

# Contra Costa County MHSA Planning

## Stakeholder Planning Group

### *Older Adults*

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#### Minutes

May 30, 2007

**Present:** Debbie Card, Barbara Whittingham, Ken Salonen, Carlos Torres, Larry Vaughan, Ace Hollister, Suzanne Davis, Suzanne Tavano, Kimberly Mayer, Elvira Sarlis, Nancy Frank, Steve Ekstrom

**Guest:** Jean Weber

#### ***Proposal from subcommittee***

A subcommittee (Barbara Whittingham, Ken Salonen, Carlos Torres, Suzanne Tavano) attended an Older Adult conference the previous week in San Diego. Based on what they learned they proposed that Contra Costa County develop the IMPACT model, developed at the University of Washington and used in several public and private settings. San Diego and Los Angeles counties are using MHSA funds to implement IMPACT. IMPACT is an evidence-based approach (stands for Improving Mood/Promoting Access to Collaborative Treatment) that relies on a partnership between mental and physical health. Services are located in health clinics. Mental health staff do cognitive and behavioral interventions, and physical health staff screen for and treat diabetes and cardiovascular problems. In the proposed model, we would need space in each of the three regional, county-operated health clinics but would not need additional physical health staff. Other features of the IMPACT proposal include:

- This would be a “systems development” program (as opposed to a full service partnership).
- MHSA-funded staffing would include:
  - A mental health clinician, trained to the IMPACT model
  - A consulting psychiatrist
  - Non-licensed staff (some would be peers) who are mobile and can provide follow-up support, make telephone contacts, check on diet, set up socializing opportunities, etc.).
- Patients are referred by physicians to MH staff for depression screening. Physicians screen for and treat diabetes and cardiovascular problems.
- Interventions are time-limited and goal-driven, based on each persons unique needs. The overall approach is similar to WRAP.
- Self-rating surveys are conducted after each contact to track progress.
- Vehicles will be required.

- Training in IMPACT will be necessary.
- One room would be needed in each regional clinic, equipped with necessary equipment (phones, computer, etc.).
- Philosophy: diagnosis is not destiny; medications aren't the primary resource or intervention; hope and resiliency are emphasized.
- The approach can reduce stigma due to treatment being provided in health clinics (vs. MH clinics).
- There would be referral capacity to other non-MH older adult services in the county.
- Long-term therapy: we'll need to do some research to see if this is a feature of IMPACT.
- IMPACT is an adaptable model that can be adjusted according to each community's needs.

For more information, see <http://impact-uw.org/>.

Subcommittee members felt that IMPACT is a good opportunity to “get a foothold.” Over time, more older adult services could be added if funding becomes available. They also noted that in other communities IMPACT has actually helped save money by reducing emergency room visits.

Discussion followed:

- Question: will Hospital & Health Center Division be interested in this? Response: initial discussions have been positive and there's reason to be hopeful.
- Comment: we might want to involve other collaborators.
- Comment: we might want to integrate this into the upcoming MHSA Workforce Education & Training component so we can train specialists in older adult services.
- Question: what about crisis stabilization? Response: IMPACT is a prevention model, not an acute service. Anyone needing crisis services would use existing resources in the county.

Following discussion the group unanimously voted to recommend the following to the MH Division:

1. Revise the original Older Adult proposal to DMH to allow us to implement the IMPACT model (with the features cited above).
2. Research the IMPACT model to make sure the feature we want to add won't negate fidelity to the model.
3. Advocate for this as appropriate.
4. If DMH approves the proposal, form a multi-agency workgroup to look at how can best collaborate.

### **Plan B**

In the event that we can't implement the IMPACT model with Hospital and Health Center support, the group felt we should consider:

- IMPACT in partnership with other FQHC community clinics.
- A version of the original proposal (mobile team, gero-psychiatrist) that does community outreach, and identifies and screens patients brought to the team's attention. MH needs

could be addressed by the team and an associated MH clinic. Health needs could be addressed by county clinics as long as the person had Medicare, Medicare/MediCal or was BHC-eligible and could qualify for services through Contra Costa Health Plan. People with dementia or Alzheimer's could receive some services from MSSP, APS, Supportive Services, Linkages, and Adult Day Care.

### ***Next steps***

- We hope to get a response from the Hospital & Health Center Division in about a week.
- If the response is positive, we'll notify members of the Older Adult Stakeholder Group, and will proceed with developing a proposal. Before we send the proposal to DMH, we'll ask this Stakeholder group to review it. Courtesy copies will also be sent to the Stakeholder Advisory Committee.
- If the response is negative, we'll notify members of the Older Adult Stakeholder Group and will call a meeting to discuss advocacy strategies.

### ***Next meeting***

- No additional meetings are anticipated at this time.