

## COMMUNITY HEALTH INTEGRATION PROJECT – CHIP

### 2007-2011 Summary

#### **HISTORY**

CHIP is an outreach co-location program of Greene County Mental Health Center in Cairo, NY. Presently in its 5<sup>th</sup> year working in the rural community of Greene County, NY, CHIP began as a means of addressing the community's need for mental health services in remote areas. Like many rural counties in New York State, to receive services residents of the county were often faced with the challenges of inadequate transportation, long distances between themselves and providers, and financial constraints. Stigma associated with receiving traditional mental health services in centralized locations also often prevented people from receiving the help they needed.

At the time of program inception, a growing body of evidence suggested that the integration of physical and mental health services provided the best outcomes for patients. In addition, rates of suicide among the elderly was found to be higher than in other groups, particularly among the isolated, as is found in rural areas. As a group, the elderly were also most often in contact with primary care physicians, at times immediately prior to a suicide attempt.

Greene County Mental Health Center (GCMHC) applied to be part of a pilot project through the Office of Mental Health (OMH) to address these needs by creating a network of satellite clinics dispersed throughout the community in primary care physician offices. The target population was geriatric at that time. The grant application was turned down, however GCMHC was offered the opportunity to participate in all collaborative meetings and events provided to other grantees in the project, and agreed to do so. GCMHC moved ahead with plans to co-locate mental health services in physician's offices, a move that has proven successful.

Today, CHIP has grown to include six satellite locations within the community, and a cooperative screening and referral program through Greene County Public Health Nursing Service. CHIP staff members have also participated in outreach services to the general community, such as public speaking engagements and presentations on relevant mental health topics. The target population has expanded to include all adults aged 18 and over. Mental health staff frequently collaborate with physical health care staff, resulting in a higher quality of care. Over 1,500 Greene County residents have been screened for anxiety, depression and substance abuse to date. Non-residents are also represented, provided screening and referred to appropriate resources local to them.

#### **STAFFING**

The initial configuration of CHIP included a coordinator of the program, social workers or social work interns to staff the offices, and direct oversight by the Community Service Director.

Today, the hierarchy has changed somewhat as the result of the needs of both the community and the program, and now operates as follows:



In the order presented above, administrative oversight is provided by the Director of Community Services and Director of Clinical Services for the agency, both of whom play a role in determining the larger make up of the program, including location of future satellite offices, screening tools used, recruiting staff, etc.

The coordinator facilitates collaboration with the satellite offices, provides training to health care staff, completes reporting requirements to administration and funders, and ensures data collection continues between various staffers.

There are three social work clinicians who staff the satellite offices, each of whom play an integral role to the project through day-to-day operations within the satellite offices, and communicating needs to the coordinator as well as to individual supervisors within the agency. Clinicians are responsible to collect and follow up on screens, schedule appointments with clients in satellite locations, complete home visits (if necessary), collaborate with the health care providers, as well as traditional clinical duties such as charting and billing for services.

Supporting the data collection and management, an administrative professional enters all data from all screens collected into the OMH database. Monthly data summaries and data are sent electronically to OMH, completing that requirement.

Finally, filing assistance is provided by an ExperienceWorks part-time assistant to file by quarter all screens that have been collected. (ExperienceWorks is a service that links disadvantaged or underemployed persons with potential employers for relevant job experience; EW supports the salary of the employee temporarily).

## **SCREENING TOOLS**

In 2007 with technical assistance and recommendations from OMH, the *Patient Health Questionnaire-9*, *Generalize Anxiety Disorder-7* and the *CAGE* were first identified and utilized by CHIP to screen all geriatric patients in primary care settings. The screening tools were formatted to fit on three pages and titled *Mental Wellness Screen* or *MWS* in 2008. The MWS (later called MWS-enhanced) included demographic information and release of information on page one; PHQ-9 and GAD-7 on page two, and the CAGE and contact information on page three. Patients were provided with a tear-off with contact information for the clinic starting in 2009, and directed from there to speak to their health care professional with any immediate concerns.

Feedback and numbers of completed screens suggested that the MWS as a tool was both too long and cumbersome to use in the primary care office settings. Administratively a shift occurred to respond to the low numbers of screens and resistance to using the screening tools. In 2010, the previous screen was modified for use by trained mental health staff persons. The *Mental Wellness Screen-basic*, which includes the PHQ-2 (with an added question about suicide and harm behaviors), the GAD-2 and the AUDIT-1 were implemented as an initial assessment tool to be used by health care professionals. This much shorter version was formatted to fit on one page, back and front. Like its predecessor, the MWS-basic asks for demographic information one page one, while page two is dedicated to the screening tools with an additional space for comments and recommendations by professional health care staff. This screening tool was found to be favored by health care professionals for identifying and capturing data while also being much more efficient.

Also in 2010 protocols for each type of screen and setting were developed. The protocols outlined when, where and how to screen patients; protocols directed staff members in how to determine the need for additional assessment as well as next steps to follow. Initially developed to provide direction to health care professionals, the protocols have also allowed for each of the satellite locations to follow a standard of practice, thus minimizing differences in screening practices and streamlining the experience for all staff involved. Protocols are now provided to each office annually and reviewed with staff during site visits.

Today, the *MWS-basic* is utilized by health care staff in primary care settings as well as Public Health staff to identify at risk patients. The *MSW-enhanced* is utilized by trained mental health professionals during the assessment/intake as well as for follow up measurements for treatment outcomes. Data from both methods of screening continue to be collected and submitted to OMH as part of the pilot project.

## **FUNDING and REVENUE**

Initially funding was sought through the OMH grant program to offset the costs of developing a new service delivery system, and was not obtained. Grants were then utilized through New York State for suicide prevention (year one) as well as through Greene County Rural Health Network (RHN). Funding from RHN has been in place since 2007, which includes funds for a project coordinator, administrative support, equipment, as well as annual training and supply budgets.

Other sources of funding come from billable service hours. Through the creation of OMH licensed satellite clinics in the primary care offices, GCMHC is able to bill for such services as assessment/intake (90801) individual verbal therapy (90806), complex care management (90882), crisis intervention, etc. in the same way that a traditional mental health clinic would bill.

## **PRESENTATIONS AND COMMUNITY OUTREACH**

CHIP has participated in several community outreach events and presentations to raise awareness about the necessity of co-locating programs, integration as well as treatment for depression and anxiety:

- 2007 – “awareness” interviews for the local newspaper about co-located services
- 2009 – community outreach presentation for the public at Washington Irving Senior Center on depression and treatment
- 2010 – presentation for professionals at University of Maine at Presque Isle on integrating care
- 2010 – community outreach presentation for volunteers of local senior centers on grief and loss
- 2011 – presentation for professionals as part of the conference for the Geriatric Mental Health Alliance/Mental Health Association on integrating care

## LOCATIONS

In 2011, CHIP expanded from five (5) to six (6) satellite locations in Greene County, with continued involvement from the Greene County Public Health Nursing Service.

Office	Cairo Family Care Center*	Catskill Family Health	Family Health Care	Jefferson Heights Family Care Center*	Dr. Joshua T. Rosenfield	Windham Family Care Center*	Greene Co. Public Health Nursing Service
Location	Cairo	Catskill	Tannersville	Catskill	Coxsackie	Hensonville	**Other
Providers	Dr. Enzien Dr. Browne Joanne Vogel, FNP	Dr. VonReu sner	Dr. Schneider	Dr. Pope Dr. McKeon Dr. Chasin Diane Braden, FNP	Dr. Rosenfield	Dr. Samedov	RN, LPN, OT, PT
GCMHC	Friday	Tuesday	Wednesday	Friday	Tuesday	Monday	***daily

\*Affiliated with Columbia Memorial Hospital

\*\*county provider

\*\*\*staffing availability varies dependant on needs of home bound patient.

Three of the offices are privately operated by primary care physicians. Three offices are affiliated with Columbia Memorial Hospital located in Hudson, NY, the primary hospital for both Greene and Columbia Counties.

## **LESSONS LEARNED**

As CHIP has expanded it has become evident that community based services, specifically co-located and integrated services, are not only desirable but also necessary. Clients report that having access to mental health services in the same office as their physical health services is convenient, efficient, and less stigmatizing than the traditional settings. Primary care physicians assert that patients are more likely to follow up on referrals when the service is offered in the same office space; that the quality of care improves enormously by increasing communication between providers and decreasing delays of service; and that patients appear to be active in their own care.

Mental health professionals report that working in integrated settings provides a unique experience unlike working in a mental health clinic, can challenge them in positive ways, and expand their knowledge base about a client's experience in the world. Access to medical information is improved and duplication of services is less likely.

While integrated care has its benefits, there are certainly pitfalls. One of which includes the way that patient or client information is stored. Electronic medical records (EMR) is relatively new in Greene County, with a handful of practices within the county utilizing a paperless system. Presently records for clients in GCMHC continue to be paper-based. For care to be fully integrated, providers would share a common electronic "chart" for each client, allowing shared access to information at a moment's notice.

Changes in staffing, both of the mental health professionals and within the primary care offices, have also presented a challenge. When a new health care professional joins a primary care office, that person has to be trained to utilize screening tools, necessitating the coordinator to schedule a visit with that office. Resistance can also be found here as staff report being overwhelmed in making the adjustment to a new office, or otherwise feel that screening patients presents another layer of work. Mental health professionals joining CHIP or leaving an office necessitates the coordination of training, locating a replacement staff person, and providing coverage for that office. On both sides there is often resistance to new staff or changes in the project that don't "fit in" with the established way of "doing things".

Office politics often determine how quickly, or if at all, a satellite program is established. Resistance to mental health services as well as stigma have contributed to the selection of some offices. Evolving practices, or practices studied in evidenced based treatment often offer the best opportunity for integrated care.

## **SUMMARY**

In the past five years CHIP has grown exponentially to include public and private offices and service providers within Greene County, NY. New locations, the creation of structure, administrative oversight, programmatic protocols, and means of sharing information have all grown as a result of impute from clients and key stakeholders. The challenges have not lessened. There are more changes ahead for this program, including strategically planning for

sustainability, taking stock of productivity and utilization, as well as outcome measurements to further define the direction of CHIP.

CHIP has only been successful by means of supportive professionals, staff and clients who have seen the vision of co-located and integrated care as a model for health care in the 21<sup>st</sup> century. Thank you to our funders, to the GCMHC staff, all the doctors, nurses, administrative assistants who welcomed mental health staffers into their work spaces, and to the clients for trusting that no matter where “the therapy is just as good”.