



INNOVATION PLAN APPROVAL SUMMARY Madera County Innovation

Total Requested for Innovation: \$854,297

Staff Recommends: APPROVAL

Innovation Plan Summary

Madera County is a small rural county in Central California. Residents know each other by name. However, in Madera County only 22% of those individuals accessing crisis services follow through with on-going outpatient services. Like many counties facing the current fiscal climate, there is a county hiring freeze.

New Model for Access Into Services

This Project is a collaboration with the emergency room staff, mental health staff and peer/family members who will engage clients (and families) in crisis. The focus of the mental health and emergency room staff will be for assessment of health problems, medication management, and crisis services. Once the need for health and/or crisis services has been resolved, the mental health staff will link the peer/family members to clients for follow-up services in hopes they will be able to assist and engage the clients in recovery activities such as outpatient treatment or community support groups.

Madera County stakeholders want to learn if the engagement of peer support and family support in crisis services and in clinic services will increase access to services and shift services to more of a recovery focus. Project 1 is designed to test what elements are necessary to create a new and successful model of a peer/family member partnership in a small, rural county public mental health system. Underlying the model is the intent to reduce stigma towards mental illness in a close knit rural setting.

Project 1 will:

- Team peer/family member (including a TAY peer) and crisis/assessment staff at the Madera Community Hospital's Rural Health Clinic and Community Hospital's ER.
- Employ an integrated team of transition age youth (TAY) and adult/family support specialists to engage clients (and families) at initiation of mental health crisis services at the Hospital's Emergency Department.
- Test whether peer and family member support will increase access in the mental health system. Will this model increase the number of people who entered county mental health outpatient services through ER?

Project 1 seeks to have the integrated team develop a model which can be replicated in other small rural counties with similar barriers to innovative delivery systems. Using this model the county will learn whether this model will result in better outcomes and reduce the stigma associated with mental illness. This is a new model, this Innovation Project staff (both professional and client/family member staff) will be the ones to design and implement it. They will also modify it as necessary (based upon data collection as part of this learning project). Modifications to the model will be done through input from the clients/family member staff, stakeholders such as the Promotores and other community members and by examining the results from the various surveys and outcomes described in the learning portion of this project.

The overall time frame for which the Project will operate will be three years. During this time frame Madera County Behavioral Health Services (MCBHS) will be able to conclude if outreach and engagement by peer and family member support staff does/doesn't engage people into services who experienced crisis/hospitalization. Information on the implementation and Project data will be disseminated quarterly to clients/family members through the Department's Quality Management Committee. There are stakeholders (including clients and family members) who sit as regular members of this committee.

This Project is similar to a recently approved Innovations Project from San Diego County. Madera hopes to collaborate with San Diego on the models and share findings with San Diego County as the projects are implemented.

Linkage to Physical Health by Pharmacist and Reverse Integration from Mental Health to Physical Health

Project 2 is an innovative collaboration between the MCBHS contracted pharmacist and local primary care providers. Project 2 resulted from stakeholders concern that physical health and mental health providers do not coordinate care and that this leads to poor health outcomes and stigmatizes individuals with serious mental illness. The pharmacist will be a critical link between the primary care physicians and MCBHS staff in coordinating the MCBHS client's mental health and physical health care. The pharmacist will call the primary care provider and make the referrals as well as an appointment for services. The pharmacist would then work with clinical staff to transition any records that need to be obtained by the primary care physician regarding

medications. This Project would also include the pharmacist transitioning those MCBHS clients who are stable and receiving only medication services from a mental health home to a medical home (reverse integration). The pharmacist has worked with mentally ill clients and their families. The pharmacist is familiar with recovery and wellness for this population.

Through the linkage of behavioral health and primary care, the pharmacist will assist in the recovery of individuals with mental health issues through innovative services that empower clients and families to achieve their goals. The pharmacist will ensure access to medically necessary services through engaging individuals with mental illness who may not be able to seek these services on their own.

Project 2 will:

- Promote interagency collaboration between community health centers and mental health in providing coordinated physical and mental health care.
- Test whether this model leads to better client outcomes.
- Test whether a pharmacist in the role of a care manager leads to better health outcomes.

This Project will operate over a three year period. There will be multiple opportunities for assessment and evaluation during this time period. Three years allows for sufficient time for learning and adaptation to occur in a way to improve the outcomes of the program. An ongoing assessment process and time after the completion of the Project will allow for the final evaluation to be comprehensive. That evaluation would include input from stakeholders, clients, and family members. Data will be gathered quarterly regarding the coordination of physical and mental health care. The project would be reviewed on an annual basis with a final comprehensive assessment after June 2013.