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Monterey County Behavioral Health Bureau: “*Transition to Integrated Care*”

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ABSTRACT

The rate of clients *discharging* from acute mental health services in Monterey County is low. According to Monterey County Behavioral Health Services Act (2017), “the demand for services has greatly increased with the ACCESS programs serving 90% more individuals in the past two years [2015-2016], and a 168% increase in the last 5 years [2011-2016].” The increase in demand for services has *impacted* staff psychiatrist and social workers in providing quality treatment services.

The Monterey County Behavioral Health Bureau (MCBH), a division of Monterey County Health Department, has identified clients who’ve shown *improvement* in their *mental health recovery* and are eligible for lower level of care treatment. In collaboration with the agency, the “*Transition to Integrated Care*” project was developed with the objective to transition *stable* clients to their Primary Care Physicians (PCP). This process is a way of rewarding clients for their recovery and increasing access for client’s who need higher level of care.

For clients who are not eligible for lower level of care, they are being referred to Adult System of Care (ASOC) where the client remains with their current psychiatrist and additional case management services are provided by a Psychiatric Social Worker.

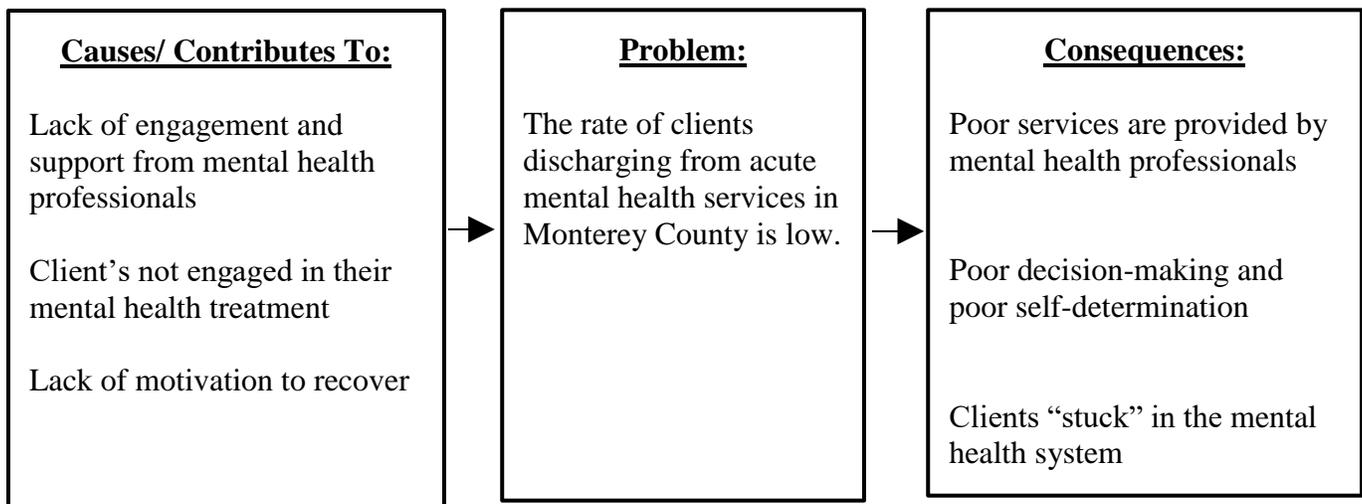
At the end of the transition process, clients are invited to participate in an *evaluation survey* that measures areas of the transition process. It is recommended that the agency continue to use the evaluation tool to gather data and improve the *continuity of care* for future transitions.

Keywords: *Discharging, Impacted, Monterey County Behavioral Health, Improvement, Mental Health Recovery, Transition to Integrated Care, Stable, Evaluation Survey, Continuity of Care*

INTRODUCTION

Monterey County Behavioral Health's (MCBH) vision is, "high quality, holistic treatment assists the individual with recovery" (Monterey County Health Department, 2015). MCBH's mission is to, "provide an approach that emphasizes healthy decision-making and coping skills to strengthen family and community support systems" (Monterey County Health Department, 2015). According to the California Health Care Foundation (2013), "1 in 6 California adults has a mental health need, and about 1 in 20 Adults suffers from a serious mental illness." Rates among children is even higher where 1 in 13 are unable to carry on daily activities due to the serious mental illness. According to the Monterey County Behavioral Health Strategic Plan (2014), "Of the Medi-Cal beneficiaries in Monterey County, 78% are Latino. Of the individuals served by the Adult System of Care 32% were Latino." Monterey County Behavioral Health (MCBH) serves all residents of Monterey County that are Medi-Cal eligible. Individuals seeking services from MCBH must have a severe mental health illness that is determined by a Psychiatric Social Worker and a Psychiatrist. Some of the specific diagnosis that an individual must be diagnosed with to receive services from MCBH include schizophrenia, bipolar disorder, atypical psychosis, and/or major depressive disorder with psychotic features (County of Monterey Health Department, 2015). Monterey County has a population of 410,370 people where 5.78% are receiving mental health services (California Department of Health Care Services, 2009). There is a wide range of ethnic groups in Monterey County that receive mental health services such as Hispanics, African Americans, Whites, Pacific Islanders and Native Americans.

Currently, the rate of clients discharging from acute mental health services in Monterey County is low. This problem leads to a high rate of untreated mental health illness in Monterey County. Causes that contribute to this issue include lack of engagement and support from mental health professionals. The consequence to this cause is poor services are provided by mental health professionals. Another cause that contributes to the problem includes clients not engaged in their mental health treatment. This cause can negatively impact a client’s decision-making and self-determination skills. Lastly, the lack of motivation to recover can cause clients to stay in a system due to the fear of not receiving support once they discharge from the mental health services program. This leads to a consequence of being “stuck” in the mental health system. The following problem model diagram can be seen in Appendix A.



MCBH is striving to expand their services to their residents by creating innovative engagement focusing on efficient and equitable distribution. According to Monterey County Behavioral Health (2017), “[the] goal is to increase services to the Latino population by five percent (5%) in five (5) years.” Additionally, MCBH is aiming to increase the rate of clients discharging from acute mental health services and expand their services to clients in need of acute mental health services but are not receiving them. To reach this goal, MCBH has identified

clients whose mental health recovery has improved and services can be transitioned to lower level of care. It was then determined that the agency needed a transition to lower level of care process to ensure an uninterrupted mental health services.

The process of “*Transition to Integrated Care*” was developed and is composed of the following steps:

- A. The first step is for the psychiatrist to identify potential clients that are eligible to be treated at lower level of care.
- B. The second step is for the psychiatrist to communicate with the social worker to further explore the transition process.
- C. The third step is a consultation between the psychiatrist and the social worker to determine what level of care best meets the clients’ needs.
- D. The fourth step is to follow up with community clinics to ensure a smooth transition to lower level of care.

While explaining the transition process, the student intern will be identified as a social worker as he is mirroring the roles and responsibilities of a social worker.

The first step of the procedure of this project begins with the initial engagement between the client and their psychiatrist. Psychiatrist explore the client’s needs, assess for case management needs, and formulate a treatment plan with the client. In collaboration with the client, the psychiatrist makes suggestions moves forward with referring the client to the social worker to further explore the transition process, evaluate the client’s psychosocial circumstances, and make suggestions to the case.

In this second step of the process, the social worker takes into consideration the following factors: length of time client has been on medications, case management needs, comfort level with receiving services with their primary care physician (PCP), the therapeutic relationship with psychiatrist, and the client's future goals in treatment. Clients are given the opportunity to share their thoughts about transitioning to lower level/higher level of care. The assessment process and informed consent takes about 3-6 weeks to complete.

In the third step of the process, the psychiatrist and the social worker consult about the case and the options that are available for the clients. In collaboration with the psychiatrist, the social worker determines the client's readiness for lower level of care or higher level of care. In this step, it is determined whether the social worker proceeds with referring the client to Adult System of Care (ASOC) or their Primary Care Physician (PCP).

In the fourth step, the social worker has the following two paths in which the client may be referred to:

Path 1: Client is ready for lower level of care and is eligible to be referred to their PCP.

Path 2: Client needs additional support in their mental health recovery; client remains with their psychiatrist and is assigned to a psychiatric social worker with ASOC.

In the first path, the social worker coordinates an interview with a medical assistant who is the liaison between MCBH and Monterey County's Sister Clinics (Laurel Clinics, Internal Medicine, Alisal Health Center, and Seaside Family Health Center). The social worker provides all the documentation included in the referral process. The documentation includes current medication list, last psychiatrist's progress notes and client's agreement of transferring services to PCP. The medical assistant will then schedule the client to meet with their PCP at one of the

sister clinics. In times where a client may face financial hardship, emotional dysregulation, and/or anxiety with the process; the social worker may assist with transportation support. Once the client has had their first consultation with their PCP, the social worker will communicate with the PCP and confirm their approval of their agreement to continue providing psychiatric treatment and fill the client's psychiatric medications. Once the confirmation from the PCP is received, the client will be discharged from services received by MCBH. This process takes about 1-2 months to complete.

In the second path, the client will continue to access their assigned psychiatrist, be referred to Adult System of Care Program and be assigned a Psychiatric Social Worker. It takes about 1-2 weeks for a client to be assigned to a PSW's caseload. The PSW will formulate a psychosocial assessment and identify the client's needs. PSW will support client with referrals to community resources, case management needs, and individual therapy.

ASSESSMENT OF THE PROJECT OUTCOMES

In collaboration with the Mentor, the intern created a survey that was composed of 7 questions to serve as an evaluation tool and measure client satisfaction during the transition process. The evaluation tool measures the following: timeliness of the transition process, satisfaction with services, quality of the services provided (customer service), cultural competence from the student intern, and ongoing medication from PCP/Psychiatrist. Combined with the survey, an informed consent to participate was developed and given to clients to provide transparency of what the data is going to be used for.

In order for the evaluation surveys to be completed, the intern contacted the clients that participated in the transition to lower level of care or higher level of care and asked them if they

would participate in the survey. Once the client agreed to participate, the intern coordinated an appointment to meet with the client to complete the survey. During the appointment, student intern reviewed the informed consent with the client and had them sign it prior to taking the survey. Clients were informed that their answers would not be reviewed by anyone else other than the intern. Additionally, the client was given information about the purpose of the survey. Once the informed consent was signed, the student intern provided client with the survey and asked the client if they needed support with clarifying questions. At the end of the survey, clients had the opportunity to share additional comments regarding the services they received. The scope of work and timeline table can be accessed in appendix B.

By using the evaluation questionnaire, the agency wanted to identify whether clients were being included in the decision-making process of their treatment plan. Additionally, the agency wanted to analyze how long it was taking for clients to transition to lower or higher level of care and whether clients were satisfied with the transition process. It was clear that the agency valued client's autonomy and promoted collaboration between behavioral health professionals and clients.

The agency requested questions that were very specific to customer service and cultural competence. With questions that focused on customer service and cultural competence, the agency would be able to identify whether staff members needed further trainings to improve their approach when engaging clients or trainings that included cultural backgrounds of the population served. These questions were geared to evaluate the knowledge of staff and to recognize when staff were doing a good job.

Finally, the last question in the questionnaire was to obtain feedback such as comments, concerns and/or questions that the clients may have had. This question gave client the

opportunity to share their experience in their own words and/or provide feedback for future transitions. The question allowed the agency to obtain direct quotes from clients and reflect on the feedback received from consumers.

PROJECT RESULTS/FINDINGS

In the “Transition to Integrated Care” process, clients were assessed and transitioned to a lower or higher level of care depending on the findings and recommendations of behavioral health professionals. As a result of the process, the expected outcome of increasing access to mental health services in Monterey County was reached. This outcome was analyzed based on caseload and the number of discharged clients. For every client that was transitioned out to their Primary Care Physician and discharged from Monterey County Behavioral Health, a new client would be assigned to the psychiatrist. On the other hand, the expected outcome of decreasing psychiatrist caseloads was not achieved because a new client would take the place of clients that were discharged from services.

The clients are actively engaged in their treatment plan and transition process to lower/higher level of care. This expected outcome was analyzed by the evaluation surveys that were distributed by the intern. In the surveys, the following question was asked: Staff allowed me to share my thoughts and opinions about transitioning to lower/higher level of care. Clients had the opportunity to answer the question with the following answers: Strongly Disagree, Somewhat Disagree, Neither Agree nor Disagree, Somewhat Agree and Strongly Agree. Based on the evaluation surveys, 50% of respondents answered Somewhat Agree and 50% of respondents answered Strongly Agree.

Clients are not having issues with their getting their prescriptions filled by their current providers after the transition process. This expected outcome was analyzed based on the

following question: I didn't have issues with getting my medications filled after the transition process. Clients had the opportunity to answer the question with the following answers: Strongly Disagree, Somewhat Disagree, Neither Agree nor Disagree, Somewhat Agree and Strongly Agree. Based on the evaluation surveys, 100% of respondents answered that they Strongly Agreed to the question.

As a result of the evaluation surveys that were distributed, the agency has statistical data that shows client satisfaction. The agency knows how long it takes for transitions to be completed. his expected outcome was analyzed based on the following question: How long was your transition process? Clients had the opportunity to answer the question with the following answers: 1-2 weeks, 2-4 weeks, 4-8 weeks, 8-12 weeks and longer than 12 weeks. Based on the evaluation surveys, 50% of respondents answered 1-2 weeks while 50% of respondents answered 2-4 weeks of transition process.

Lastly, the agency is aware of areas where they may need to improve for future transitions. During the evaluation process, clients had the opportunity to share comments, concerns and/or suggestions for further transitions. From all clients that participated in the survey, 40% provided feedback. The following statements were shared by clients that participated in the survey:

- I. "My experience has been positive for me and my mental health"
- II. "Everything is good"
- III. "Services were great"
- IV. "I like coming here, staff is great"

Overall, in the duration of the internship, the student intern was able to transition a total of 43 clients. The transitions were successfully carried out by implementing the "Transition to

Integrated Care” process. Based on these results, the psychiatrists were not able to decrease their caseload but provided intensive mental health services to new clients with a severe mental health illness. Lastly, the project was able to reach the expected outcome of clients actively engaged in the transition process and treatment plan. As part of the process, it was a requirement for client’s to be included in the decision of whether they felt it was appropriate to move their services to lower/higher level of care. After receiving all the surveys from the client’s, all clients strongly agreed with the statement “Staff was sensitive to my cultural background.”

The was one challenging task that was experienced during the distribution of evaluation surveys. Originally, the surveys were going to be sent via mail but it was then determined that it would be more efficient to complete the evaluation surveys in person with clients to maximize the participation rate. Doing surveys in person was challenging because coordinating the date and meeting with clients would not always coincide. Additionally, many clients refused to participate in the evaluation process.

CONCLUSIONS/ INTERPRETATION

My recommendation to the agency is to continue to collaborate with the clients when making recommendations in their treatment plan. Clients have the power of choice and can decide whether they would like to receive services with their primary care physician (PCP) or continue to receive services from their current provider. Additionally, I recommend that the agency use the data obtained from the evaluation tool to improve future services provided to clients. The evaluation tool provided valuable information that showed many areas of the transition process. The evaluation tool may be updated to reflect changes in the agency and services being provided.

I recommend that the agency use the data and tool to evaluate other clients being served within the Adult System of Care team. I believe that there are other clients that have shown great improvement in their mental health recovery and may meet criteria to receive psychiatric services at a lower level of care. By doing so, it will alleviate high caseloads for Psychiatric Social Workers or fill the spot with other individuals who may be lower functioning and may be in higher need of acute mental health services.

More importantly, this evaluation tool served a great purpose in obtaining statistics of services provided for clients and the timeliness of the transition process. Clients had the opportunity to provide feedback about the services they received and the customer service quality they received. In this evaluation tool, the clients had the opportunity to fully disclose whether they felt a bias when receiving services or if they felt like they were not included in the decision-making process. This information is critical because it may turn into a policy change with improving client involvement in their treatment plan.

After implementing the “Transition to Integrated Care” process and evaluating the performance of staff, I learned that recovery among mental health consumers can be reached at a greater rate with the support of behavioral health professionals. With time, professionals utilize re-assessment tools to determine whether a client may be ready to transition to lower level of care. If an agency is not promoting this process then client’s may feel “trapped” in a mental health system without reaching recovery. Now, with a reaching recovery mentality and a change in culture among behavioral health professionals, clients can actively engage in their treatment and motivate themselves to use acute services as needed and then move on to lower level of care.

Another important aspect of this process that I valued was the fostering of self-determination and allowing clients to steer their mental health treatment. I learned that cases

need to be treated in a case by case basis and some clients may need more support than others. During the assessment process, psychosocial circumstances and current stressors need to be integrated in the decision process of the next steps for a client. Additionally, behavioral health professionals need to be transparent so clients can be aware of their options for treatment.

In terms of the social health problem that this project addressed, I believe that if this transition process continues to be practiced, client's perspective of mental health services will change. Clients who only need temporary acute mental health services will receive their services and move on so others can take their place. The purpose of this change is to remove barriers that may be stopping clients from recovering and reaching future goals.

For future students that may intern with Monterey County Behavioral Health, I recommend to research what the agency is currently doing to promote reaching recovery. The agency is always changing treatment plans, techniques in engaging clients and tools to support clients in reaching recovery. Utilize the strengths assessment model to acknowledge clients' strengths in participating in their treatment and support clients in enhancing their current skills to improve their overall all quality of life.

References

- California Department of Health Care Services. (2009). California Prevalence Estimates.
Retrieved from
<http://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf>
- California Department of Public Health. (2015). Portrait of Promise: The California Statewide Plan to Promote Health and Mental Health Equity. Retrieved from
[https://www.cdph.ca.gov/Programs/OHE/CDPH%20Document%20Library/Accessible-CDPH_OHE_Disparity_Report_Final%20\(2\).pdf](https://www.cdph.ca.gov/Programs/OHE/CDPH%20Document%20Library/Accessible-CDPH_OHE_Disparity_Report_Final%20(2).pdf)
- California Health Care Foundation. (2013). Mental Health Care in California: Painting a Picture.
Retrieved from
<http://www.chcf.org/~/.media/MEDIA%20LIBRARY%20Files/PDF/PDF%20M/PDF%20MentalHealthPaintingPicture.pdf>
- County Health Rankings & Roadmaps. (2017). Health Rankings: Monterey County Demographics. Retrieved from
<http://www.countyhealthrankings.org/app/california/2017/rankings/monterey/county/outcomes/5/snapshot>
- County of Monterey Health Department. (2015). Services for Adults. Retrieved from
<http://www.mtyhd.org/index.php/services/behavioral-health/services-for-adults/>
- County of Monterey Health Department. (2014). Monterey County Behavioral Health Department Strategic Plan 2014. Retrieved from
https://www.mtyhd.org/QI/wp-content/uploads/2014/09/Final_Stratplan_08-26-14.pdf
- Monterey County Health Department, Behavioral Health Division. (2017). The Mental Health

Services Act. Retrieved from

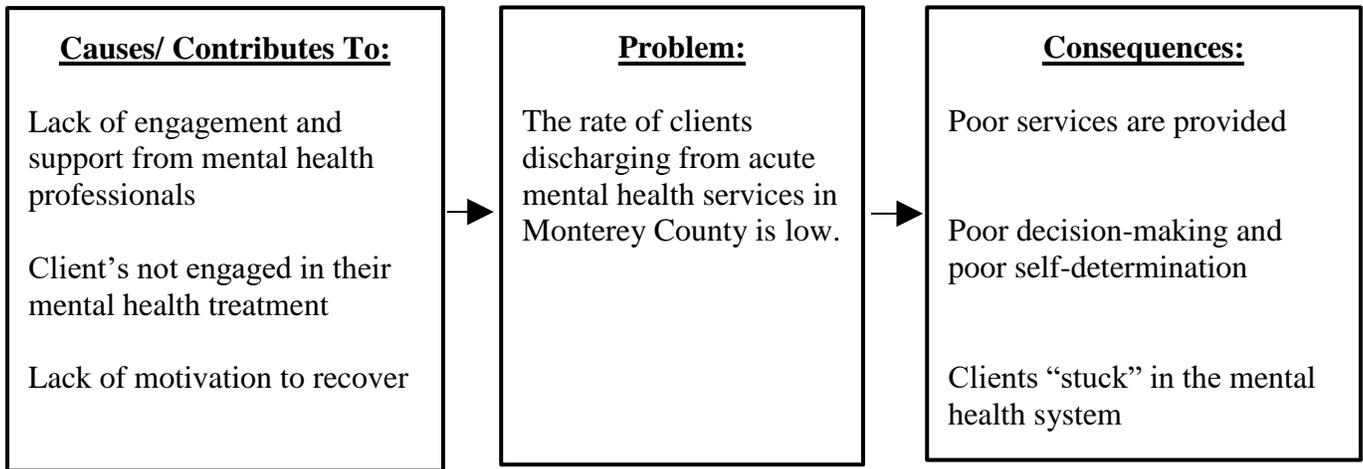
<https://www.co.monterey.ca.us/home/showdocument?id=46412>

Monterey County Health Department. (2015). Welcome to Monterey County Behavioral Health.

Retrieved from <https://www.co.monterey.ca.us/home/showdocument?id=18464>

Appendix A

Problem Model Diagram



Appendix B

Scope of Work and Timeline Table

Activities	Deliverables	Timeline	Deadline
Gather confidential information through research, review of medical records, consultations	List of clients that will be participating in the <i>“Transition to Integrated Care”</i> evaluation plan	August 23, 2017 - September 22, 2017	September 22, 2017
Prepare survey questionnaire for evaluation plan, discuss with mentor and psychiatrist	Completed questionnaire	August 23, 2017 - September 22, 2017	September 22, 2017
Survey- In-person appointments with participants to complete surveys	Completed Surveys by participants	October 2, 2017- October 20, 2017	October 27, 2017
Review all survey answers and formulate a statistical analysis with recommendations based on the data received	Excel spreadsheet, Statistical Analysis, Charts and Graphs	October 30, 2017- November 17, 2017	November 17, 2017
Present the data to mentor and Capstone Presentation	Presentation/ PowerPoint	November 20, 2017 - December 12, 2017	December 15, 2017