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COMMUNITY UPDATE

June 2007

Feature Article

INTEGRATED CARE – A Transformational Direction

There are big changes coming to Southwest Colorado Mental Health Center under the heading of integrated care. These changes are coming both to the Center's internal operation and with a new initiative to integrate our resources with primary care in the community.

Internal Operations. Integration of internal operation will focus on reducing separations between our existing service programs. This means that we will be establishing a centralized intake and scheduling system that will do away with multiple and separate intake evaluations for each service. It will give us a broader view of the client needs and get clients into treatment quicker. This will help reduce the cancellations and no shows that are so costly and will lead to shorter, more effective treatment.

These integration efforts will also lead to a great deal more cross-training of mental health, substance abuse, and vocational staff to better meet client needs. We are developing more programs that cross traditional service lines. In addition to the very successful SUCCESS Program (combining vocational, substance abuse and mental health), we are establishing an Integrated Dual Diagnosis Treatment (IDDT) program beginning in July 2007. This is a State defined Evidence Based Best Practice that will serve, in an integrated manner, clients with both mental health and substance abuse problems. Research has shown that up to 60% of persons with a mental health diagnosis have a co-occurring substance abuse concern, and vice versa.

Primary Care. Integration of behavioral health with primary care is a major initiative not just in terms of its application across our five counties in Southwest Colorado, but also in terms of its transformation of how the Center will serve our communities and do so much more effectively. Though we are among the leading Centers on integration in Colorado, this concept has proved effective and is gaining momentum across the country.

This next year will see us partnering with primary care operations in some areas and could, but not necessarily, lead to us becoming a primary care resource in others – all with the vision of an integrated health care system, a medical home where medical and behavioral health (mental health and substance abuse) integrates with public health (prevention and healthy lifestyles) and

other resources (e.g., adult and child protective services) for better health outcomes and greater access to quality of life.

Why is this needed? Integrated primary care with behavioral health and public health is needed because it makes great conceptual sense, and mostly because it has been shown to significantly improve health outcomes for those presenting with a medical problem, for those presenting with a mental health concern, and for those presenting with both.

David Satcher, MD, Ph.D., the 16th Surgeon General of the United States, has stated and repeated emphatically that, *“Mental health is fundamental to overall health and well being - that mental disorders are physical disorders and are real.”* He also references the following quote, *“The greatest mistake in the treatment of diseases is that there are physicians for the body and physicians for the soul, although the two cannot be separated”* – Plato. You would think we would have learned this by now.

Here are some facts to consider:

- Well over 60% of mental health services nationwide are provided in a primary care setting;
- Referrals from primary care to mental health specialists are rarely followed through on;
- Just under half of the persons presenting with a physical health complaint in a primary care setting have a co-occurring mental health issue;
- Depression is associated with risk-taking behaviors such as smoking, substance use, unsafe sex, and not following medical regimens;
- Rates of depression are higher in people with chronic disease (e.g., diabetes, arthritis, asthma, cardiovascular disorders, cancer), as are rates of suicide;
- Major depression can precipitate chronic disease or be exacerbated by it;
- Individuals with depression are at greater risk for developing cancer or cardiovascular disease;
- When behavioral health is addressed in a primary care setting, healthcare costs are reduced two- to threefold;
- A recent study found the average life expectancy of someone with a significant mental illness to be as much as 25 years shorter, in large measure because of poor health practices and primary care access; and
- Less than 2/3 of healthcare needs are addressed in the typical primary care visit.

An integrated health care system would not only address the issues above, it also has a significant economic return on investment. For about 1 in 5 Americans, adulthood is interrupted by mental illness. Left untreated the result is lost productivity (including job loss),

unsuccessful relationships (also contributing to lost productivity as well as workplace problems), significant distress and dysfunction and adverse impacts in caring for children. Economics also enter the picture when you recognize that:

- Mental or emotional problems are the 6th leading cause in the US of disability among persons aged 15 years or older;
- Among non-fatal diseases, depression is the leading cause of years of life lived with disability in the world;
- Globally, 5 of the 10 leading causes of disability are mental disorders;
- 80-90% of mental disorders are treatable using medication and other therapies;
- Yet (primarily due to stigma) it takes on average just under 10 years from initial identification of a major disorder for persons to seek treatment; and
- Fewer than half of the adults get help and only 1/3 of children actually seek help.

Outcome studies from the integrated Washtenaw Model established in Washtenaw County, Michigan showed significant health improvements with persons presenting with either or both physical and mental health concerns.

What will a transformed system look like? Across our entire southwest Colorado region we have primary care challenges which offer all of us an opportunity to build a much better system. In Montezuma/Dolores Counties, a survey found that there was a primary care shortage of five FTE providers (MDs and/or mid-levels). With the departure of Valley-Wide, La Plata/San Juan Counties had a shortage of between five and eight primary care providers. In Archuleta County no studies have been done on primary care provider shortages that I am aware of, but the rapidly growing and senior populations are putting pressure on the primary care providers and on emergency needs. A transformed system would look different in each of these regions.

Montezuma/Dolores. **Chuck Bill**, CEO of Southwest Memorial Hospital, is leading an effort to establish a provider (hospital) based Rural Health Clinic. A start has already been made with the hiring of **Diana Fury, MD**, and the start of the clinic. Our Center will be contributing a half-time staff member to the clinic in June and we will have a full time staff member in January when the clinic hopes to obtain Rural Health Clinic status. We will contract with Southwest Memorial's clinic to be part of an integrated care system, providing both primary care and mental health services. In Dove Creek we are co-located with the Health Center and staff are present one to one and a half days per week. Here we coordinate, but services are not yet as integrated as they could be.

La Plata/San Juan. **Kirk Dignum**, CEO of Mercy Medical Center, has established the Health Services Clinic, a stop-gap clinic designed to help protect chronic patients who lost their medical home with Valley-Wide's departure. This is a short-term, stop-gap measure only. It is not a primary care clinic nor is it exactly an urgent care facility, but a hybrid of both. At the clinic our staff are present two to three hours a day. **Vanessa Feliciano, MD**, and two mid-level practitioners are

working with our staff in a truly integrated fashion. Kudos to both **Lynn Westberg** (Health Department Director) and to **Lezlie Mayer** (Director of La Plata DHS) for their partnership in this vision as well as contribution of staff. Both patient and staff satisfaction are very high so far. While this clinic is operating, a consultant is preparing to make a recommendation for a primary care solution or solutions in La Plata County. Their report is scheduled for release in the third week of August.

If the report recommends that an additional primary care group be established to focus on the unserved population in La Plata County (primarily Medicaid, Medicare and indigent clients), the Board of Directors of Southwest Colorado Mental Health Center has authorized me to explore the possibility of the Center transforming into a Health System that integrates primary care with behavioral health, public health and other human service resources. This would not be a mental health center running primary care as one of its programs. It would be a fully transformed non-profit integrating services to the advantage of all in the community.

In Durango there is a second and smaller scale primary care initiative of which we will be a part – the planned Durango High School Based Health Center scheduled to open in October 2007 with the start of the new school year. This effort, led by **Jayne Fontecchio-Spradling, RN**, and **Sherrod Beall, NP**, will serve as a regional pilot. If successful, and we are confident that it will be successful, the hope would be to extend this model to the Middle Schools and to both Bayfield and Ignacio.

Archuleta. A new 10-bed Critical Access Hospital is being constructed on the Mary Fisher Clinic grounds. It is our desire, if the community supports it, to move our operation to the campus. This would allow us, at very least, to co-locate with primary care and begin to build a collaborative/integrated relationship.

When the next *Community Update* newsletter comes out we will update you on this transformation, which we are confident will result in better health outcomes, longer lives, and less reliance on emergency care.

This article was written by Bern Heath, Ph.D., Chief Executive Officer of SWCMHC. Please contact Bern at bheath@swcmhc.org with any questions or requests for further information.

Notes from Bern

Program/Service News:

Acute Treatment Unit (ATU): The Acute Treatment Unit (ATU) opened in mid-October. The ATU has received 27-10 certification (allowing for emergency evaluations and commitments), but we have been unable to secure the full complement of nursing staff needed to operate under 27-10 status. This limits such things as use of our safe rooms, but does not otherwise limit our ability to treat those in crisis.

Since the opening of the ATU 7½ months ago, we have served 69 clients with 93 stays and 375 bed-days (average length of stay was 4.03 days). Clients served in the ATU have come from Montezuma, La Plata and Archuleta Counties and all municipalities within these counties except the town of Dolores, as well as the Southern Ute Tribe.

Office of Community and Family Affairs: There have been several changes since **Carolyn Murphy** came on board January 1, 2007 as a Recovery Specialist. We have added a peer support group for DBT graduates at the Cortez Kiva which meets every Wednesday morning at 10:30. We have also completed a WRAP group at the Kiva and are actively seeking participants for another. We have added a recovery group at the ATU which meets six days a week. We now have a Recovery Forum consisting of both consumers and family members which meets monthly. The focus of the recovery forum is on systems advocacy and networking with training components to support those efforts.

General News:

Quality Improvement: Quality Improvement is a critical aspect of the Center. We are constantly trying to be a better resource for our clients and our communities. There are two mechanisms we use to do so.

The primary quality improvement mechanism is the Quality Improvement Steering Committee (QISC). This committee meets monthly for two hours and reviews all Complaints/Grievances, Incident Reports, proposed and revised Policies and Procedures, record reviews and work group efforts. The QISC is open to community membership and a client currently sits on this important committee. If you are interested in serving on the QISC, please contact me at bheath@swcmhc.org.

Two customer service surveys comprise the second quality improvement mechanism. In January and April the Colorado Division of Mental health sends out the Mental Health Statistical Improvement Program (MHSIP) survey to our clients. In November we send out the Community Partners Survey to assess the satisfaction of our community partner agencies with our services. On the MHSIP we scored higher than the State average on all five domains (Access, Appropriateness/Quality, Outcomes, General Satisfaction and Participation in Treatment). On the Partners Survey we saw significant improvement in our community image, though there is certainly room to improve. Access to service remains a major community concern. Quality and Appropriateness of Service emerged as our strongest domain. Summaries of these surveys may be obtained from bheath@swcmhc.org.

Evidence Based/Best Practice: Increasingly you may be hearing the terms Evidence Based Practice or Best Practice. These are treatment approaches which research has shown to have positive outcomes. However, the definitions of “evidence based” and “best practices” vary somewhat and the narrowness of the

prescribed practices themselves is often limiting, especially for rural applications.

Despite these limitations, the Center has initiated the following evidence based practices, a number of what we would consider best practices, and is about to initiate several promising practices:

Federally Defined Evidence Based Practice (SAMSA)

- Integrated Dual Diagnosis Treatment (IDDT will begin at the Center 7/1/2007)

State Defined Evidence Based Practices

- Supported Housing – through our Valle de Merced partnership with Mercy Housing Southwest
- Matrix Model substance abuse treatment (ADAD evidence based practice)

Best Practices

- Adult and Adolescent Dialectical Behavior Therapy (DBT)
- Columbia Model child/adolescent treatment
- Televideo Psychiatry – remote televideo linkage to substantively improve access to psychiatric services
- Crisis Intervention Teams – we were the third CIT in Colorado and the very first rural CIT site in the Nation.

Promising Practices

- High Fidelity Wrap-around – scheduled to begin 6/1/2007
- Parent Child Interaction Therapy – scheduled to begin 7/1/2007
- Nurturing Parent – scheduled to begin 8/1/2007

Facts and Figures

Service Statistics & Facts: The volume of service provided by the Center to our communities has steadily risen over the years. The number of hours of service in Fiscal Year 2006 (July '05 – June '06) rose 9.6% from the previous fiscal year to 37,709 hours. At the same time, we served 2,906 unduplicated consumers in Fiscal Year 2006, which represents a 7.6% increase over the previous year.

It is worth noting that the largest increase of service came in the area of Crisis Services. In Fiscal Year 2006 we served 970 unduplicated clients in Emergency Services across our five-county region, an increase of 10.7%. In so doing we provided 3,262.5 hours of crisis services, representing an increase of 14.2% over the previous year. While our new ATU and continuum of emergency service resources will certainly serve us well, these statistics tell us that we need to be putting a significant emphasis on identifying persons/families with mental health issues earlier in their development. The Durango High School, School Based Health Center and our involvement in the solution to the La Plata County primary care crisis will be critical in this regard.

Additional information is available at our website, www.swcmhc.org, or in our 2006 Annual Report. The Annual Report is available in hard copy by e-mailing a request to Karen Spungen at kspungen@swcmhc.org, or electronically via our web site under *About Us*.

Comings and Goings

Goings: In January **Lori Roberson**, Administrative Assistant at New Day, moved to Nevada. In April **Leslie Dezendorf**, LPC, left to pursue adoption work, and **Kelli Wakefield**, our Durango receptionist, moved back home. In May **Devera Larson**, LCSW, moved back to Denver, and **Rachel Pfothauer**, MA, Therapist in our Cortez office, is returning to California. **Mark Mueller**, LCSW, left on June 1 to take a position in Utah.

Comings: **Julyet Kudo**, LPC, returned to the Center from back East to join our Regional Youth team. **Laura Boe**, RN, and **Lora Murray**, RN, joined our Nurse Clinician Staff at the ATU (new positions). **Angela Stout** is our new receptionist at New Day and **Jenna Ring**, BA, is our new receptionist in Durango. **Allison Reeves**, BA, is our Vocational Specialist and Community Resource Specialist in Pagosa Springs. **Sandra McManus** filled our new Reimbursement Director position. **Conny Heischkel**, LCSW, has joined our Emergency Services Staff at the Assessment Center at Crossroads. **Anna Freeman**, BA joined our Triage staff.

Open Positions: With 140 positions region-wide our percentage of unfilled positions is at an all-time low. At the Columbine Center in Durango we are looking for a PC/Network Technician, a Therapist to cover the Ignacio area, a Mental Health Therapist and a Triage Therapist. New Day is recruiting a Substance Abuse Counselor, and at the ATU at Crossroads we need a Vice President of Residential Services. In Cortez we need a Regional Youth Therapist.

If you are interested in any of these positions, please see our website (www.swcmhc.org) or contact Pat Roy at proy@swcmhc.org.

Coming Attractions

In future newsletters look for updates on the Center's involvement and evolving role in addressing our primary care crisis. Please let me know (bheath@swcmhc.org) if you have any other topics you would like addressed.