Primary Care, Mental Health, and Substance Use Integration

A Webinar Series Sponsored by:

California Institute of Mental Health, Alcohol and Drug Policy Institute and, Integrated Behavioral Health Project

Bridging Differences in the "Cultures of PC/MH/SU

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Faculty:

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San Mateo Behavioral Health and Recovery Services Panel

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Linford Gayle, **Director Office of Consumer & Family Affairs**

Cynthia Chatterjee, MD, **Psychiatrist, Primary Care Interface Team**

Stephen Kaplan, LCSW, **Director of AOD Services**

Gale Bataille, MSW, Moderator and Integation Consultant to CiMH

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Cultural Challenges to Integrating Care

- **National policies, systems-level financial and regulatory barriers have led to "silo's" of care**
- **Physical and behavioral health clinicians have different practice and diagnostic styles that have led to very different work "cultures"**
  - Different work and productivity patterns.
  - Different training, professional orientations, philosophies and perceptions of behavioral health conditions.

Primary Care Behavioral Health Compared to Mental Health/Substance Use Treatment

Primary Care Behavioral Health	Mental Health/Substance Use
Population-based; mental health seen as just one component of overall health care	**Client-based; specific requirements for service acceptance; focus on mental health care or substance use treatment**
Treatment usually for person with mild to moderate impairments, those coping with situational stress and stabilized persons with serious mental illness	**Treatment typically restricted to persons experiencing or at risk of serious mental illness or those experiencing psychiatric emergency or crisis; substance use services often narrow and restricted typically due to funding**
Treatment usually limited ; one to three visits; typically shorter in duration, 15 to 30 minutes (though could be longer depending on co-morbidity)	**Often long-term treatment; number variable, related to client condition; visits may be longer in duration; include psycho-social and rehab options beyond individual visits**

Primary Care Behavioral Health Compared to Mental Health or Substance Use Treatment

Primary Care Behavioral Health	Mental Health/Substance Use
Informal counseling session, vulnerable to frequent interruption; visits often timed around medical provider visits; therapeutic relationship generally not primary focus	More formal session, private interchange; mental health or substance use is reason for visit; establishment of therapist-client relationship important; substance use group sessions
Treatment often encompasses behavioral aspects of healthcare, like pain management, smoking cessation, etc.	Treatment emphasis is on mental health or substance use interventions or rehabilitation services
Care management is often minimal, due to lack of reimbursement	Care management emphasis is often on psychosocial aspects of care
Behavioral counselor part of a healthcare team; intervention supports medical provider decision making	Counselor relationship often nonaligned with a team; intervention generally not tied to medical healthcare

Primary Care Behavioral Health Compared to Mental Health or Substance Use Treatment

Primary Care Behavioral Health	Mental Health or Substance Use
Documentation tends toward brief, immediate, problem focused records and often integrated with the medical treatment chart	Documentation generally more extensive in response to public funding requirements and greater range of services; records stand-alone; substance use confidentiality standards
Stigma often minimal due to normalization of setting	Stigma usually high
Primary care physicians may lack knowledge of behavioral health care which may lead to under-diagnosing and/or reluctance to identify and treat or may be dismissive of complaint due to perceptions about mental health or substance use	Specialty providers may over-diagnose; difficult to find mental health professionals "traditionally" trained willing to work in primary care model

Opportunities to Bridge the Culture Gaps

- **Integration efforts must occur at** multiple system levels**.**
- Aligned financial incentives **can jump-start activity and provide needed focus to program partners.**
  - **Rewarding quality care (i.e., pay-for-performance)**
  - **Mechanisms for sharing savings from reductions in avoidable emergency and inpatient utilization across delivery systems**
- Buy in from administration/management **–need to understand and promote the value of integrated behavioral health (relatively low cost strategy to improve care quality, productivity, and client/provider satisfaction)**

Opportunities to Bridge the Culture Gap

- Provider engagement **is critical to achieving buy-in and sustainability.**
  - Shared philosophy of care for patient/collaborative team approach and belief in the model
  - How to adapt to PC setting; flexibility in dealing with the physical acuity of the population, as well as the environment where interruptions are the norm
  - Offering practitioner toolkits and learning collaboratives to customize and implement best practices for their delivery point and

Opportunities to Bridge the Culture Gap

- Consumer engagement **is key and efforts should leverage peer support specialists for outreach, enrollment and obtaining consent.**
  - **Selling point preventing adverse drug interactions.**
  - **Shared development of care plans, maintaining provider relationships and engagement of program design**

- Team-based approach **allows access to necessary range of clinical skills, expertise and may be most resource efficient.**
  - **Clear designation of physical and behavioral health home**
  - **Care coordination support for beneficiaries and providers (care homes)**
  - **Access to psychiatric consultation for PCP medical provider**

Opportunities to Bridge the Culture Gap

- Information exchange **need not be high-tech, but must be actionable and shared, high priority.**
  - Importance of routine communication, consultation and coordination
  - Structures to support information sharing through medical records
  - Sharing of educational materials and strategies and ongoing trainings (beyond the person providing therapy or behavioral intervention)
  - IT infrastructure that tracks behavioral health data and clinical outcomes/use of registries

Opportunities to Bridge the Culture Gap

- Increasing recognition of mental illness and substance dependence/addiction as chronic condition**s has the potential to further "de-stigmatize", provide new shared methodologies for integrating care and standardizing treatment approaches.**
  - Adaptation of the chronic care model
  - Movement towards "person centered" treatment
  - Integrated person-centered model shares many of the underlying principles of a "recovery" model

Bridging Cultures at Integration Points
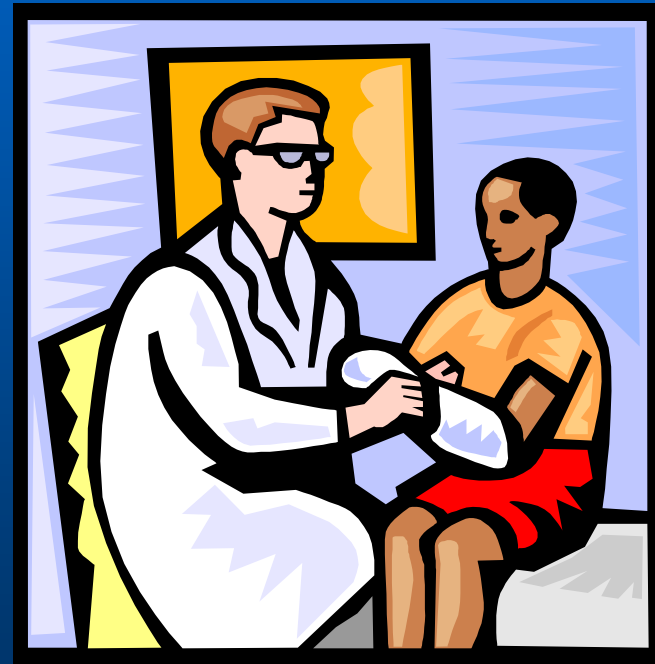
County of San Mateo Behavioral Health
and Recovery Services

Moderator/Introducing San Mateo Panel Bridging Cultures: A Consumer Perspective

- San Mateo will provide a brief overview of their approach to integrated services and then share their perspectives as service providers at different points of integration, but first…

- Linford Gayle, as a consumer with both medical and mental health issues, what has your experience been like navigating primary care and having to deal with the different cultures between PC, MH and SU services?

- As a consumer leader in CA, you speak from your own direct experience but are also aware of the perspectives of many others. What has helped or hindered people with mental health and substance use problems in getting access to care and treatment in primary care settings?

- Why it is important to "bridge" cultural differences as we work to integrate care?

Consumer Perspective

Linford Gayle-Director of Consumer and Family Affairs

- **As a consumer I have lived with mental illness, a chronic medical illness and a history of substance use**

- **I received treatment for these conditions in mental health and primary care settings**

Consumer Perspective
Linford Gayle-Director of Consumer and Family Affairs

- **Primary care at times has looked at consumers with mental illness as not really experiencing the medical illness that they have come to the clinic for, making the consumer feel that they think that they are delusional.**

- **AOD clients, if they are experiencing pain have at times been made to feel that they are medication seeking and not really feeling pain.**

Consumer Perspective--Why is Integration So Important?
Linford Gayle-Director of Consumer and Family Affairs

- **Many consumers (particularly of color) attribute their MH symptoms to physical illness & go to Health Clinic or Emergency Room**
  - May be referred to MH from PC, but many never go to MH Services due to stigma
- **Stigma reduction through integrated care**
- **PC has historically been more open to input from consumers, family and other caring individuals**
- **Linkage/coordination of care is critical when dealing with chronic illness(s)**

Consumer Perspective--Perspective--Why is Integration with PC Important?

Linford Gayle-Director of Consumer and Family Affairs

- **PC is less restrictive for people trying to access treatment/services;**
- **PC allows more flexibility--you may have greater say in who you select for your primary and specialty provider**
- **As a hindrance, in my personal experience there was not an African American therapist available in my insurance network**

Moderator/Question?

San Mateo has over 12 years experience in providing integrated PC/MH/SU services facing challenges & opportunities including:

- **Reaching a shared philosophy/shared integration goals**
- **How to adapt MH/SU to PC environment (including pace)**
- **Team based approaches**
- **Opportunities for consumer engagement**
- **Information sharing**

Cheryl Walker, as Unit Chief for San Mateo's Primary Care Interface Team, how has your organization worked to integrate care?

Benefits of Integration

Cheryl Walker, MFT, Unit Chief, Primary Care Interface Team

Integration points strive to provide seamless continuity of care for medical, mental health, substance abuse treatment. Integration points are where we experience work related challenges and have opportunities to build effective collaboration.

Interface Team Integration Points

The Interface Team is embedded in seven primary care clinics. We have five full time bi-lingual bi-cultural Spanish speaking therapists, one bi-lingual Chinese therapist, and two part time bi-cultural psychiatrists-one is Spanish speaking.

Two full time bi-cultural therapists-one is African American the other speaks Spanish, are placed in the County's Human Services Agency. They are embedded part time in four work centers.

Additional Behavioral Health Integration Points

Two nurse practitioners are embedded in three specialty behavioral health clinics and provide primary care to S.M.I. consumers.

Behavioral Health Resource Team: Provide case management to assist homeless mentally ill consumers obtain housing, primary care and behavioral health treatment for mental illness and addiction.

Primary Care Interface Criteria for Mental Health Treatment

Mental or emotional illness negatively impacting medical care

Crisis intervention/5150

Serious mental illness /linkage to ACCESS team

Primary Care Interface Services

- Assess, consult, treat, link, collaborate
- Brief Solution Focus treatment
- Identify SMI and link to the correct BHRS specialty team.
- Link consumers to alcohol and drug treatment and collaborate with those partners.
- Facilitate communication between primary care and mental health

Key Differences: Primary Care Behavioral Health

- **Work Culture**
  - **Focus of Treatment**
  - **Volume**
  - **Pace**

Common Ground

Passion for wellness

The desire to help

Bridging Cultures to Facilitate Collaboration

"Culture is the integrated pattern of human knowledge, belief and behavior". **Webster's Dictionary**

Work culture of an organization is born out of the organization's strategic intent and values. **BluEnt**

It seems reasonable that changing the work pattern of employees from referral to specialists, to effective collaboration requires a structural change in belief and behavior.

Bridging Work Culture

- The first step is recognizing that work cultures exists and resists change that is not meaningful to the cultures.

- The next step is to look for naturally occurring integration points and recognize these can become points of effective collaboration.

- The last step is to acknowledge and grow the collaboration mindfully.

Bridge Building Tools

Collaborative team able to engage and work with other staff

Identify tools common to both work cultures

Low Tech-Mid Tech-High Tech

Moderator Question?

Dr. Cynthia Chatterjee, you are a psychiatrist who has worked in both Primary Care and Mental Health clinic settings.

- Please discuss your role as a Primary Care Interface Team psychiatrist working in primary care clinics ?
- Would you share some vignettes of your work with clients?

Psychiatrist Role Cynthia Chatterjee M.D

- **Assessment**
  - More in depth than time allowed in PC.
  - Additional co- morbidity often diagnosed

- **Consultation/Brief Treatment**
  - One time or brief treatment and return to provider or transfer to specialty mental health

- **Training, support and education for primary care doctors**

Referrals from the Interface Team
To Higher Level of Care

- **The Interface Team screens about 1500 referrals annually and treats 1000**

- **Transfers to a higher level of care are less than 5% and are handed off to the appropriate outpatient adult or youth unit chief by the Interface unit chief. This prevents transition errors.**

One-Time Consultation Case Vignette

- **48-yo woman of Mexican origin with a history of depressive episodes since her 30's, currently depressed for 1 1/2 years. PCP referred her to Interface 6 months ago and therapist began treatment. Patient had no history of antidepressant use. Five months ago therapist suggested to PCP that an antidepressant might be needed, and PCP started Celexa 20 mg. She initially responded, then worsened again. PCP then increased Celexa to 30 mg, but she did not respond. Interface psychiatrist assessed patient and recommended that Celexa be increased to 60 mg daily, and that if this dose ineffective to then switch to SNRI.**

Short-Term Treatment and Referral to Mental Health Clinic Case Vignette

31 yo AA male college student referred to Interface to assess depression and anxiety. Was treated with Lexapro up to 30 mg by PCP but not improved. Interface psychiatrist assessed pt. Pt had mixed manic symptoms, paranoia, OCD, and PTSD (lost 5 friends to violence), and cannabis abuse. Labs revealed hyperthyroidism and pt subsequently diagnosed with Graves disease. Psychiatrist stabilized him on antipsychotics and Depakote. Therapist supported with therapy. Endocrinologist treated thyroid condition. Patient referred for substance abuse counseling. Still unclear how much of patient's symptoms due to thyroid disorder and cannabis abuse, but patient will likely be referred to the mental health clinic for long-term treatment.

Short-Term Treatment and Returned to Primary Care Case Vignette

33 yo woman of Philippine background referred for depression, anxiety, and irritability. She had been started by primary care on Lexapro 10 mg. Assessment revealed 17 year history of methamphetamine, marijuana, and alcohol. Patient had recently entered outpatient substance abuse program and was clean and sober only 3 months. She was also drinking excessive amounts of coffee and had poor sleep hygiene. Patient was started on Campral for alcohol cravings, advised to decrease caffeine, and advised about sleep hygiene. She responded very well and after 3 months returned to primary care for medication management.

Training, Support, and Education for Primary Care Providers

Example:

Case presentation of a patient referred to Interface, with discussion of relevant journal articles to clinic's primary care providers

Example:

Case conference that included patient, patient's primary care provider, therapist, substance abuse counselor, and psychiatrist, to provide a unified treatment plan

Moderator/Question
Substance Use Services in Primary Care- Integration and Cultural Bridging

Stephen Kaplan, as AOD Director for Behavioral Health and Recovery Services, what are some of the challenges/barriers to integrating substance use screening and intervention into primary care clinics?

- What are some approaches that you are using to break down silos that are barriers to integration?

Alcohol and Other Drugs
Stephen Kaplan-Director

- **PIER – SMC's version of SBIRT**

- **Key "Cultural" Aspects**

- **Steps Taken**

Provider Viewpoint

- **MD**
- **SBIRT**

San Mateo: Future Steps

Integrative approach to clients with chronic pain

Medical Home Web Page

Expanding SBIRT to all primary care sites

Embedding AOD Specialist into Interface

System Integration/Preparation for Health Care Reform

Q&A

Contact and Resource Information:

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