The Integration of Care

Presented by Michele D. Curran,
Peer Program Educator

Curran and Associates Educational Consortium

How It All Began in CA

- The Mental Health Services Act—2004-6
- The President’s New Freedom Commission on Mental Health—2006
- The Integration of Mental Health and Substance Abuse Services
- National Movement of Person-Centered Health Care Homes
- Affordable Health Care Act—2010-14

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What is the Mental Health Service Act?

The MHSA was a proposition on the CA ballot in November of 2004 that requires county mental health providers to offer services and programs that have been designed by the residents of that county. It prescribes a planning process and sets requirements for the county to fulfill. Programs/services will be based on the principles of wellness/recovery, must be client-driven and be voluntary in nature.

How is it funded?

The MHSA’s funding mechanism was a provision that allowed the State to set-aside a 1% fee from those citizens declaring over $1 million in earnings, exempting the first million from being taxed.
The Basic Principles of the MHSA

Client-driven programs

“Consumers of mental health services must stand at the center of the system of care. Consumers’ needs must drive the care and services that are provided.”

- Presidents New Freedom Commission Report

“If we don’t transform the system, we will have failed.” - DMH spokesperson
“Recovery from a mental illness is not only possible, it is to be expected.”

President’s New Freedom Commission on Mental Health-2006

Services Based on Recipient Need

- Designed by the Community
- Based on Needs Assessments and Community Planning
Who Does the Planning?

- Stakeholders representing all four age groups
- County services
- State services
- Federal services
- Specialists in each component field

Stakeholders

Primary as named in the MHSA
- Clients
- Family members
- Caregivers to children
- Client supporters

* Who was missing?

Also named in MHSA
- Education
- Justice system
- Juvenile justice system
- Governmental agencies
- Business community
- Labor representatives
- Community-Based Organizations
- Un- and under-represented groups
Service Programs by Age

Children - ages 0 – 18

Transitional Aged Youth 16 – 24

Adults 19 – 55

Older Adults 50 and older

PEI (not a trucking company)

• Early screening
• Early signs
• For all ages
• Educating the community
• Using “gatekeepers”
• Short duration
• Less intensive
• No diagnosis
WET (not a swimming pool)

- Workforce Development
- Inclusion of Peers as Staff
- Staff and Stakeholders Trainings
- Career Pathways
- Academic Opportunities
- Internships and Scholarships
- High School Academies
- Loan Forgiveness
- Entry Level to Doctorates

Integrated Systems Development

- Behavioral Health
- Mental Health
- Drug & Alcohol Support

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“No Wrong Door”

- An approach to care delivery that shares all resources
- “Co-occurring disorders”
- “Dual Diagnosis”
- Anytime, anywhere
- Harm reduction

Person-Centered Health Care

- The Integration of Primary Care and Behavioral Health Services
- Forming Multi-Disciplinary Teams
- Portable, Electronic Records
- Holistic Approach
Person-Centered

....person- “centeredness…providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.”

(IOM, Crossing Quality Chasm, 2001)

How can my practice be person-centered?
What supports do I need as a practitioner from my agency/department?

To engage in such practice, what does your agency/department need?
A Person-Centered Approach

- Recipient of services is expert of her/his own experience.
- We must listen well to communities of color, to their wisdom, their stories, their histories, and experiences in order to realize their gifts.
- We must affirm their strengths & resources.
- We must engage them as equal partners in learning.

Culturally Sensitive

Culture is “the learned, shared, and transmitted values, beliefs, norms, and life ways of a particular culture that guides thinking, decisions, and actions in patterned ways and often inter-generationally”.

--Leininger & McFarland, 2006
Culture frames a person’s beliefs and values, a person’s ways of seeing, thinking and behaving.

It influences a person’s meaning making, attributions, and ways of coping.

Cultural Competence

- It must not be an appendage to our lives, our research, our practice.
  - It must be rooted in justice.
- It is not a fixed attribute that we attain by going to workshops or training
  - It requires humility—we all have room to grow--
  - It transforms us, makes us more human and more authentic.

Cultural competency is more than just knowing the content—the language, preferences, history of a people.
Affordable Health Care Act

- Expansion of recipients
- Coverage for pre-existing conditions
- Inclusion of behavioral health parity
Who’s involved?

- Primary Care
- Mental Health
- Alcohol and Other Drugs
- Public Health
- Vision
- Dental
- Social Services
- Across the Life Span

Specialists

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Bidirectional Integrated Care

• “…in essence integrated health care is the systematic coordination of physical and behavioral health care….Integrating services to treat both will yield the best results and be the most acceptable and effective approach for those being served.”*


Bidirectional Integration Settings

Integrating Primary Care services into Mental Health and Substance Abuse settings

AND

Integrating MH/SU services into Primary Care settings

In both cases, the services are not just provided, but coordinated with other care delivered in that setting
Integration of Services

- This may or may not involve the integration, or merging, of departments and use of facilities

Why is this integration necessary?

- Most people seek help for Behavioral Health concerns in Primary Care settings
- Nearly ½ of all care for common bh disorders/challenges is given in PC settings
- Populations of color are even more likely to seek and receive care in PC settings than in specialty BH settings
Some of the reasons---

- Uninsured or underinsured
- Limited access to public BH services
- Cultural beliefs and attitudes
- Stigma and fears of discrimination
- Lack of availability of BH services, especially in rural areas

Behavioral Health concerns brought to Primary Care

- Mild to moderate BH issues are common in PC settings
  - Anxiety, depression, substance use in adults
  - Anxiety, ADHD, behavioral problems in children and youth
    - Should be viewed as a Prevention and Early Intervention opportunity
How common medical problems connect to BH concerns

- People with common medical disorders have high rates of BH issues
  - E.g., Diabetes, heart disease, asthma often couple with depression
- BH problems often go undetected and untreated in Primary Care
- When PCPs do detect BH concerns, they tend to undertreat them

Medical Issues Brought to a BH Setting

- Oregon State study found that those with co-occurring MH/SU disorders had worst early mortality gap
  - Average age of death for those with co-occurring is 25 years sooner than those without—the quoted study placed average age of death at 45 years*

*B.Mauer & C. Weisner (2010) CIMH webinar: The Case for Integrated Care
www.cimh.org/LinkClick.aspx?
Key Opportunity

- Integrating care offers an important opportunity to reduce disparities:
  - Eliminate early mortality gap
- Reach people who cannot or will not access specialty Behavioral Health care
- Intervene early before issues develop or worsen

Philosophy of Providing Services

An Holistic Approach

- Mind
- Body
- Spirit
Navigation of the Systems

Balance of Care

- Basic Needs
- Partnerships
- Shared Service Plans
- Personal Goals
- Peer Services
- Counseling
- Meds
- Personal Growth
How the Puzzle Fits Together

Trust
Respect
Empowerment
Wellness
Diversity
Humanity
Recovery-based
Person-Centered
Collaboration

Working Together Towards One Goal
Any Questions/Comments?

Michele D. Curran
(office) 209-295-1229
(cell) 209-304-7319
(email) CurranTraining@gmail.com
(web site) www.curranconsultants.com