



The San Diego Vision: Behavioral & Physical Health Integration

CIMH Policy Forum
May 5, 2011

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Motivation & Theoretical Basis



Mortality Disparity

“Persons with serious mental illness (SMI) are now dying **25 years earlier** than the general population.”

“Recent evidence reveals that the rate of serious morbidity and mortality in this population has accelerated.”



“Morbidity and Mortality in People with Serious Mental Illness,”
2006, National Association of State Mental Health Program
Directors (NASMHPD) Medical Directors Council (emphasis added)

Mortality Disparity

- Only 30% - 40% of excess deaths due to SMI
- 60-70% due to preventable/treatable medical conditions
 - Cardiovascular
 - Diabetes
 - Pulmonary
 - Infectious disease



Mortality Disparity

- Modifiable risk factors
- Impact of psychotropic medications
- Access to health care
 - SD Study: 2/3 of clients perceive no access to primary care (including Medi-Cal clients!)



We Believe
The “Cure” is the.....
“Person-Centered Medical
Home”



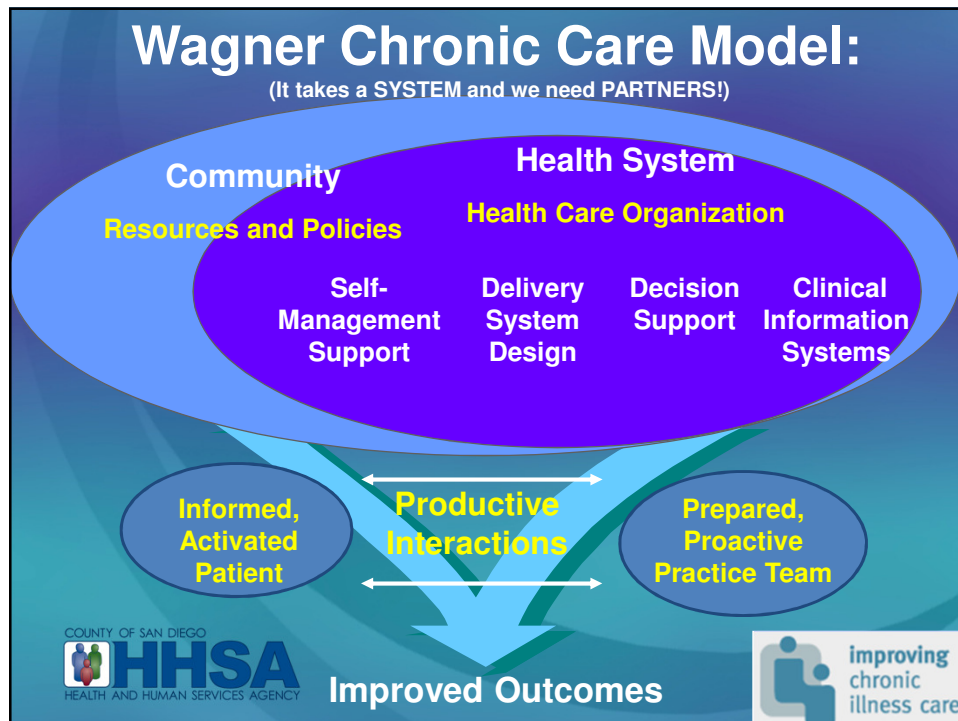
Crossing the Quality Chasm,
2001

What Is a Patient-Centered Medical Home?

- A Patient-Centered Medical Home (PCMH) is a model for care provided by physician practices that seeks to strengthen the physician-patient relationship by **replacing episodic care** based on illnesses and patient complaints with **coordinated care and a long-term healing relationship** (NCQA).
 - Invites a population management paradigm, where people get what they need when they need it, and help is continuously available for the spectrum of severity and acuity



Adapted from Joint Principles of the Patient-Centered Medical Home, 5/07: http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.dat/022107medicalhome.pdf.



Operational Realities



San Diego County: A Complex Web of Safety Net Services

- Population: 3.2M
- HHSA Behavioral Health Division:
 - MH Serves approximately 61,000 clients / year
 - 18,000 Kids (70% insured)
 - 43,000 Adults / Older Adults (only 50% insured)
 - ADS serves 12,000 clients / year
- Almost all BH services contracted to organizational providers and/or FFS (Dozens of clinics & programs)



San Diego County: A Complex Web of Safety Net Services

- Physical Health Safety Net **NOT controlled by County:**
- Kids: numerous Medi-Cal providers
- Adults: primarily 17 major **INDEPENDENT** primary care provider clinic organizations (FQHCs / non-profit clinics)
- Approximately **100 primary care clinic sites**



The San Diego Vision



The San Diego Vision:

A ground up and population management based approach to integrated system delivery



Vision for San Diego County

- GROUND UP Partnership Development:
 - “Integration in situ” (vs. “quadrant based approach”)
 - Pairing of:
 - Dozens of Federally Qualified Health Center (FQHC) sites, all under private and INDEPENDENT management by their parent FQHC organization
 - Primarily independent contractor organizations for MH and ADS, and a few County operated clinics



Vision for San Diego County

- POPULATION MANAGEMENT:
 - Can assist all 50-100K of the clients we serve
 - Behavioral Health is a PARTNER in the management of the full range of BH and medical illness, for a population we SHARE with the primary care safety net
 - Paired BH and Primary Care clinics can together provide a full range of services for all severities of illness, efficiently and effectively, for a **shared population**



Vision for San Diego County

- Not dependent on co-location or new funding source
- Avoids the “new categorical program” approach
 - Emphasis isn’t on a single elegant model for specific clinics
 - Such models leave many people unserved, falling through the cracks among programs



Vision for San Diego County

Paired (and partnering) provider organizations:

Continuum of care = Virtual PCMH's

- “Virtual” Person-Centered Medical Homes, serve a SINGLE population, “owned” jointly
- Bi-directional Flow (Clients and Info)
- Continuous, not quadrant defined



Vision for San Diego County

Continuum of care = Virtual PCMH's

- Clients can be seen for BH illness anywhere along a spectrum
- Stable SMI clients migrate toward more care being provided within primary care home
- Behavioral Health system = “scarce specialty services”
- MH system provides services ONLY for the most severely ill, especially psycho-social rehab & recovery services
- The most stable SMI clients can be seen – along with less severe MI – by primary care doctors alone or with consultative support
 - Inclusive of psychotropic medication management



Vision for San Diego County

What's in it for Behavioral Health?

- We shift less acute clients to FQHCs (separate Medi-Cal)
- We improve access to our system for the most SMI
- We now have partners to attend to the physical health needs of our combined population



Vision for San Diego County

What's in it for Primary Care (beyond idealism)?

- Incentivization of PCPs: “a quid pro quo”
 - Unprecedented access for clients needing specialty MH
 - Unprecedented education of providers AND support staff
 - Unprecedented access to consultation
 - Not just for SMIs



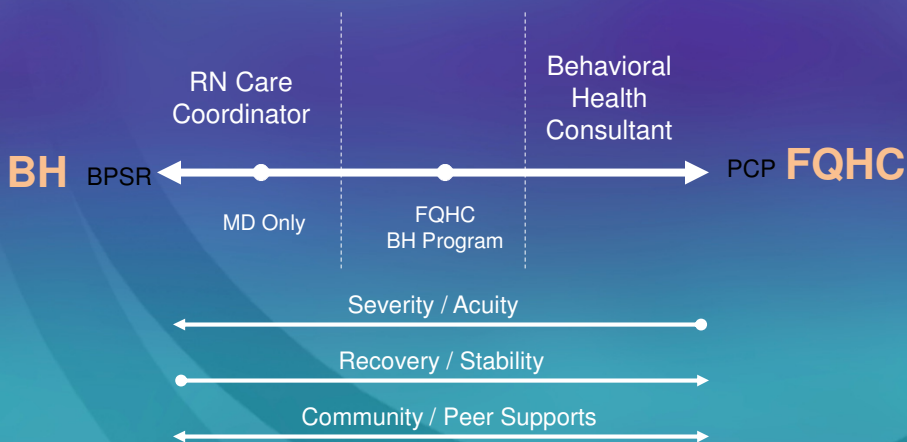
Vision for San Diego County

- Each clinic pairing is a unique, fluid system
 - Differing resources and competencies
- Boundaries are constantly changeable
 - Subject to ongoing negotiation



Integrated Care System

Bi-directional, seamless flow of clients & information



Emerging Best Practices

- Partnership structures
 - How, when, and who to meet
- Cross-referral protocols
- Common definitions (e.g. what is “stable SMI?”)
- Cross-communication protocols
- Operational MOUs
- Trust-building: Mirrors the Patient-Centered Medical Home (continuous healing relationships)
- Regional Integration collaboratives



Some Lessons Learned

- MH providers may be MORE resistant than PCPs
 - Work Flow / Acuity challenges
 - “The other side of stigma” = Infantilization
 - Resistance to phone “curbside consultation”
- Consumers are supportive, see this as “mainstreaming” and a recovery step
- PCPs and MH providers both need support
 - Clinical skills for PCPs
 - C/L skills
 - Change management



Vision for San Diego County

HHSA as “Civic Entrepreneur”

- Distinctive synergies & challenges dependent on participants’ organizational assets
- HHSA Behavioral Health facilitates
 - Regional Behavioral Health Integration workgroups
 - Judicious investment of MHPA funding in structural support elements in strategically chosen pilot sites
 - Leveraging of other resources (e.g. SAMHPA grant)
 - Dissemination of accumulating Best Practices



CHALLENGE: BHC’s Consultation/Liaison Skills Needed

- FLEXIBILITY: Appointments an exception!
- New Paradigm: the PCP team as CLIENT
- Rapid diagnosis
- “Curbside consultation”
- Linkage to outside Mental Health specialists
- Specialty MH = A scarce medical specialty resource
- Can model Shared Decision Making paradigm



Integration Related System Interventions



Some Current SD County Projects (in historical order)

- Mental Health & Primary Care Integration Services (CCC)
- East County Integrated Health Access pilot
- SAMHSA grant
- MHA PEI Rural Integrated Behavioral Health & Primary Care Services (Vista Hill-Smart Care)
- MHA Innovations



MHSA MH & Primary Care Integration Services (CCC)

- Through Council of Community Clinics
- Our first integration model – 5 years old
- IMPACT & Promotora Models
- Specialty MH Services (10 FQHC sites)
- Review 3 years ago, lessons learned:
 - Co-location is NOT integration
 - FQHC definition of Specialty MH medical necessity NOT SMI
 - Majority of specialty MH services used for simple depression, averaged 3 visits per client treated



East County Integrated Health Access PI Project

- Proved it's worth assisting SMI clients with eligibility process for County Medical Services coverage
 - i.e. that MH clients will follow through with medical care
- County Mental Health clinic identified clients with significant medical problems
- 50 Indigent SMI clients > Assistance with/ CMS
- Identified health needs and measurements
 - Established in PCMH's (# PCP visits within 6 months)
 - BMI, BP, HbA1C, lipids (LDL)– all improved



SAMHSA Grant

- MHS, Inc.– fiscal lead
- Outplaced RN Care Coordinators and NPs from FQHCs into MH clinics
- Two mental health agencies
- Two primary care clinic sites
- Preliminary data:
 - Expanded access for underserved minorities



MHSA PEI Rural Health Care Project

- Rural family practice clinics
- Behavioral health prevention, education, & intervention
- Treatment of SMI within the primary care team
 - Stable SMI clients seen entirely by primary care providers without specialty MH services
 - Consultative support for less severe MI treated by PCP
- Embedded behavioral health consultant within PCP teams
- MH consultation easily available to PCPs



MHSA Innovations Project

- A “soup to nuts” integration demonstration pilot, just started
- Paired MH Clinics and FQHC sites
- Behavioral Health Consultant (Masters Level) implanted in primary care team
- RN Care Coordinator implanted in MH team
- Alcohol & Drug Counselor shared by paired clinics
- Education/training for FQHC providers & office staff
- Easy access to psychiatric consultation
- Expectation:
 - 300 stable SMI clients to be treated entirely by primary care physicians
 - 300 clients remaining in MH clinic will have coordinated care with PCP
 - Support for PCPs treating less severe MI within primary care teams



“MCE”

Medicaid Expansion

- Part of LIHP (Low Income Health Program) / 1115 Waiver
- For people under 133% of Federal Poverty Level and who meet residency requirements
- Replaces CMS (County Medical Services for indigents) for those eligible
- Will fund Mental Health treatment within primary care clinics (FQHC’s) as well as current MH system providers
 - investment in FQHC infrastructure
- Starts July 2011
- Means SOME Mental Health clients will have better physical health access – initial cap on SMI enrollment until ongoing cost impact can be assessed



Accomplishments

- 19 mental health clinics paired with 22 FQHC sites
- 2 MHSA projects with significant infrastructure investment to support the paired model and develop Best Practice Models
- **Transformation:** Outpatient crisis MH walk-in services now available throughout the regional mental health clinic system
- **Education program** in place for primary care doctors
- **Integration Institute or "I²"** (Comprehensive change mgmt./ best practice development & dissemination package)
- EMR now used to identify which mental health clients have a primary care doctor
- Successful **Integration Summit Summer, 2010**
 - Over 200 FQHC and MH/ADS CEO's, Medical Directors, other leaders

COUNTY OF SAN DIEGO Community commitment to new paradigm



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