Improving Cross-System Collaboration Through Shared Treatment Planning and the Use of Transition Visits

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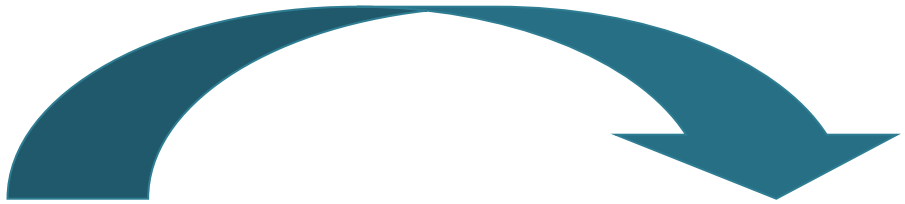
When we started *Integration* was



MH clinician

Primary Care

MHSA/County funded

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“Reverse” Integration

Mental Health Program

NCM

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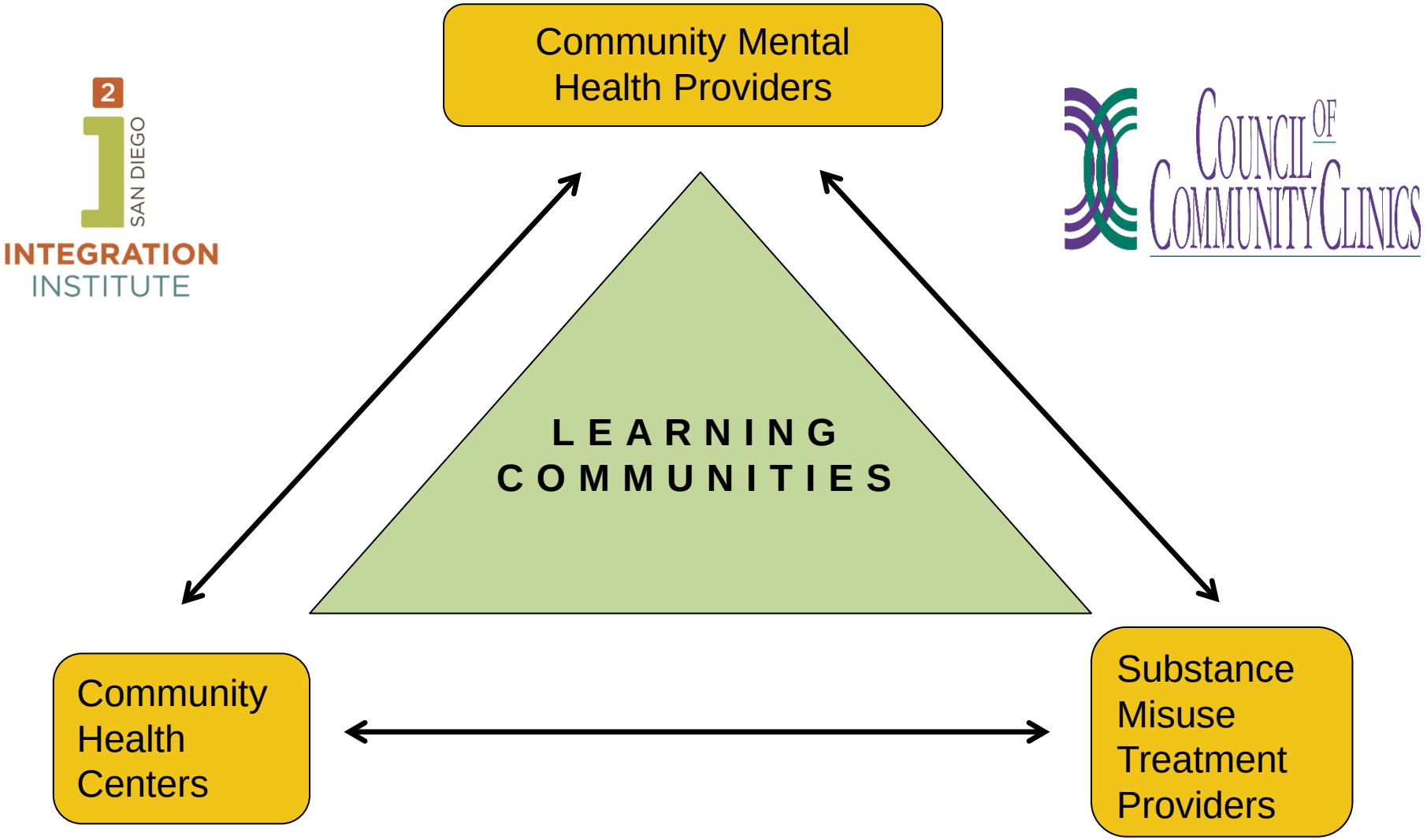
Learning Communities



Learning Communities

Varied and Interesting Reactions

MH

"You had me at hello!"

PC

"Do you really need me there?"

AOD

"Wait, what?"

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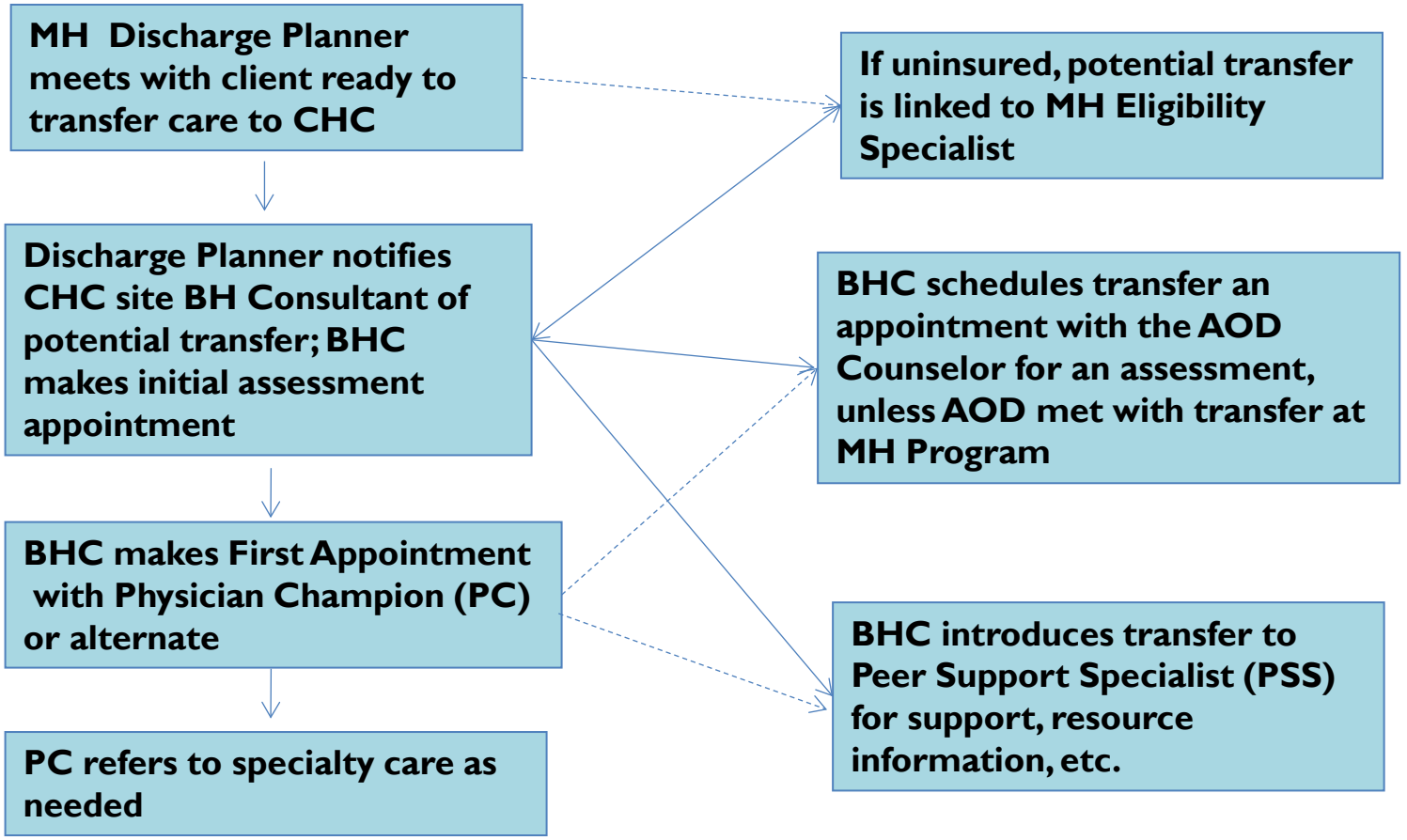
ICARE- Collaborative Care Model



Collaborative Care Model involving transition of stable clients to primary care, assessment for chronic diseases of those with SMI, assessment by AOD counselor and use of peers to facilitate transition from specialty MH to PC.

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Blue Shield Grant

The primary objective of the Blue Shield *Advancing Primary Care and Behavioral Health Integration through Community Collaboration* grant is to improve and facilitate integration across the primary care, specialty mental health and substance use disorder treatment systems.

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Blue Shield Grant

6 components

2 pilots:

- "Shared Treatment Planning"

and

- "use of Transition Visits to facilitate graduation to primary care"

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Address 25 year mortality disparity

People with serious mental illness die, on average, 25 years earlier

Only a small portion of such deaths attributable to MH.

Most deaths caused by the same preventable and treatable illnesses that kill the rest of us.

Recent research suggests the 25 year mortality disparity is growing rather than shrinking.

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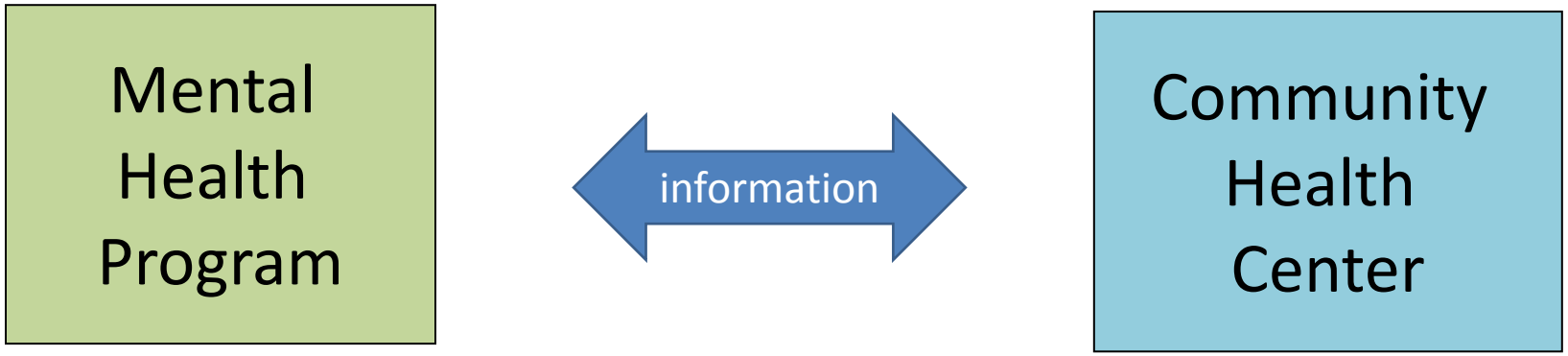
Pilot A- Shared Treatment Planning



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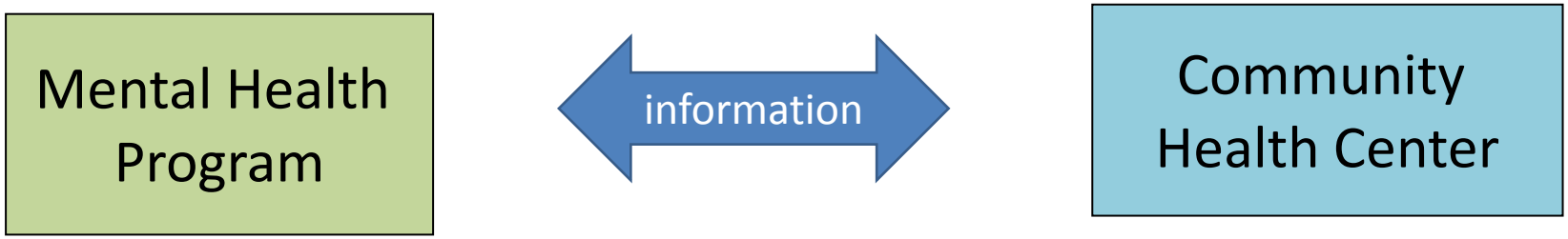
Pilot A- Shared Treatment Planning



Pilot Protocol Steps

1- ID Clients/Patients of partnering CHC
2- Confirm client/patient on panel of PCP
3- Meet with client /patient to obtain consent
4- Assign ID number
5-Staff review list and agree who to review
6- Share initial information

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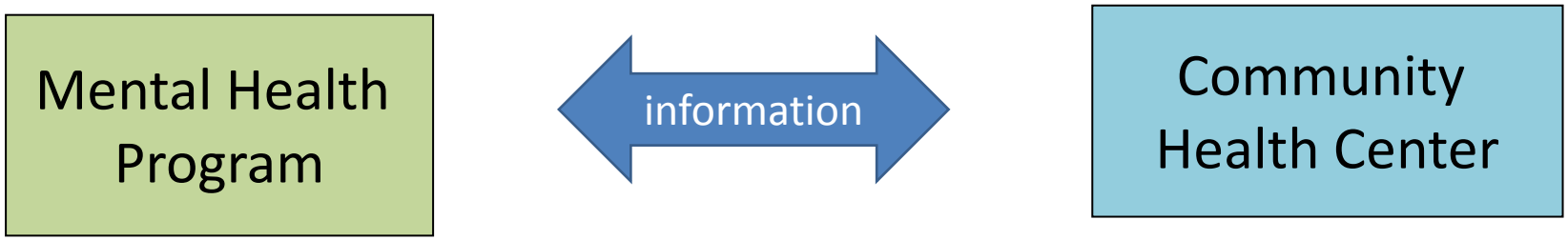
Pilot A- Shared Treatment Planning



7 – Talk by phone to Compare and Reconcile:

7a – Reconcile Diagnoses

7b – Compare Problem Lists/Treatment Goals

7c – Reconcile Medication Lists

7d – Compare Lab Results

7e – Treatment Challenges/Strategies

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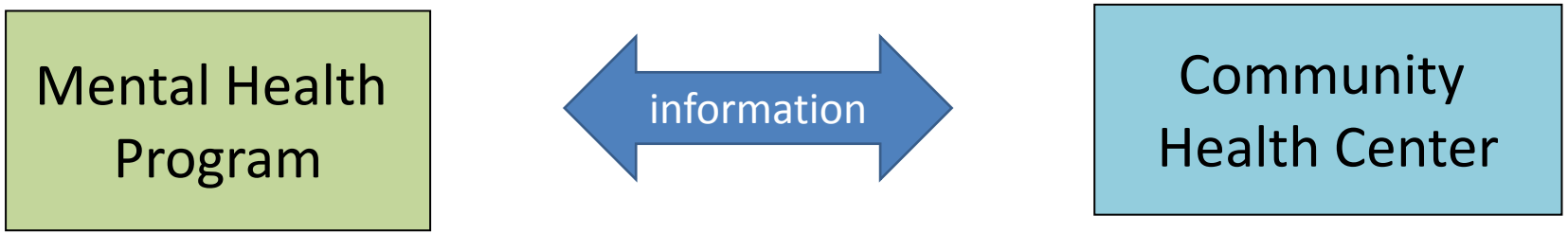
Pilot A- Shared Treatment Planning



Pilot Protocol Steps

8- Review additions and changes with respective staff and adjust treatment accordingly

9- follow-up with partners on anything if necessary

10- evaluation: interview staff prior re: expectations and desired results , and then after re: satisfaction with process and results,

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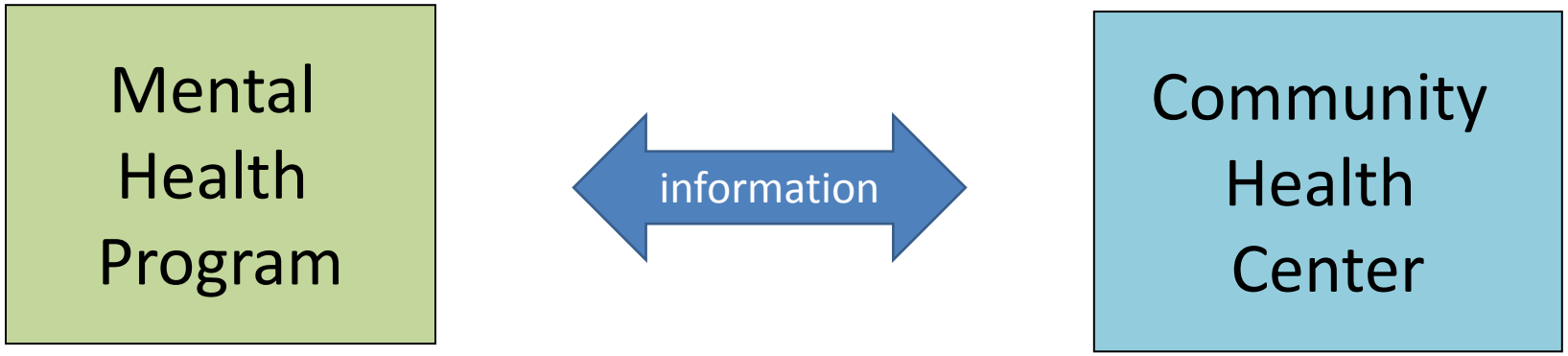
Pilot A- Shared Treatment Planning



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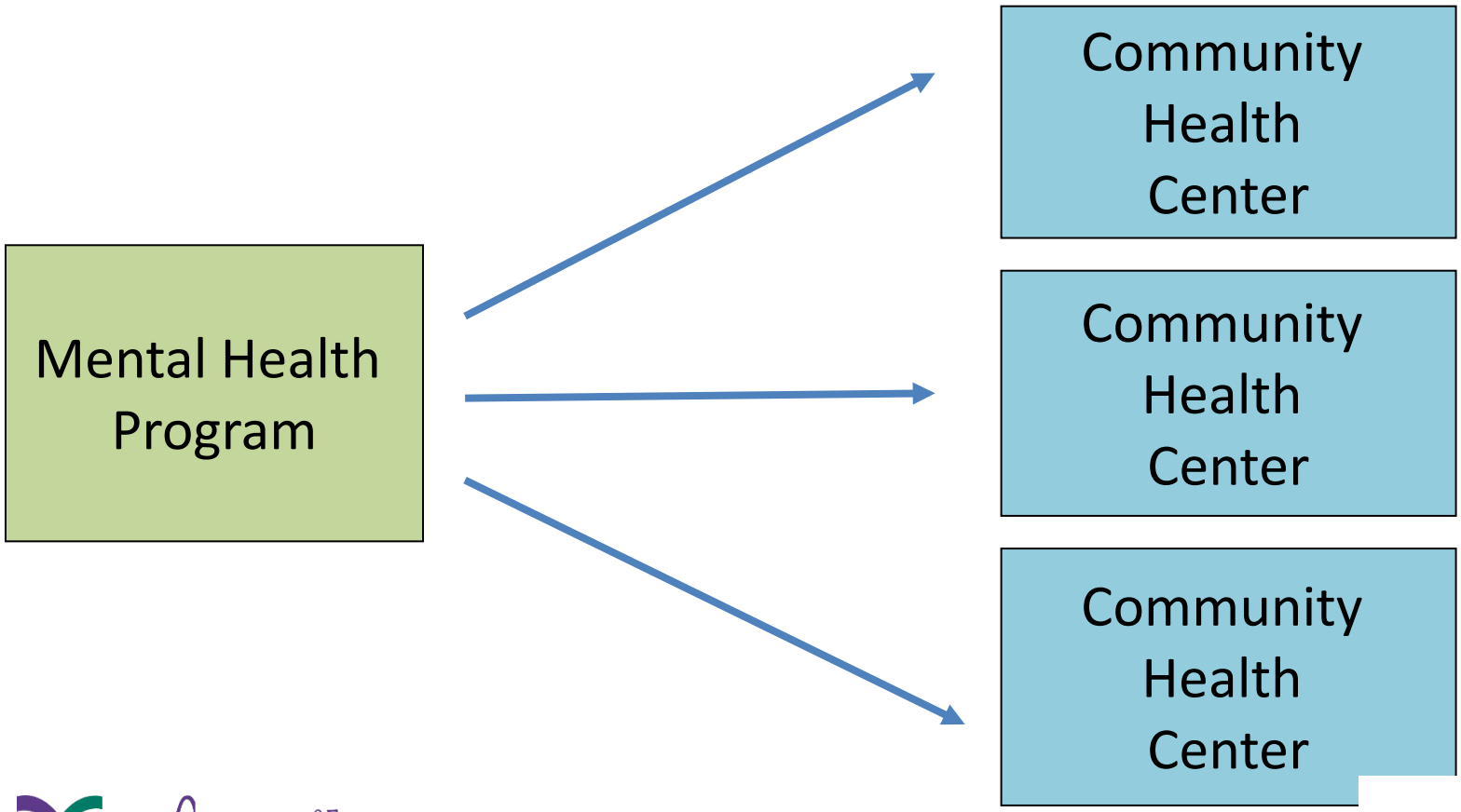
Pilot B Transition Visits



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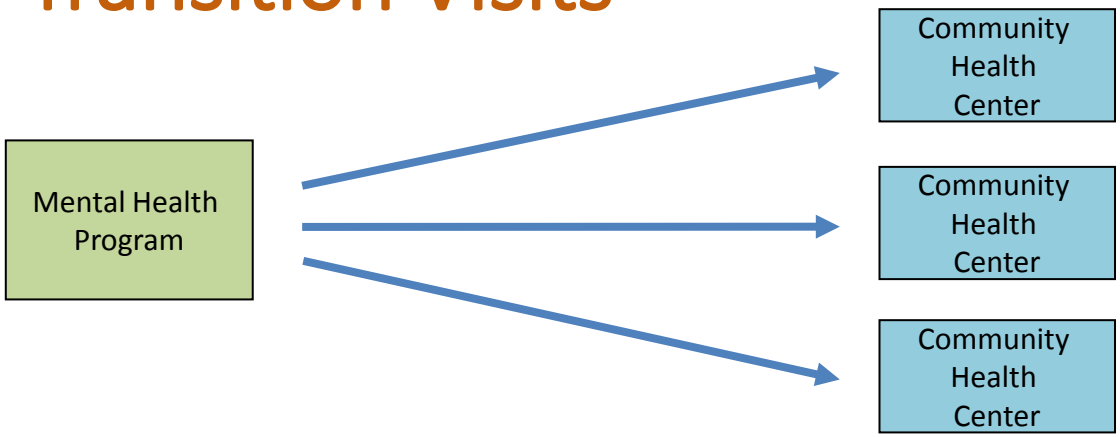
Pilot B Transition Visits



Step 1- Patient/Client Selection

MH Center staff will identify individuals who have demonstrated stability in their psychiatric condition and appear ready to transition to primary care for both their primary and behavioral healthcare.

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Pilot B - Transition Visits

What is “stable”?

- Have a stable medication regimen for at least six months
- Not be receiving Intra-Muscular Psychotropic medications
- Have a good record of keeping appointment with psychiatrist and/or nurse for medication management services
- Be able to function as a “medication management only” individual at the specialty mental health program without the need for intensive services for at least 6 months
- Have a score of at least 5 (and clinically stable) on the Milestones of Recovery Scale (MORS);
- Have a stable living arrangement
- Have Medi-Cal

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Pilot B - Transition Visits

Step 2 – Preparing Individual and Obtaining Consent

MH Center staff person meet with individual to discuss the transition.
Transition referred to "graduation". The conversation includes;

- designating a CHC ,
- the reasons MH Center staff feel that the individual is ready to "graduate",
- an overview of the services available at the CHC,
- review of the advantages of having regular access to primary care
- assurance the MH Center will remain available to the individual in the future.

MH Center staff will also:

- Obtain consent to appropriate CHC
- Assign a client/patient number

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Pilot B - Transition Visits

Step 3 – Providing Transition Visits

CHC staff will provide two transition visits at MH Center with the transitioning individual for the purpose:

- Providing the individual an opportunity to get to know someone from the CHC
- Allowing the staff person from the community health center a chance to prepare the individual for the difference of a CHC environment
- Allowing the CHC staff person an opportunity to confirm the individual seems appropriate for care at the CHC

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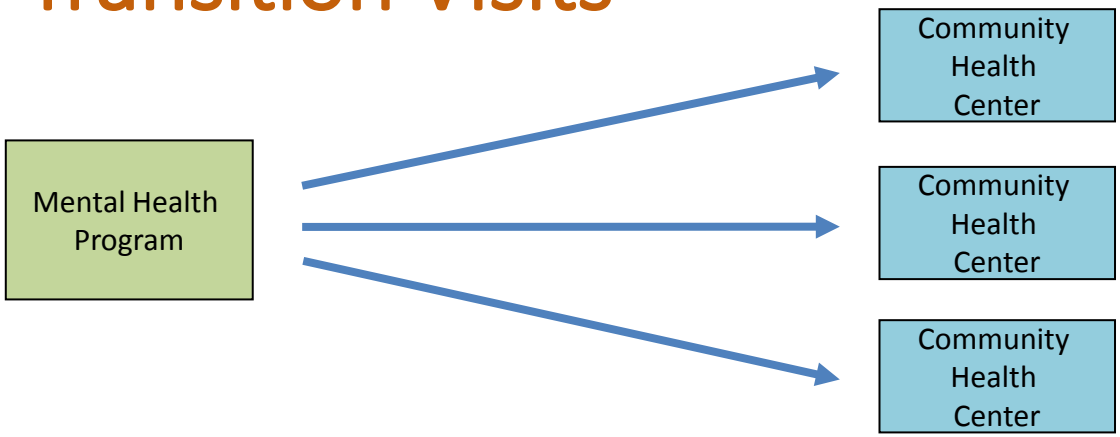
Pilot B Transition Visits



Step 4 Follow-up and Evaluation

Within one week of individual's first scheduled appointment at the CHC the designated MH Center staff person will contact the individual to evaluate the status of the transition. The evaluation conversation should follow the "Follow-up Conversation Diagram" included on the next slide.

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Pilot B – Transition Visits

Follow-up Conversation Documentation Tool

Client Name: _____ Date: _____ Date of PC Appt. _____

1) Have you been to the clinic? ☐ Yes ☐ No [If **No**, skip to # 9]

2) How was your visit? ☐ Good ☐ OK ☐ Poor Details: _____

3) Was it what you expected? ☐ Yes ☐ No Explanation: _____

4) Have you identified any goals you'll be working on at the Community Health Center (CHC)

☐ Yes ☐ No Explanation: _____

5) [*If answered* 'OK' *or* 'Poor' *#2*] What are your concerns? Explanation: _____

6) Are you planning to return to the CHC? ☐ Yes ☐ No [If **No**, skip to #9] Explanation: ____

7) [*If answered* 'Yes' *above*] Do you have another appointment scheduled? ☐ Yes ☐ No

8) [*If answered* 'Yes' *#7*] Can I call you after the appointment to see how it went? ☐ Yes ☐ No

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Pilot B- Transition Visits

Follow-up Conversation Documentation Tool

9) [*If answered* '**No**' *#1 or #6*] Why not? ☐ Fear of New provider/clinic ☐ Transportation

☐ Client does not feel visit is necessary ☐ Other_____

10) Would you like help making an appointment? ☐ Yes ☐ No Explanation: _____

11) Is there something else I can do to help resolve the situation?

☐ Requested another transition meeting at Gifford ☐ N/A ☐ Other_____

For reviewer to complete (*not for interview with client*):

Where did the client go for care? ☐ Clinic ☐ Hospital/ER

☐ Has not yet be seen for primary care ☐ Returned to MH Center

What services are they using? Are the clients' medical concerns being addressed? ☐ Yes ☐ No

Is the client engaged? ☐ Yes ☐ No **Narrative:**

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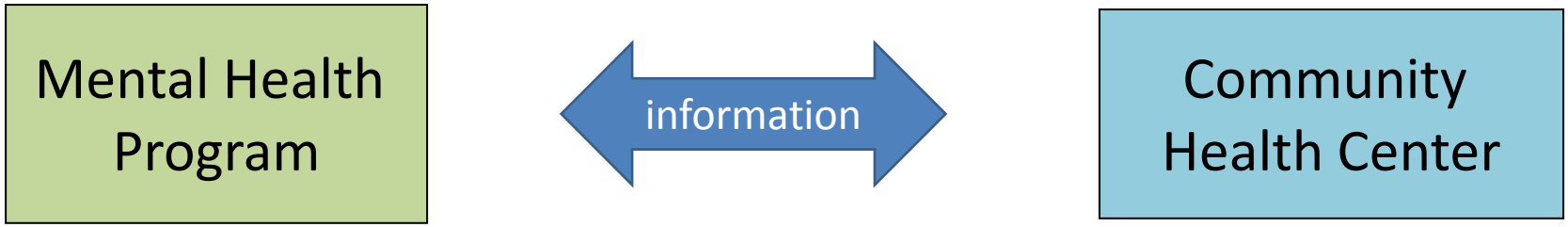
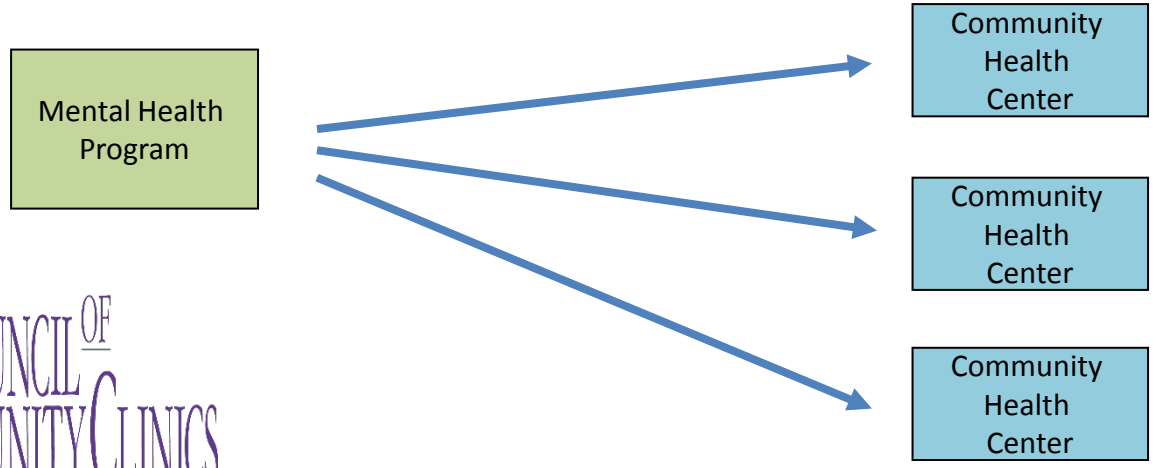
Blue Shield Pilots

Shared Treatment Planning



Transition Visits



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