

Big Ideas! Comments from Participants at the 2011 Integration Summit on 9/20/2011

Do you have a BIG IDEA? Well, then go ahead and share it! We will collect these throughout the Summit. If time allows we will share with the audience. We will post these on the I² webpage also.

1. Integrate with preventative health care treatment so we can reduce the increasing severity of illness and therefore, decrease the need for crisis interventions.
2. When considering use of peers there needs to be cross-training of PC, MH and Peers. Clients need to be viewed as colleagues in the workplace and not patients. Salaries need to be living wage – remember we are the experts on what works for us in recovery.
3. RE: SBIRT / MH Screening: County BH already developed a BH & DV screening tool – “COST”....5 Questions in Spanish and English are available through BHETA.
4. Provide basic trainings about physical health for MH and ADS providers the way the reverse has been done.
5. Give ADS and PC providers access to Anasazi.
6. Include trained peer support and family members through all integration steps and throughout all systems.
7. National commitment to integration of physical, mental, substance abuse assessment and treatment for these cross-over patients cost \$\$ and payment reform is key.
8. More Peers in all areas of County services. Customer service re-training on courtesy and respect. Peers in community clinics. Peers can speak out to any and all locations to get better understanding, knowledge and resources to community!

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9. National medicine not low cost health plan for everybody documented or undocumented.
10. Partner with academic institutions on research. San Diego is cutting edge in integrated care and rigorous, prospective studies could support future work. Both quality of life and financial savings could be evaluated.
11. Mental health and physical medical records combined on a user friendly system (not Anasazi).
12. Develop a central site to recruit BH professionals. Recruitment is very difficult and there are not specific sites to post ads on for health center recruitment.
13. While Pediatricians are important to participate in Integration Model Family Practice Physicians cannot be left out of children's model of care and specifically for funding opportunities for Integration. Integration needs to be focused on inclusion of all modalities in PC and BH.
14. I think that in order to integrate AOD and MH services the public health model has a proven track record. In order to combat problems we must work with the community, families and the health industry (hospitals) to get better outcomes and results.
15. Partner with nutrition, education and physical activity based organizations to prevent childhood obesity and related chronic illness.

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16. Implement nutrition education services and BH obesity prevention programs for the pediatric population via Primary Care.
17. Give County contractors a list of Pediatricians, PCPs and health clinics that are on board with Integration.
18. Since most of the services in San Diego County are contracted wouldn't Integration be easier if coordinated with the help of the County, who has more leverage and connections? Integrate as a County instead of having each provider working on it on their own time.
19. What can be done to have community clinics better serve the under-insured? Some folks have 60% coverage and cannot afford their 40% coverage. Of course, they don't qualify for the LIHP so they go untreated and end up in our ER or actually attempting suicide.
20. Identify the top users of Medical or County physical behavioral services and then develop an integrated plan to provide services for them with linked services and "joined" funding incentives and measures if costs can be reduced. Most are those with behavioral, Axis II and medical problems that don't fit in any system.
21. Behavioral Health and medical use different vocabulary, abbreviations, assumptions; we need to learn each other's language to better communicate.

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22. Asking a PC doctor to treat 40 year chronically mentally ill people is asking them to do "psychiatry" and "geriatrics". Do they have both competences?
23. Give out validated and instant (P+P) for office, clinic, hospital, SNF for drug and alcohol screenings.
24. Next year put all medical doctors at same table so we can interact and share experiences and concerns.
25. Development of training (webinars) for chronic physical health conditions geared towards mental health specialists (similar to CCC's work, but for MH facilities).
26. Research provides valuable data on quality of life and financial savings that support future work. Partner with universities to begin research studies on integrated care. Data could determine qualitative and quantitative data that is cutting edge.
27. Make use of Promotoras in Community Health Care Centers. Repetition of information the clients need will be better accepted and followed up with.
28. Need more consistent funding for permanent mental health services. It seems as though services are part-time and limited service hours. There is no greater need within our community especially in the underserved population (on-site clinic).
29. Salud Programs should be extended and offered to all adults with diabetes to fully develop the purpose of integration in the future.
30. Child support groups

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31. Funding; 80% of funding is for adult population and 20% is for adolescents. 85% of adolescents in San Diego Juvenile Hall have substance abuse and behavioral health issues. Funding for more high risk adolescents.
32. Care coordination needs to include mandatory drug testing for all individuals receiving welfare / subsidy payments.
33. Create art programs that allow these issues to be addressed. Art therapy motivates consciousness to real life issues.
34. Create an integration status, i.e. how capable a program is of addressing BH and MH issues. Create tools to assess integration status.
35. Require any patient who receives financial aid to attend parenting classes on various topics from nutrition to discipline to the standard parenting curriculum, with info on the symptoms of mental illness in children and the resources.
36. We need to work together to connect our patients to all the resources and programs available in the local community. This is beyond integrating primary care and behavioral health (working with dental care, etc.)
37. Use the SBIRT Model not only for substance issues but also for mental health issues. For example: Asking all patients who go to see their PCP PHQ2 (the first questions of PHQ9), then provide with a brief intervention, and then possibly refer them to appropriate

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services and treatments. Peers and community health workers can facilitate with a warm handoff at PC clinics to link the patient with appropriate services.

38. Same day mental health PCP appointments will help decrease transportation problems, and allow better access of information to both providers. Set aside a small block of appointments for these visit types.
39. COMMUNICATION: if all agencies have the same information distributed so the same service is provided no conflict will be present in giving service! Have a central agency where all other agencies can go to get the same info – that can be distributed.
40. Develop a mobile AOD service to take the clinics on the road to remote regions. This could integrate AOD services into local community health clinics and other health outlets.
41. In suicide prevention our goal is zero suicides. In integrated health management our goal should be 100 years old for each person.
42. Integrate MH and AOD service treatment. Hire Peer support staff / liaisons / advocates for intake assessment and referral of pre-screening.
43. Provide CME credits to physicians who work in private practice settings, who identify action steps to integrate services with BH providers.
44. Need to plan for integrated MH services (just as Anasazi is being fully deployed, we need a “Paired EHR”)

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45. Need to create payment incentives to support multidisciplinary team consults.
46. Where do behavioral pediatric practitioners fit in?
47. Increase the number of Medi-Cal clinics and house them with FQHCs and or community clinics, which will increase access and care coordination while tapping different funding streams.
48. Goal of having a personal health record available to every person who receives physical, behavioral health and social services that can be accessed through a central portal on the web.
49. Incorporate mental health screening into onsite student health screenings at elementary, middle and high schools. This is the opportune time to be able to bring appropriate services to those kids.
50. Create pairings between adult mental health and substance abuse services like we do with primary care.
51. Create a triangle relationships with MOUs (PC – AOD – BH)
52. Multicultural competency across the board so that all segments of the population can benefit from PC and BH integration. Especially for the underserved populations, one has to be culturally sensitive to better break through the stigma that limits access to services.
53. Communication should be improved across agencies.

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54. Expand the concept of SAMHSA to address the needs of the clients who won't / can't go to a PCP medical home by: establishing a full-fledged small satellite PC FQHC facility at the MH sites.
55. CCC/CCHN/County: develop a training program for peer educators to be deployed in the CHCs to do the needed screenings / referral / brief interventions.
56. Working at pediatric clinics I notice that there is a central resource for parents. It would be great to have a service that is focused on parent's needs (parenting, daycare, recovery, MH issues, etc.)
57. Connect with Rosalyn Carter Center to build peer recovery system and pursue CA legislation / federal support for those programs Medicaid pays for in some states.
58. For children's services in order to ensure all children's needs are being taken care of I think that it would be great for kid's school health cards to be comprehensive of all health needs. When the school receives cards with areas that are missing information a school social worker can connect that child's parents with community agencies that can provide services in that missing field. This way all families can know where their child can receive services even if they are not needed yet.
59. Can we give or authorize a medical detox for patients once a year or every three years under CMS or Medi-Cal? Folks end up having to keep using to avoid tremors, seizures or other known detox symptoms. We have some folks in our BH units reporting SI with a

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plan to receive detox protocol care. I appreciate what we currently have available and thank god for everyone here – but there needs to be more treatment available for co-occurring disease – again more of a comment than idea. Let’s work together for solutions we are having here with a problem solving attitude.

END