



INNOVATION PLAN APPROVAL SUMMARY

Inyo County Innovation

Name of Innovative Program: Coordinated Care Collaborative

Total Requested for Innovation: \$322,800

Duration of Innovative Programs: Three Years

Staff Recommends: APPROVAL

Review History

County Submitted Innovation Plan: July 28, 2014

Mental Health Services Oversight and Accountability Commission (MHSOAC) vote on Innovation Plan: August 28, 2014

Innovation Plan Summary

Inyo County is seeking MHSOAC approval for the following Innovative Program:

Coordinated Care Collaborative

Inyo County Mental Health recently completed their Community Program Planning Process and identified increasing access to and coordination with primary care services for their clients with serious mental illness as a high priority. This Innovation project will develop strategies to promote wellness and integrate health care, mental health, and substance use services to improve health outcomes for clients in a rural community. The primary purpose of this Innovation Program is to increase the quality of services, including better outcomes, by expanding the focus on wellness and engaging consumers in community activities that can have a positive impact on overall health. Inyo County will work collaboratively to identify the most effective ways to involve consumers in the development and fulfillment of personal wellness goals. This three-year Innovative Program will link clients who are suffering from a serious mental illness with a primary care provider of their choice, including alternative healthcare providers, to receive physical and behavioral health care services and foster improved collaboration and communication, and increase the capacity to track client outcomes.

Inyo County is especially interested in the role of peer supporters as a key component of collaborative care and will investigate whether and how a peer supporter facilitates

better communication with the health provider and helps the consumer meet health and recovery goals.

Key indicators will be compiled into Individual Wellness Reports, which will be given to each client, Behavioral Health staff, and the primary care provider every six months. Behavioral health staff will meet with the client to review their health indicators, identify wellness and mental health goals, and to share the information with the primary care provider. This approach will provide the opportunity for all team members to work together to identify chronic health conditions and risk factors, identify measurable goals, and improve communication, collaboration, and services to improve outcomes for each client.

Evaluation:

Inyo County will test whether and how the coordinated care approach, if successful, improves coordination of and satisfaction with care and improved health outcomes. The evaluation will measure changes in clients' health indicators including mental health and substance-related, fulfillment of wellness and recovery goals, use of self-management skills, and peer support. Health indicators will include the results of lab tests, conducted at least annually.

In addition to indicators for individuals, the evaluation will assess shared (physical health, mental health, substance-abuse services) system impacts, including

- Increased screening for mental health, substance use, and chronic medical conditions within each care setting
- Higher percentage of clients with shared care objectives that address both physical and behavioral health, with shared measures of progress
- Improved and updated medication reconciliation
- More timely response to an urgent health care or mental health care need
- Consumers' and providers' satisfaction with care.