI) patients die 25 years sooner than the general population. Third, there are a large number of patients with significant mental health needs, however our two systems have traditionally worked in silos and communication about shared patients was virtually non-existent.

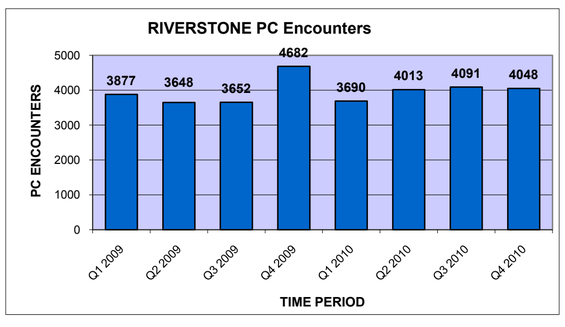
Many patients with mental health challenges require a disproportionate time and can be very disruptive to the practice. Our providers expressed a desire for greater accessibility to counseling staff and psychiatric consults. We strongly believe that these services should be available on-site as the fiscal reality, as well as the culture of our community, makes traditional mental health services difficult to access.

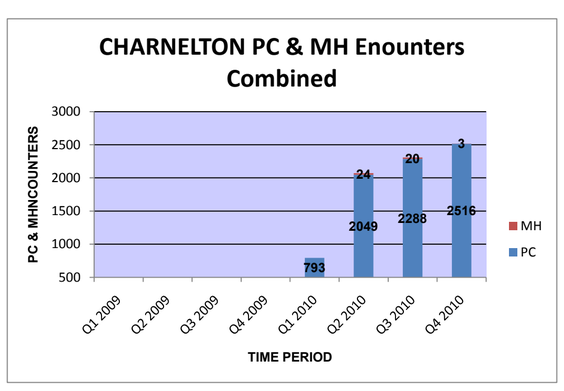
In 2005, CHC management brought a mental health specialist into primary care services. The therapist had an easily accessible office and provided brief behavioral interventions, consulted regarding resources, and supportive counsel to clients struggling to incorporate changes in their lives. In 2008, a satellite primary care office was co-located within our county's community mental health program. A primary care provider, medical assistant and an office assistant are located within the county mental health program. Co-location has resulted in immediate benefits in the number of shared patients with chronic health issues, as well as acute care needs.

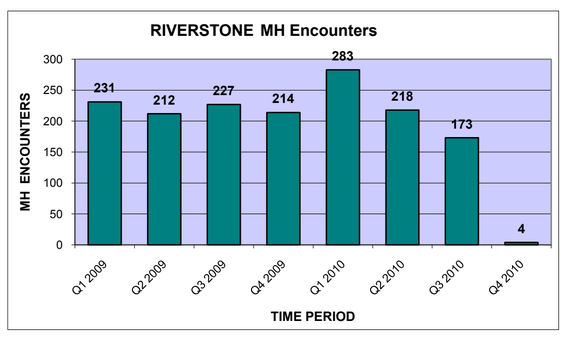
CHANGES

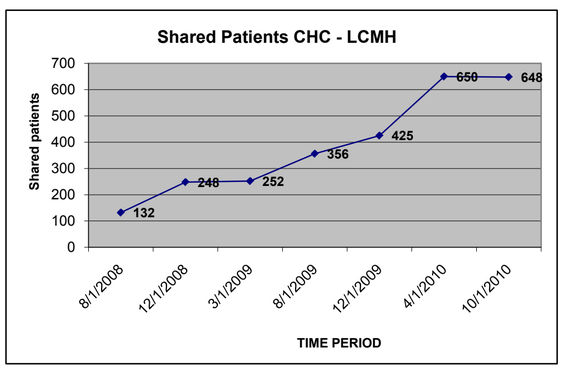
Change One: Co-Locate Primary Care Providers at the County Mental Health Program

- Specific problem – A high percentage of SPMI patients had poor access to primary care.
- Hoped to achieve – Increase the percentage of clients scheduling and keeping appointments with primary care providers, improve overall health of the patients who get services at the community mental health program, and reduce the utilization of urgent or emergent care for routine needs.
- Plan for making the change –Remodeled to accommodate the clinic space. Trained all staff in availability of resources and opportunities. Contacted patients and encouraged them to meet with providers. Trained providers about the complex behavioral presentation of the SPMI population. Created work-flows between front office staff in both PC and MH.
- Learned - Co-location is not sufficient, so early discussions with staff regarding roles and responsibilities were needed to get buy-in. A shared record would have eased the process significantly.
- Recommend – Early joint meetings between clinical, administrative, and supervisory staff to identify issues of turf, roles and responsibilities and development of relationships. Develop easy to use data-trackers to demonstrate change. Develop record keeping system so that both sides have ease of access.
- Data – Shared patients by the end of 2010 is 648.









Change Two: Imbed a Mental Health Clinician into the Primary Care Practice

- Specific problem – Many primary care visits have a behavioral health issue associated with them. Primary care providers were working outside of their comfort level or expertise to meet the needs/ demands of patients.
- Hoped to achieve – Improved patient, provider, and staff satisfaction through utilization of a mental health provider in real time in the practice.
- Planned for making change – Reviewed with other providers who have integrated care in their practice. Brought regional expert in to train staff on the ideas and practices. Developed workflows with all staff, at all levels.
- Learned – Need to figure out where the provider fits right away. Reimbursement for services was slow to be put into practice. Confusion amongst staff about roles was challenging.
- Recommend – Hire two staff to create a team dynamic. Use a care manager along with the provider to assist with case management needs, and coordinate supervision with other providers. Credential staff to bill along traditional mental health lines.

Change Three: Consultation Model with Community Mental Health Program

- Specific problem – Access to psychiatry is extremely limited and many clients are disinterested in participating in mental health treatment, but could benefit from psychiatric medications.
- Hoped to achieve – Offer patients who present with severe mental health disorders a service that will assist their health, resiliency and recovery, while meeting them where they want to be seen. Offer support to providers in prescribing psychiatric medications. Finally, develop a path to refer clients to community mental health program, which traditionally is difficult to access.
- Planned for change – Identified the problem from providers' perspective and the needs for patients. Met with community mental health program staff to develop work flows, expectations, referral process, etc. Implemented with review of process after 90 days.
- Learned – First attempt to initiate consults was staff specific and not written into policy or procedure. The expense of the consult was not determined, and the location of the consult was out of the norm for a specialty.
- Recommend – Write out the policy and procedure making sure the referral process is between staff that have that as part of their job description. Identify psychiatrist who is invested in the process. Have a clear definition of clinical acuity for the CMHP prior to starting the process.

PATIENT IMPACT

"Co-location and coordination of care between CHC and mental health has made a tremendous difference in my ability to provide care for patients with mental illness. You cannot separate the two; they have to be treated in conjunction for the patient to experience real change. It has been vital to have mental health specialists available to assist, reinforce and clarify the message for patients. Additionally, the ability to huddle or hallway chat with the psychiatric providers eases my concerns with appropriate practice and prescribing trends. Integration does not eliminate or reduce the challenges of serving this population, but it creates a team dynamic that eases your individual workload and provides better care for the individual." —Family Nurse Practitioner

"Working alongside mental health office staff provides a smooth workflow between our two teams and with patients. We are now familiar with each other's systems, allowing for patients to have a more positive experience at the front desk. Before, both primary care and mental health providers wondered about what was happening over there and why they did things a certain way. Each system is different, however having worked closely together, I now understand how patients react to and need the system in mental health. The relationships are so vital and often contain such history that any change is overwhelming. Working alongside their front office staff has allowed them to see the pace of work in primary care and understand how the availability of providers is a driving force of the care provided. The dynamic of misunderstanding is reduced significantly and would be even more improved if we shared a health record." —Office Assistant

Although initially slow, we began to make progress and individual patient outcomes improved. We made medical diagnoses of diabetes, heart disease, and even cancer that had gone untreated. The medical and mental health clinicians began to see the value in caring for patients collaboratively. The medical providers joined case management meetings with the mental health providers allowing for formal, as well as informal, coordination of care. A little over two years later, we have over 600 shared patients.—CEO

PROVIDER OR STAFF IMPACT

"Historically, we did not work well together and struggled to communicate about specific patients or share information. We knew our patients were not being well cared for. When the primary care clinic moved into the community mental health program, we had combined meetings to work out the details, and initially things were difficult. We had low buy-in, resistance to change, difficulties sorting out whether we could share patient information, and didn't speak the same language. We spent months working on things and assuring everyone that we are one entity working together to improve patient care."—CEO

"I have had an unusual introduction to the benefits of integrated care. My background as a licensed clinical social worker included providing, supervising and directing integrated care at a local non-profit agency across mental health, substance abuse and primary care services. My initial training informed me that traditional mental health services were the driving force of change that was required to implement integrated care. However, over the past year I have changed my view. I now understand that primary care services need to implement a mental health component (and substance abuse treatment as well) to truly meet the needs of our population. Without primary care being the driving force of integration, we cannot improve our response to the large numbers of patients who seek mental health support. With 70%-80% of primary care visits having mental health issues at the origin and 90% of all psychiatric medications being prescribed in primary care, the demand is there. It is unethical to continue to practice without adding appropriate mental health providers to our team." —Healthcare Operations Manager

Safety Net Medical Home Initiative

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