MIDD Briefing Paper

ES 1g Prevention and Early Intervention Mental Health and Substance Abuse Services for Adults Age 50+

Existing MIDD Program/Strategy Review X MIDD I Strategy Number 1g (Attach MIDD I pages)
Type of category: Existing Program/Strategy NO CHANGE

SUMMARY: MIDD Strategy 1g Prevention and Early Intervention Mental Health and Substance Abuse Services for Adults Age 50+ provides prevention and intervention services for older adults to reduce or prevent more acute illness, high-risk behaviors, substance use, mental and emotional disorders, and other emergency medical or crisis responses. Strategy 1g provides screening for depression, anxiety and substance use disorder for older adults (age 50+) receiving primary medical care in the health safety net system. Older adults who screen positive are enrolled in the Mental Health Integration Program (MHIP)[1], a short-term behavioral health intervention based on the Collaborative Care Model.

Collaborators:

Name	**Department**
Jen DeYoung	**PHSKC**

Subject Matter Experts and/or Stakeholders consulted for Briefing Paper preparation. List below.

Name	**Role**	**Organization**
Anne Shields, MHA, RN	Associate Director	Advancing Integrated Mental Health Solutions (AIMS) Center, University of Washington (UW)
Debra Morrison	Behavioral Health Program Manager	Neighborcare Health
Patricia Kennedy, MSW, LICSW	Social Work Program Manager, Community Health Services	PHSKC
Susan McLaughlin	Health & Human Services Integration Manager	King County Department of Community and Human Services (DCHS)
Sherry McCabe	Program Manager, Cross Systems & Contracting Services	DCHS
Lisa Kimmerly	Program Manager, System Performance Evaluation	DCHS
Kaetlin Miller	Program Manager, Community Health Partnerships	PHSKC

The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

[1] https://aims.uw.edu/washington-states-mental-health-integration-program-mhip

A. Description

1. **Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?**

MIDD Strategy 1g Prevention and Early Intervention Mental Health and Substance Abuse Services for Adults Age 50+ provides prevention and intervention services for older adults to reduce or prevent more acute illness, high-risk behaviors, substance use, mental and emotional disorders, and other emergency medical or crisis responses. Strategy 1g provides screening for depression, anxiety and substance use disorder for older adults (age 50+) receiving primary medical care in the health safety net system. Older adults who screen positive are enrolled in the Mental Health Integration Program (MHIP)[2], a short-term behavioral health intervention based on the Collaborative Care Model.

Strategy 1g currently supports five community health center (CHC) organizations (HealthPoint, Neighborcare Health, Country Doctor, International Community Health Services and SeaMar) and Harborview Medical Center, operating 22 primary care sites throughout King County.

The Collaborative Care Model is a specific model for integrated care developed at the University of Washington Advancing Integrated Mental Health Solutions (AIMS) Center[3] to treat common mental health conditions that are persistent in nature and require systematic follow-up. MHIP focuses on a defined patient population identified through screening and uses measurement-based practice and treatment to reduce depression and anxiety (as measured by validated screening tools such as the Patient Health Questionnaire-9 and Generalized Anxiety Disorder-7[4]). Primary care providers work with behavioral health professionals to provide evidence-based medications and psychosocial treatments supported by regular consultation with a psychiatric specialist and treatment adjustment for patients who are not improving. Treatment lasts on average for six months.

Adults with more severe or complex needs that cannot be adequately treated in primary care are referred to mental health and substance use disorder treatment. This strategy has been on the cutting edge of healthcare integration efforts serving over 11,000 clients since 2008.

2. **Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area** (Select all that apply):

☐ **Crisis Diversion** ☒ **Prevention and Early Intervention**

☐ **Recovery and Re-entry** ☐ **System Improvements**

Please describe the basis for the determination(s).

Strategy 1g provides increased access to behavioral health information and services in a non-traditional setting (primary care). Through screening for depression, anxiety and substance use disorders, older adults are identified for short-term intervention delivered in the primary care setting to address these problems and prevent them from escalating.

[2] https://aims.uw.edu/washington-states-mental-health-integration-program-mhip
[3] https://aims.uw.edu/
[4] http://www.phqscreeners.com/

B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes

1. Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.

The number of older adults in the United States is expected to increase dramatically from 40.3 million in 2010 to 72.1 million in 2030. Nationally, between 14 percent and 20 percent of older adults have one or more mental health and substance use conditions. Depressive disorders are one of the most prevalent but substance use is also a significant problem.[5] Washington State Department of Social and Health Services estimates 40 percent of elderly (age 65+) low-income residents who are dually eligible for Medicaid and Medicare have mental health needs.[6]

While comprising about 13.75 percent of the population, 16.37 percent of all suicide deaths occur in older adults (age 65+). Depression, often undiagnosed and untreated, is a leading cause of suicide in older adults.[7] A review of 40 studies with data on suicide and rates of health care contact found that on average, 77 percent of older adults had contact with a primary care provider within a year of their suicide and 58 percent had contact within one month.[8] This data led the U.S. Surgeon General and the National Action Alliance for Suicide Prevention to call for better integration of physical and behavioral health services as part of the 2012 National Strategy for Suicide Prevention.[9]

Depression also negatively impacts the severity and interferes with the treatment for many chronic conditions more common in older adults such as diabetes, high blood pressure and heart disease. Older adults with depression visit the doctor and the emergency room more often, use more medication, incur higher outpatient costs and experience longer hospital stays.[10]

If Strategy 1g is not implemented as part of MIDD II, older adults in the health safety net system will have decreased access to screening and short-term intervention for mental health and substance use disorders in the primary care setting. Embedding these services within primary care also increases

[5] Institute of Medicine. (2012). *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* 2012. Washington, DC: The National Academies Press.
[6] Washington State Department of Social and Health Services (2009). Coordinating care for Washington State dual eligibles. https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/Dual Eligible Population Profile.pdf. Accessed on December 28, 2015.
[7] American Association of Suicidology. Elderly Suicide Fact Sheet Based on 2012 Data. http://www.suicidology.org. Accessed December 13, 2015.
[8] Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: a review of the evidence. American Journal of Psychiatry 2002;14:909-916.
[9] Office of the Surgeon General (US); National Action Alliance for Suicide Prevention (2012). National Strategy for Suicide Prevention: Goals and Objectives for Action: A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention. Washington, DC: US Department of Health & Human Services. http://www.ncbi.nlm.nih.gov. Accessed on December 15, 2015.
[10] U.S. Department of Health and Human Services. Older Adults and Mental Health. In: Mental Health: A report of the Surgeon General 1999. http://profiles.nlm.nih.gov. Accessed December 13, 2015.

access by reducing stigma as a barrier to receiving mental health services. Those with more severe and complex needs may not be identified for referral to the mental health and substance use disorder treatment services they need to recover. As a result, these conditions will remain undiagnosed and untreated, resulting in increased mortality and poorer health outcomes in this population and increased cost to the health care system. As the percentage of older adults in the U.S. population continues to grow over the next 15 years, this gap will only widen.

2. **Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.**

In 2014, King County health safety net providers (including all Federally Qualified Health Centers and Harborview's Pioneer Square Clinic) served over 66,000 low income medical patients between 35-59 years of age and an additional 23,000 low income patients over age 60. Strategy 1g supports screening and short-term evidence-based treatment in primary care for depression, anxiety and substance use disorders as well as referral, as appropriate, for mental health and substance use disorder treatment services for the older adult population of low income, vulnerable patients in King County's health safety net system.

3. **What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.**

The MIDD Sixth Annual Report published data analyzed on nearly 2,000 older adults who engaged in MHIP services under Strategy 1g after initially screening positive for depression. Of these, 62 percent had improved depression scores or stabilized below the clinical threshold of concern. This group received an average of 479 treatment minutes. By contrast, the portion of this group (38%) with symptoms above moderate or worsening over time averaged only 383 treatment minutes.[11]

The MIDD Seventh Annual Report published Year Six results for long-term outcomes, including reduction in visits to the Harborview Medical Center Emergency Department (ED). For clients who engaged in MHIP treatment under Strategy 1g, ED visits were significantly reduced by 29 percent from the pre-intervention period to the third post-intervention period (the year following the second anniversary of the clients "MIDD start").[12]

4. **Please specify whether this New Concept/Existing MIDD Strategy/Program is a/an: Evidence-Based Practice Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.**

Strategy 1g supports implementation of MHIP in the health safety net system. MHIP is based on the Collaborative Care model developed at the University of Washington AIMS Center. A 2012 Cochrane

[11] King County Mental Illness and Drug Dependency (MIDD) Oversight Committee. MIDD Sixth Annual Report: Implementation and Evaluation Summary for Year Five October 1, 2012—September 30, 2013. February 2014.
[12] King County Mental Illness and Drug Dependency (MIDD) Oversight Committee. MIDD Seventh Annual Report: Implementation and Evaluation Summary for Year Six October 1, 2013—September 30, 2014. February 2015.

Summary conducted a meta-analysis of 79 randomized control trials (the 'gold standard' in scientific research) of Collaborative Care that included 24,308 patients worldwide. The Review concluded that Collaborative Care was associated with significant improvements in depression and anxiety outcomes compared with usual care.[13]

In addition, the Centers for Disease Control and Prevention named IMPACT, a Collaborative Care program for older adults, as one of two recommended evidence-based interventions in its "Call to Action: Addressing Mental Distress in Older Adults" in *The State of Aging and Health in America 2013*.[14]

5. **What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?**

As demonstrated in MIDD I, King County can expect continued improvement in depression scores and reductions in visits to the ED for those who screen positive for depression. Other expected outcomes include reductions in suicides, anxiety and alcohol and drug abuse among older adults in King County. As a result, additional reductions in health care costs can be expected for this population.

C. Populations, Geography, and Collaborations & Partnerships

1. **What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program:** (Select all that apply):

☐ **All children/youth 18 or under**	☐ **Racial-Ethnic minority (any)**
☐ **Children 0-5**	☐ **Black/African-American**
☐ **Children 6-12**	☐ **Hispanic/Latino**
☐ **Teens 13-18**	☐ **Asian/Pacific Islander**
☐ **Transition age youth 18-25**	☐ **First Nations/American Indian/Native American**
☐ **Adults**	☐ **Immigrant/Refugee**
☒ **Older Adults**	☐ **Veteran/US Military**
☐ **Families**	☐ **Homeless**
☐ **Anyone**	☐ **GLBT**
☐ **Offenders/Ex-offenders/Justice-involved**	☐ **Women**
☐ **Other – Please Specify:**	

Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.

Since 2008, Strategy 1g has served a total of 11,359 clients with the following demographic profile:

Race/Ethnicity:

[13] Archer J, Bower P, Gilbody S, Lovell K, Richards D, Gask L, Dickens C, Coventry P. Collaborative Care for people with depression and anxiety. Cochrane Database of Systematic Reviews 2012. Issue 10.

[14] Centers for Disease Control and Prevention. *The State of Aging and Health in America 2013*. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2013.

52% White
17% Asian/Pacific Islander
15% African American
2% Other
1% Multiracial
12% Unknown

Age Groups:
39% 45-54 years
44% 55-64 years
17% 65+ years

Other demographics: 58 percent of clients were female; 42 percent male; and 13 percent reported experiencing homelessness when they entered the program.

2. **Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection**: County-wide

Strategy 1g serves low income, older adults county-wide. Data on clients served since 2008 indicates highest utilization for the South King County Region and Seattle.

Strategy 1g Clients served since 2008 by King County Region:
42% South
7% North
7% East
34% Seattle
10% Other/unknown

3. **What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities, law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.**

Community Health Centers and Harborview Medical Center primary care clinics implementing MHIP under Strategy 1g collaborate with each other, along with PHSKC, University of Washington AIMS Center and the Community Health Plan of Washington to share best practices and lessons learned in implementation as part of the King County Behavioral Health Managers Group that meets every other month. In addition, partnership with the University of Washington AIMS Center is necessary to provide linkage to specialty psychiatric consultation, technical assistance on implementation and maintenance of the MHIP patient registry database used by all sites to support population management. The Strategy 1g clinic sites also maintain referral relationships with mental health and drug and alcohol treatment providers to assure appropriate treatment of those individuals whose treatment needs cannot be managed in primary care.

D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. **What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?**

In 2014, the Washington State Legislature passed legislation, Senate Bill 6312, which calls for full integration of physical health and behavioral health by January 1, 2020. In response, King County has convened a Physical and Behavioral Health Integration (PBHI) Design Committee to develop a vision for a regional model of fully integrated physical and behavioral health for both children and adults. The Design Committee is expected to complete its work by the end of 2016. The State recognizes MHIP as a model for successful integration of services and has expressed interest in taking the model to scale throughout the State as part of its PBHI effort.

To support the move towards full integration, the State has established two mechanisms: 1) the establishment of Accountable Communities of Health (ACH) in regions throughout the state, including King County and 2) pursuit of a global 1115 Medicaid waiver[15]. ACHs are regionally governed, public-private collaboratives tailored by each region to align actions and initiatives of a diverse coalition of participants in order to achieve healthy communities and populations. One of the priorities for the King County ACH is to endorse a model of care for full PBHI that emerges from the PBHI Design Committee. Additionally, the State is working to secure a global 1115 Medicaid waiver, which would help support the State's move to full integration by allowing for greater flexibility in how the healthcare delivery system is transformed to better meet the needs of residents. The State is currently in negotiations with the federal government over whether it will accept the State's waiver application and hopes to reach resolution by April 2016.

Given the rapidly changing environment in Washington State and King County around PBHI, it will be essential that there is flexibility built into Strategy 1g and other related MIDD strategies in order to ensure and allow for alignment and/or incorporation into any of these and other emerging initiatives.

2. **What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?**

Since Strategy 1g is currently being implemented successfully, no barriers to implementation are anticipated for continuation as part of MIDD II.

3. **What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?**

Since Strategy 1g is currently being implemented successfully, no unintended consequences are anticipated for continuation as part of MIDD II.

4. **What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?**

[15] 1115 Medicaid Waiver: Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. The purpose of these demonstrations, give states additional flexibility to design and improve their programs.

If Strategy 1g is not implemented as part of MIDD II, older adults in the health safety net system will have decreased access to screening and short-term intervention for mental health and substance use disorders in the primary care setting. Embedding these services within primary care also increases access by reducing stigma as a barrier to receiving behavioral health services. Those with more severe and complex needs may not be identified for referral to the mental health and substance use disorder treatment services they need to recover. As a result, these conditions will remain undiagnosed and untreated resulting in increased mortality and poorer health outcomes in this population and increased cost to the health care system.

5. **What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?**

Alternative approaches are currently available for integrating primary care and behavioral health. One intervention that is also used within King County is the Behavioral Health Consultant (BHC) Model. This model includes a behavioral health consultant as part of the primary care team and aims for immediate access in conjunction with a primary care encounter with minimal barriers. This model usually includes no more than two to four brief visits. Compared to MHIP/Collaborative Care, the BHC model does not necessarily require screening for depression, anxiety or substance use disorders with a standardized tool to guide treatment until a clinical target is reached. It is also not usually done in conjunction with medication therapies. MHIP is based on "treat to clinical target" and includes regular case review for patients not showing improvement with a psychiatric specialist. Average enrollment is around six months. At this point, the evidence base for the BHC model is not as robust as Collaborative Care. Several clinics participating in Strategy 1g blend these two models and direct patients with short term needs that do not require medication to BHC and patients with chronic depression or anxiety, still treatable in the primary care setting, to MHIP.

E. Countywide Policies and Priorities

1. **How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?**

This strategy exemplifies the principles set for by the Health and Human Services Transformation plan and takes steps to support achievement of the plan's vision that "By 2020, the people of King County will experience significant gains in health and well-being because our community worked collectively to make the shift from a costly, crisis-oriented response to health and social problems, to one that focuses on prevention, embraces recovery, and eliminates disparities."

For example, adults screened in the primary care setting under Strategy 1g with more severe or complex needs that cannot be adequately treated in primary care are referred to mental health and substance use disorder treatment agencies already under contract with the King County Department of Community and Human Services. Since 2008, 348 clients screened through Strategy 1g were referred to the Regional Support Network for specialty mental health services and 181 were referred for substance

abuse treatment. This partnership allows for a more seamless referral system for this difficult to engage population and prevents a possible behavioral health crisis by ensuring the patient is receiving the level of care they most need.

The Veterans and Human Services Levy (VHSL) also supports MHIP services targeted at the following populations with unique vulnerability to depression, anxiety and substance use disorders: veterans, mothers, low-income uninsured/underinsured. Strategy 1g provides for focused screening and services to meet the unique needs and vulnerability of the older adult population.

See also the response to #D1 for details on this strategy's connection to the State and County's work on PBHI.

2. **How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?**

Strategy 1g is rooted in the principles of recovery and resiliency in that community health centers are addressing not only a patient's medical issues but also any possible mental health or substance use disorder needs which are essential for overall health. This whole health approach promotes prevention and early intervention for this growing population and integrates principles of trauma-informed care in the primary care setting.

3. **How does this New Concept/Existing MIDD Strategy/Program enact and further the County's EQUITY and SOCIAL JUSTICE work?**

Strategy 1g seeks to increase access to treatment for depression, anxiety and substance use disorders for low income vulnerable adults in the health safety net system to alleviate disparities in mortality through suicide and poor health outcomes for chronic diseases exacerbated by undertreated mental health conditions and substance use disorders.

F. Implementation Factors

1. **What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program** (staff, physical space, training, UA kits, etc.)**?**

The resources needed are already in place within Community Health Centers as a result of funding provided under MIDD I for Strategy 1g. These include Care Coordination staff at each clinic site to work with clients and primary care providers to deliver the intervention; office space for the Care Coordinator to meet with clients; regular case review with a psychiatric specialist; staff time to administer screening instruments; staff time to maintain caseload data in the MHIP registry.

2. **Estimated ANNUAL COST. $501,000-$1.5 million Provide unit or other specific costs if known.**

Strategy 1g maintained an annual funding level of $450,000 from 2008-2014 in MIDD I. An inflationary increase was provided to subcontractors for the first time in 2015-2016 bringing the total 2016 cost to $470,982. Since costs to implement the program increase each year, additional funds are requested to provide a one-time cost of living adjustment at the beginning of MIDD II and to provide for an annual inflationary increase to subcontractors and include annual inflationary adjustments.

Restore strategy to original allocation of $500,000 plus 10% inflationary increase ($50,000) and administration of 8% ($40,000) (to Public Health, Seattle-King County) and include ongoing annual inflationary adjustments.

The annual amount requested is $590,000.00

3. **Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.**

For patients enrolled in health insurance, clinic sites can bill the insurance plan for any components of the intervention that are covered. The full cost of the intervention is not currently covered by health insurance. VHSL also supports implementation of MHIP services targeted at the following populations with unique vulnerability to depression, anxiety and substance use disorders: veterans, mothers, low-income uninsured/underinsured.

4. **TIME to implementation: Currently underway**
    a. **What are the factors in the time to implementation assessment?**
    b. **What are the steps needed for implementation?**
    c. **Does this need an RFP?**

This is an existing strategy; therefore no implementation time is necessary, funding would need to be amended into existing contracts.

G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

Strategy Title: Increase Access to Community Mental Health and Substance Abuse Treatment

Strategy No: 1g – Prevention and Early Intervention Mental Health and Substance Abuse Services for Older Adults

County Policy Goals Addressed:

- A reduction in the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.

- A reduction of the number of people with mental illness and chemical dependency using costly interventions such as jail, emergency rooms and hospitals.

1. Program/Service Description

◊ *A. Problem or Need Addressed by the Strategy*

Undiagnosed and untreated depression and drug and alcohol abuse are contributing factors to high suicide rates for older men and women. A recent report of the Surgeon General cites depression symptom prevalence estimates of 17% to 35% in older adult primary care patients.

◊ *B. Reason for Inclusion of the Strategy*

In 2007, King County Health Centers served an estimated 20,000 low income adults over 55 years of age. In recent studies among those 55 years and older who have completed suicide, 77% had contact with a primary care provider within a year of their suicide and 58% had contact with the primary care provider within a month of their suicide. These studies suggest that identifying and treating high risk older adults in health centers is an effective strategy.

◊ *C. Service Components/Design*

Mental health/chemical dependency staff will be integrated into the staffing of primary care teams in the safety net clinics. (Safety net clinics include community health centers, public health centers, and Harborview primary care clinics. These clinics work closely with community centers and senior centers in many suburban communities, and a number of clinics are piloting new outreach and integrated service strategies to serve older adults under a state grant to King County Care Partners through Senior Services.)

Mental health/chemical dependency staff will screen older adults for depression and/or drug or alcohol abuse. Brief interventions and treatment will be initiated in primary care. Adults with more severe or complex needs that cannot be adequately treated in primary care will be referred to mental health and chemical dependency treatment agencies already under contract with Mental Health, Chemical Abuse and Dependency Services Division.

Mental health and chemical dependency providers integrated in primary care will also be responsible for coordinating referrals to MHCADSD contracting agencies,

facilitating communication between primary care teams and mental health/chemical dependency treatment providers, and assuring that treatment plans are coordinated.

◊ *D. Target Population*

Adults age 55 years and older seen in primary care clinics who are low income and/or otherwise have no medical health insurance.

◊ *E. Program Goal*

Provide screening and treatment for depression and for prescription or illegal drug or alcohol abuse in older adults who are seen in primary care clinics.

◊ *F. Outputs/Outcomes*

A reduction of the number of people with mental illness and chemical dependency using costly interventions such as jail, emergency rooms and hospitals. Screening and appropriate interventions will occur for 2,500 to 4,000 individuals annually.

Expected outcomes include reductions in suicides, alcohol and drug abuse among older low income adults in King County. Additionally reductions are expected in health care costs because older adult patients with depression visit doctors and emergency rooms more often, use more medications, and incur higher inpatient charges than those who are not depressed.

2. Funding Resources Needed and Spending Plan

The mental health and substance abuse service enhancement for safety net primary care clinics will have an annual cost of $500,000.

Dates	Activity	Funding
Sept – Dec 2008	Start-up (staff hiring and training)	$150,000
	Total Funds 2008	**$150,000**
Jan – Mar 2009	Continued start-up	$250,000
Jan – Dec 2009	Phasing in ongoing services	$250,000
	Total Funds 2009	**$500,000**
2010 and onward	Ongoing safety net clinic Services with enhanced mental health and substance abuse services	$500,000
Ongoing Annual	**Total Funds**	**$500,000**

3. Provider Resources Needed (number and specialty/type)

◊ *A. Number Type of Providers*

Mental health providers in safety net clinics include psychologists, MSWs, and RNs or ARNPs with specialized psychiatric training. Many clinics would like to include chemical dependency providers on their primary care team, but the shortage in trained chemical dependency providers has generally not made that feasible.

The equivalent of 10.0 FTE mental health providers will be added to clinic staff. Resources will be spread among 15 or more clinics so as to include those clinics that serve significant populations of older low income adults.

◊ *B. Staff Resource Develop Plan and Timeline (e.g. training needs, etc.)*

Dates:	Activity:
Sept 15 – Nov 30, 2008	• Treatment providers hire staff
Sept 15, 2008 – Mar 30, 2009	• Start up activities
Oct 1, 2008	• Training for primary care related to ongoing services
Nov 1, 2008	• Services start in those clinics where capacity is developed and ready
June 1, 2009	• Fully operating programs

◊ *C. Partnership/Linkages*

The clinics will need to develop and maintain referral relationships with mental health and drug and alcohol treatment providers to assure appropriate treatment for those individuals whose treatment needs cannot be managed in primary care.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

As this is an addition to existing programs the planning is substantially complete; refinements to the plan will be completed by July 2008.

◊ *B. Procurement of Providers*

The providers are currently under contract with the County.

◊ *C. Contracting of Services*

Contracts amendments will be in place by August 30, 2008.

◊ *D. Services Start date(s)*

Services will begin no later than November 1, 2008.