What are the Goals of this Summit?

- Bring together leaders and providers from, MH, PC and SUD treatment systems
- Provide opportunity to learn together about common issues
- Promote cross-system collaboration by building bridges across systems, thus and making the silos semi-permeable.

Cross-System Collaboration Example 2

Terry Aperule CADC II: Mental Health Systems, Program Manager Family Recovery Center

Collaboration: Vista Community Clinic for Primary Care and Mission Treatment and SOAP MAT for Medicated Assisted Treatment

Cross-System Collaboration Example 2

Our overall goal to ensure optimal physical, emotional and psychological health of our clients.

Cross-System Collaboration Example 2

Our success in collaboration is measured by increase in identification of comorbid disorders

Increase in client interest in addressing their medical concerns

Increase in communication between counselors, Doctors and other mental health professionals

9th Annual Primary Care & Behavioral Health Integration Summit

Cross-System Collaboration Example 2

Staying future focused on client and family success

Cross-System Collaboration Example 3

Nicole Anderson
LCSW, Integrated Care Manager
Family Health Centers of San Diego

Collaboration:

FHCSD and the Sheriff Department:
Progress Program established July 17, 2018

HEALTH CENTER PARTNERS of Southern California

2-1 SAN DIEGO INTEGRATION INSTITUTE

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO LIVEWELLSD.ORG

9th Annual Primary Care & Behavioral Health Integration Summit

Cross-System Collaboration Example 3

Purpose/Overall Goal: The Progress Program is to provide MH services to inmates that are still serving time for non-violent, misdemeanor offenses. Many of the progress clients have never received mental health, medical and substance use services. The goal is to offer mental services, connect them to medical services and substance use counseling. The Sheriff Department's goal is to increase support system for these clients, help them transition back into the community and decrease the recidivism rate. FHCSD has served 21 clients since July 2018.

What does this look like for the clients?

- Instead of traditional jail, these inmates are placed in an alternative custody setting (i.e. a community home near the FHC clinic) 1-4 months prior to their release date. This alternative custody setting is focused entirely on community reentry.
- They all wear GPS trackers and have counselors within the home.
- Besides attending these medical appointments at FHC, they are unable to leave the home.
- All clients are non-violent offenders, charged with misdemeanors and will be on probation for at least 2 years post release. Average number of times in jail per client ranges from 10-17x
- The house setting has capacity for 24 residents; currently 15. All are referred to FHC for mental health services to reduce recidivism rates in the future

HEALTH CENTER PARTNERS of Southern California

2 1 SAN DIEGO INTEGRATION INSTITUTE

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO LIVEWELLSD.ORG

9th Annual Primary Care & Behavioral Health Integration Summit

Cross-System Collaboration Example 3

How do we achieve these goals?

- FHCSD and Sheriff Department staff have established key contact persons to coordinate appointments
- Calls and requests are handled in timely manner.
- FHCSD have created specific appointment types that are reserved for the Progress referrals.
- Clients are seen within 1 week of referral.
- Having close communication with staff have facilitated the coordination of these referrals.
- A deputy transports the clients to the site weekly for appointments allowing the therapist to coordinate with him as needed. He waits until the clients finish the appointments to transport them home
- When it is 30 days prior to release, clients also have the opportunity to practice increased independence by having GPS tracker removed and attend appointments independently if they feel ready.
- Therapist also has coordination of care conversations with the Progress counselors

Cross-System Collaboration

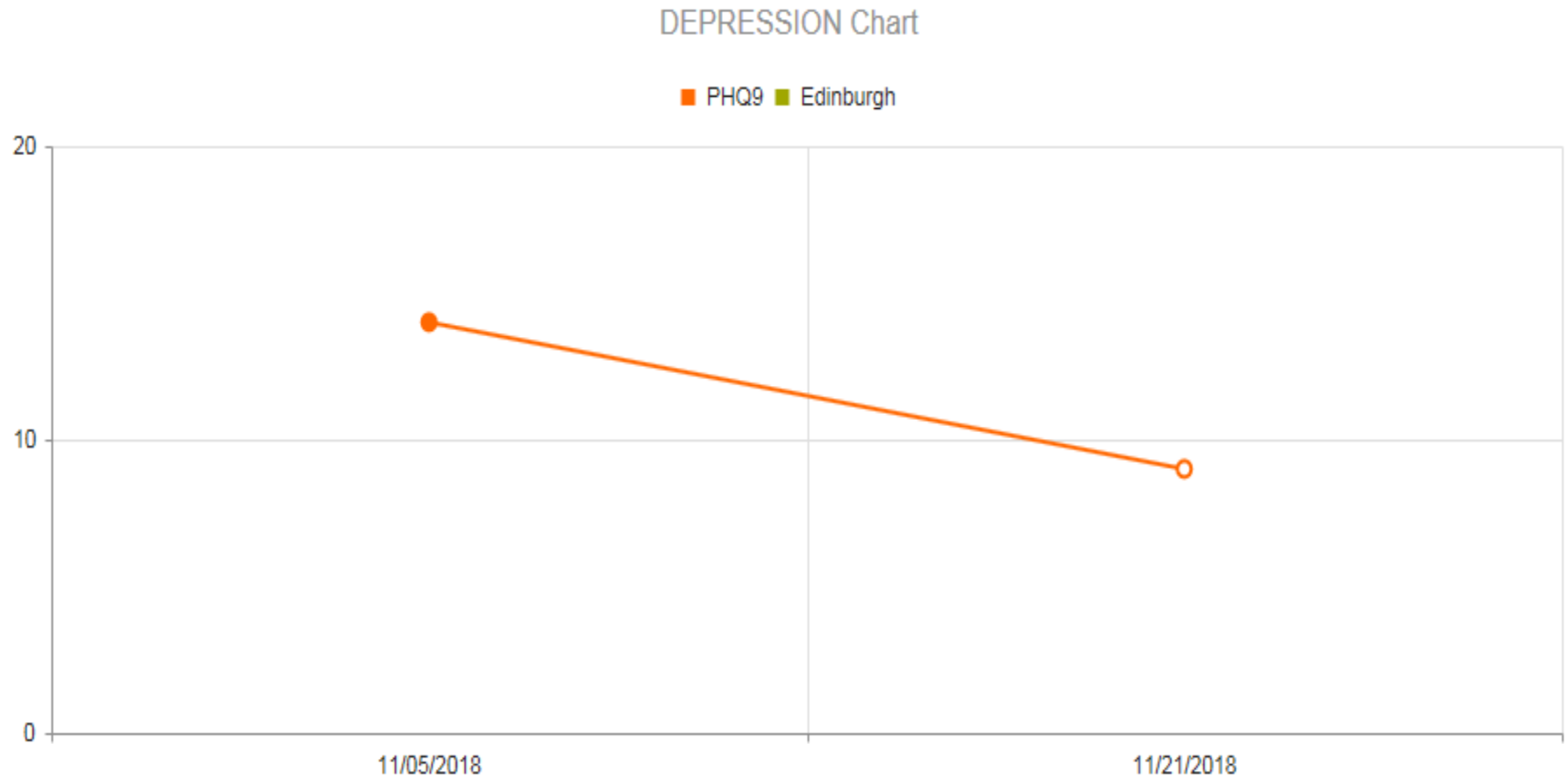
Outcomes:

- Clients felt hesitant to participate in the mental health services. With empathy and genuineness, we have been able to gain the trust of the residents, opening up about their struggles and traumas. Overall, feedback has been that residents feel valued, heard and supportive.
- Success stories (coordination of care with primary care)

Lessons Learned: The project initially started as a small pilot at FHC's National City clinic. Due to the location and not fully having the funding piece solidified yet, there were initial challenges. Through an augment to an existing County contract with HQP to serve clients who have no Medi-cal in the mental health department, the program was moved to FHC's Family Counseling Center in Logan Heights, which is very close to the community home. The partnerships as well as communication with the Sheriff's Department were instrumental in making this program successful.

Cross-System Collaboration Example 3

Outcomes: Example of PHQ9 score decrease for one 20-year old client after initial BHA intake; Has been incarcerated 13-15x in life and has been sober from methamphetamine for almost 6 months. Able to see psychiatrist who also ordered Narcan kit due to history of opiate use.



Cross-System Collaboration Example 3

Looking into the future:

- Recidivism rate will decrease if residents continue to be consistent with mental health treatment, substance use and medical services.
- Residents will be more successful if they get connected with housing and obtain employment.

Where would you like to go next?

- Would like to see more programs like progress in the community so we can expand our collaboration
- Will work on developing strong relationship with the new program Director and establish on going coordination of care for the clients.