How and Why Collaboration with Primary Clinics Happened and Features of the Agreement

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Why MH-Primary Care To Advance Transformation?

- Access to Care and Service Availability
- Holistic Approach/Responsiveness to co-occurring disorders
- Advances culturally competent care
- Combat stigma
- A CSS strategy under outreach an engagement

Why Did You Decide On The Particular Model You Are Now Using?

- Model: Contract with the Council on Community Clinics (CCC) who then subcontract/reimburse participating health clinics that provide mental health services. This is a clinic association model with Administrative Services Organization (ASO) features.
- Ten participating clinics who subcontract with the CCC voluntarily; includes one non member clinic: Family Health Clinic who subs with CCC through an MOU. Model is a brief treatment model.
- Why? County has track record in contracting with CCC for our County Medical Services (CMS) program for the provision of health care services to indigents
- Why? CCC had joint interest with the County to implement an integrated program as part of this overall effort. This includes IMPACT is an evidence based model for the Collaborative Treatment of Depression in Primary Care.

What Stakeholders Were Involved In The Decision?

- Broad range of stakeholders spanning our CSS planning workgroups: Older Adult, Adult and Children with recommendations on our CSS plan generated by our Cross-Threading Group.
- The CCC were active partners in all of our workgroups; due to potential conflict of interest they removed themselves from being a voting member of the workgroups
- Other stakeholders included hospital administrators and healthcare practitioners.

From Vision To Signed Agreements Provision Of Services?

- Extended period of time to finalize agreement with CCC
- Took two months from signed contracts to providing services
- Have been some minor revisions to the contracts since original execution of contract

How Does The Agreement Work? Who Is Responsible, For What?

- CCC does authorization and payment for services provided by community clinics per fee-for-service arrangement; paid at Medicare rates
- County is responsible for monitoring contracts and reviewing/approving any changes to the contracts

Key Features

- Total contractual amount (maximum payment) for CCC: 1.98 million
  - 3 separate budgets
  - Dollars included for depression care managers in adult and older adult budgets (IMPACT)
- Clinics make direct referrals for mental health services for clients with SMI or SED
- Scope of Service: primary approach is brief treatment
  - Modalities include:
    - Assessment
    - Individual
    - Group care
    - Med eval and monitoring
    - Care consultation to primary care providers (i.e. collaterals)
    - Referrals to other existing org providers for those clients with SMI and SED to need more extended services
  - Depression care managers provide brief intervention, case management and support primary care docs who provide psychotropic meds

Key Features (continue)

- CCC provides clinical consultation to clinics through clinically trained Program Manager
- Expected length of treatment:
  - Older Adult/Adult: up to 12 sessions
  - Children: up to 24 sessions

Lessons Learned and Potential Strategies

- Slow start up with particular slow ramp ups for Older Adults and Children
  - Potential strategies: look at directly contracting with a community health clinic in a particular region; Could more directly address access issues
  - In some regions, consider transitioning program to a Prevention and Early Intervention program; could be more relevant MHSA component for this community clinic population

Lessons Learned and Potential Strategies

- "Siloing" of MH in primary care setting
  - Strat: Ensure mental health is embedded in overall community care approach
  - Strat: Cross training/consult to build capacity to identify, diagnose, plan care and treat for problems in area unfamiliar to a particular profession (physical healthcare, MH and AOD)

Lessons Learned and Strategies

- Will care lead to positive health outcomes?
  - Need to closely look at value added of evidence based practice or best practices in clinical settings
    - Project IMPACT/Project Dulce
    - Brief therapy models to address depression and anxiety with appropriate application of psychotropic medication (e.g. problem solving therapy)
    - Rely on proven primary care based models for consultation that reduces physical and MH symptoms while encouraging patient/family management of illness
    - Need to evaluate management and service structure and processes to determine what best facilitates integrated physical and mental health services

Lessons Learned and Potential Strategies

- Will transformational features (e.g. "Whatever it takes array of care"; cultural competence; client centered care; training requirements) be cost prohibitive to establish efforts in community care settings?
  - Strat: Rely on individualized care; avoid dropping too many bells and whistles on clients who either don't require this level of care or do not seek it
  - Strat: Be realistic on numbers of individuals to be seen; get the model going-make adjustments, then take it to greater scale
  - Strat: Counties need to reimburse for non-traditional resources and service activities; Could be better realized in a more direct contractual relationship between County and community clinic
  - Strat: Don't get strung out on MHSA funding only; look to blending other sources (e.g. Research grant funding for Evidence Based Practice)
  - Strat: Continue to learn from each other's system regarding how to best serve this population

Future MHSA Opportunities

- Two of our 8 strategic areas for Prevention and Early Intervention are: 1) serving the Rural/mountain communities, and 2) services for Native-Americans, both efforts to involve community clinics
- Ensure that community clinic partners are engaged in Workforce, Education and Training planning and implementation efforts
- Perhaps through Innovations funding, advance primary care-MH consultation effort