Integrated Behavioral Health in a Person-Centered Healthcare Home: Linking ‘Respite Care’ and ‘Frequent User’ Programs

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Case Example: The Effort

Physical Health

Mental Health

Alcohol & Other Drug
Physical Health

Program

• Primary Care (FQHC)
• Subsidized Primary Care
• Family Planning
• Breast Cancer Screening
• T3
• Interim Care Program
• Employment Physicals and Social Security
• Family and Adolescent Skills Training (FAST)
• Prenatal Care
Alcohol and Other Drug

Program

• Detoxification
  – HIV+ Clients
• Residential Rehabilitation
• Outpatient
  – Prop. 36
  – General Population
  – Private Pay
  – FAST (AOD component)
• Drug Court
• Drug Testing
  – Federal Courts
• Juvenile Justice
Mental Health

Program

- Child & Family Counseling (EPSDT)
- Adult Mental Health Counseling
  - HIV+ clients
  - CPS-related counseling
  - Private Pay
- Crisis Services
  - Suicide Prevention Crisis Line
  - Parent Support Crisis Line
- Child Abuse Prevention
  - Family Resource Center
  - Birth & Beyond
- St John’s Shelter
Integrating Programs: Blending

Physical Health

Mental Health

Alcohol & Other Drug
Making Primary Care More Inclusive

To what extent can we treat clients in Primary Care?
To what extent do we need to refer clients out of Primary Care?
Physical Health & Mental Health Continuum

- **Integrating Fragmented Treatment**
  & changing regional service delivery:

1. Sacramento County
   i. Filtering patients coming into adult mental health system
   ii. ‘Graduating’ stable patients from adult mental health system
2. Sutter Center for Psychiatry
3. Linking Birth and Family Health Center with Birth and Beyond
Primary Care and AOD Continuum

- Integrating Treatment:
  - Making addiction counseling available within Primary Care
  - Providing *medical* treatment for addiction
  - Linking Primary Care services with Detoxification and Residential Rehabilitation
Mental Health and AOD Continuum
“Co-Occurring Disorders Treatment”

- Integrating Mental Health and Addiction treatment:
  - Residential Rehabilitation
  - Outpatient Counseling
    - Proposition 36 treatment program
    - Dependency Drug Court
    - Adult Drug Court
    - Youth on State Parole
  - Youth in custody
  - St. John’s Shelter Program for Women and Children
Integrated Behavioral Health

“Integrated Behavioral Health” is a phrase describing the state-of-the-science blending of physical health, mental health, and addiction treatment.

- Primary Care. Integrated Mental Health and Addiction treatment represent 60% of billing in California’s FQHCs.

- Housing, addiction and mental health treatment are the cornerstones to medical stability in the following programs:
  - T3
  - Interim Care Program (ICP)
  - Sutter Center for Psychiatry
Integrated Behavioral Health (IBH) and Medicine

- Choreographed protocols (medical & counseling services) for each disease process and major medical area. For example:
  - Asthma
  - Obesity
  - Diabetes
  - Cardiovascular Disease
  - Hypertension
  - Depression
Medical Respite for the Homeless

The Interim Care Program

ICP
Program Structure

• The Effort
  - Administration
  - Case management
  - Nursing / Medical – FQHC Satellite Clinic

• Shelter-Based
  - Designated 18 beds
  - 3 meals a day
  - Daytime stay
Major Budget Elements

- Sacramento County Department of Health and Human Services – $118,614
  - $18 per bed per day

- 4 Hospitals – $301,873
  - $75,478 per hospital
ICP Outcomes

- Over 500 patients admitted to date
- 33 day average length of stay
- Referrals to AOD, MH, COD (*% complete*)
- 82% exit to housing / shelter
- 100% exiting with health coverage

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ICP Outcomes

• Significant reduction in Emergency Department visits
  - Average 3 visits per quarter while clients in program
  - 33% reduction of ED visits when comparing 6 mo pre-ICP to 6 months post-ICP

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ICP Outcomes

• Significant reduction in Inpatient Bed Days
  – 81% reduction of inpatient bed days when comparing 6 mo pre-ICP to 6 months post-ICP

See YouTube “ICP Referral”
ICP+

- 15 additional beds to serve special populations and tailored by referring hospital
T3

Triage Transport Treatment

A “Frequent Users” Program
T3

- **Case Management**
  - Personal connection with clients
  - Comprehensive assessment
  - Development of a case plan
  - Linkage with additional community services: food, clothing, legal services

- **Mental Health Services**
  - Psychiatric services
  - Medication management
  - Linkage into long-term psychiatric outpatient services
  - Individual therapy
  - Support groups

- **Medical Services**
  - Primary care services at The Effort clinic
  - Linkage to in-patient, emergency services and specialty services
  - Assistance with application for CMI SP and/or Medi-Cal including obtaining medical documentation for SSI claim

- **Substance Abuse Treatment Services**
  - Medically Managed Detox
  - Residential 90-day program
  - Outpatient counseling

- **Housing**
  - Transitional housing dedicated to the T3 program
  - Partnership with the 10-Year Plan for Permanent Supportive Housing (Mercy Housing)

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12-Month Outcomes

• 54% reduction in use of Hospital Emergency Department
  – 65% reduction for clients engaged in program for more than 6 months
• 35% reduction in inpatient bed days
• 70% of clients chronically homeless
• 80% clients reduced substance use significantly*
12-Month Outcomes – Substance Abuse

• ‘Labeling’
• Coordination with Detox
• Coordination with Residential
• Coordination with Outpatient
• ‘Services First’ and the role of harm reduction
12-Month Outcomes
- Mental Health

• ‘Labeling’
  - Diagnosis and Assessment
  - Psychiatry
  - Crisis intervention
  - Counseling
  - Co-occurring disorders treatment

• Referral into FQHC

• Referral into county-funded services (75% meet local Core Target population criteria)
12-Month Outcomes – Case Management

- The ACT model
- The Stationary Support Team (SST) model
- Striation
  - 25% Moderate Intensity (1x per week)
  - 50% High Intensity / Subacute (2-4x per week)
  - 25% Very High Intensity / Acute (5x per week)
12-Month Outcomes – Housing

- ‘Labeling’
- ‘Maintaining Homelessness’ - T3 Transitional House
- Permanent Supportive Housing
  - Housing First
  - Collaboration
- Keys to Hope and other ARRA supports