Here and Now: Reducing Barriers to Behavioral Health Integration

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National Hispanic and Latino ATTC symposium

September 16, 2016

- *"Latinos seek mental health care services more frequently from primary care than any other resource, including specialty mental health care."*

Bridges et al., 2014

Objectives

- Review levels of Behavioral Health Integration and discuss strategies to help your clinic achieve the highest level of integration.
- Review SBIRT (Screening, Brief Intervention, and Referral for Treatment) processes and the application of this model in community clinics.
- Address common pitfalls and barriers associated with the delivery of integrated behavioral healthcare to u
  populations, along with solutions and creative ad
- Address aspects of integrated care specific to the
  Latino population.

***Clinical lessons, not administrative

My Background

- ICU and emergency room nurse
- University of Utah
- Utah State Prison
- Fourth Street Clinic
- Polizzi Clinic
- Juvenile Justice
- University of Utah: Clinical Instructor
- Utah Behavioral Health Planning and Advisory Council: Executive Committee
- Utah behavioral Health Community Network: Co-Chair
- Utah APNA Council of Psychiatric APRNs: former chair
- A pretty decent boys' soccer coach, fair to poor handyman, terrible mechanic

FOURTH STREET CLINIC

HOMELESSNESS HURTS. HEALTH CARE HELPS.

- Fourth Street Clinic was **founded in 1988** as a triage clinic staffed with one part-time nurse who relied heavily on hospitals for patient treatments. Today, with a **staff of 50 and a volunteer network of more than 150**, Fourth Street Clinic is an AAAHC Patient Centered Medical Home that serves 4,700 homeless men, women and children with 30,000 medical, mental health, substance abuse, dental, and case management visits. The ALSAM Foundation Pharmacy at Fourth Street Clinic dispenses 59,000 medications annually. By increasing homeless Utahns' access to primary care, Fourth Street Clinic is a major partner in ending homelessness, promoting community health, and achieving across-the-board health care savings.

http://www.fourthstreetclinic.org/about-us/our-mission-history

FOURTH STREET CLINIC

HOMELESSNESS HURTS. HEALTH CARE HELPS.

- 17% Hispanic and Latino
- 50%-80% with Behavioral Health Disorders

Medical

Pharmacy

Dental

Outreach

Family Practice

Behavioral Health

Other services

FOURTH STREET CLINIC
HOMELESSNESS HURTS. HEALTH CARE HELPS.

- Specialty medical care
- Case Management
- Assistance with disability benefits
- Assistance with housing applications
- Placement into skilled nursing facilities
- Referrals to residential substance abuse treatment centers

A “low-barrier clinic”

- Homeless live o
- Nothing is easy
- Some maladapti
  reinforced
- Always another
- Organizational s
  - Adverse chil
  - Head injurie
  - Substance ab

- "SAMHSA defines integrated care as the systematic coordination of general and behavioral healthcare. Integrating mental health, substance use disorders, and healthcare services [that] produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs"

SAMHSA

ATTC Issue Brief: ADVANCING THE INTEGRATION OF SUBSTANCE USE DISORDER SERVICES AND HEALTH CARE, OCTOBER 2014

Integration is a priority

Integration

- Helping primary care meet the BH needs of their patients.
  - 52% of patient requests for mental health treatment occur in primary care setting
  - Up to 60% of primary care patients have a psychiatric disorder.
- Why do patients see a PCP for mental health problems?
  - Stigma
  - Cost
  - Convenience
  - accessibility

Pincus HA, Tanielian TL, Marcus SC, et al. Prescribing trends in psychotropic medications: primary care, psychiatry, and other medical specialties. JAMA. 1998;279(7):526-531
WHO & Wonca. 2008. Integrating mental health into primary care: a global perspective. <http://www.who.int/mental_health/policy/Integratingmhintoprimarycare2008_lastversion.pdf

- Helping BH patients receive primary care.
  - For recurrent depression, the average reduction in life expectancy was 7-11 years
  - For bipolar dis
  - For schizophre
  - For drug and a
  - For heavy smo
    expectancy is

Risk of all-cause and suicide mortality in mental disorders: a meta-review; Edward Chesney et al.; World Psychiatry June 2014: Vol 13, No 2, pp 153-160.

Substance Use disorders

- 25-40 million Americans are in recovery from addiction
- Traditionally, SUD services were provided in specialized service settings, funded by public, non-Medicaid sources.
- The ACA act will alter this system, as more individuals will access BH services though mainstream settings.
- “Medicalization of SUD treatment”
  - Outpatient, physician-directed, pharmacologic, consolidation of providers

ATTC Issue Brief: ADVANCING THE INTEGRATION OF SUBSTANCE USE DISORDER SERVICES AND HEALTH CARE, OCTOBER 2014

- “*The medical community needs to come up with more effective models of treatment delivery that are more practical and accessible for the majority of those in need*”

NAMI

- http://www2.nami.org/Template.cfm?Section=Top_Story&template=/contentmanagement/contentdisplay.cfm&ContentID=158934

Bridges et al., 2014

Reasons for disparities

- Concerns about cost of services
- Lack of insurance
- Lack of Spanish-speaking providers
- Fears of deportation
- Lack of transportation
- Cultural responsiveness of interventions

Bridges et al., 2014

In-House or Refer out?

- Integrated care= 81% of patients made contact with behavioral health provider
  - 71% of these on the same day

Auxier, A., Runyan, C., Mullin, D., Mendenhall, T., Young, J., & Kessler, R. (2012)

- Our previous rate of completed referrals to local community mental health providers is estimated at 10%-25% (Fourth Street Clinic)

Access

- Over half of primary care providers report problems arranging outpatient mental health referrals.
- Demand/supply
- Communication
- Location
- Case Management

Trude, S., & Stoddard, J. J. (2003). Referral gridlock: primary care physicians and mental health services J Gen Intern Med (Vol. 18, pp. 442-449). United States.

What does a well-integrated program look like?

Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013

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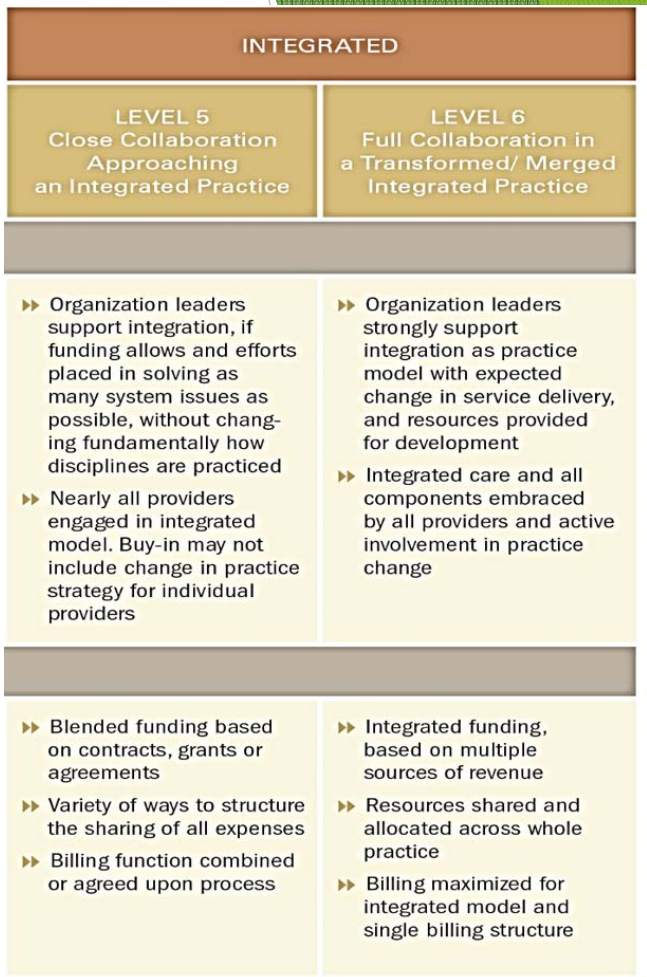


Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington D.C. D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013

Who needs behavioral health services?

Identifying those in need: Screening

1. Choosing the appropriate instrument[s]
    1. AUDIT, DAST, CAGE, PHQ-9 (PHQ-2), GAD-7, PC-PTSD, MDQ
    2. Formal vs informal. (Informal probably not as effective as we think)
2. Choosing the method of administration
    1. Paper, electronic, self-administered vs interview
3. Choosing the target population
    1. All patients? Only those with risk factors? Screening Interval?
4. Choosing the location for the screening
    1. Exam room? Waiting room? At home before the visit?
5. Choosing the staff member responsible for ensuring the completion of screening
    1. How will they know whether a patient has already been screened?
6. Choosing how the results of the screening will be documented and retained.

Integrating Screening into Primary Care

- How to introduce the topic
  - How it may help the patient
  - How it may help the clinic
  - No obligation
  - Confidentiality
  - Optional *but preferred*
- Considerations for the Latino population
  - Family involvement
  - Respect for limited time
  - Instruments translated into Spanish
  - Privacy while completing or discussing the screening instruments.

SBIRT

- Screening
  - AUDIT, DAST, CAGE, PHQ-9, GAD-7, PC-PTSD, MDQ
- Brief Intervention
  - MI, ACT, SFT
- Referral for Treatment
  - In house
  - External

Brief Interventions

- BH staff or Primary Care
- Can bridge gap to more in-depth BH evaluation or be a self-standing intervention
- Basically education and "change talk"
- 5-15 minutes

http://www.integration.samhsa.gov/clinical-practice/sbirt/SBIRT_Colorado_WhySBIRT.pdf

Brief Therapy

- Centered around client goals
- Typically 4-6 sessions
- motivational discussion
- client empowerment
- assessment
- education
- problem-solving
- coping mechanisms
- building a supportive social environment

http://www.integration.samhsa.gov/clinical-practice/sbirt/SBIRT_Colorado_WhySBIRT.pdf

Motivational Interviewing

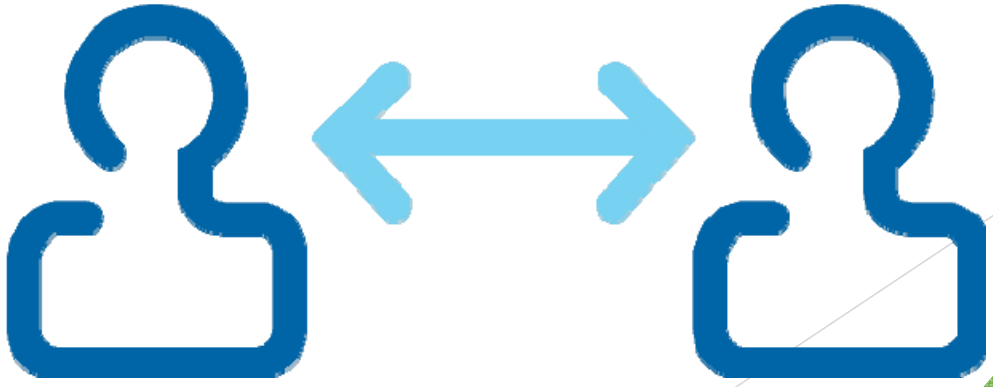
- **Express empathy.** Accepting people as they are frees them to change. Acceptance of the individual is the not same as agreement with or approval of his or her behavior.
- • **Develop discrepancy.** When a behavior is seen as conflicting with important personal goals, change is more likely to occur.
- • **Roll with resistance.** Arguing is counter-productive; reluctance and ambivalence are natural and understandable.
- • **Support self-efficacy**. A person's belief in the possibility of change can be an important motivator.

Motivational Interviewing

- **Open-ended questions.** Examples include, “How can I help you?” “What are the positive things and what are the negative things about your behavior? What do you want to do next?”
- • **Affirmations.** These should be genuine statements that recognize clients’ strengths and build confidence in their ability to change.
- • **Reflective listening.** Defined as “a particular, active form of listening in which the counselor serves as a kind of mirror, reflecting back and clarifying for the person the meaning that he or she is expressing.” 15 Reflective listening can involve rephrasing, paraphrasing, or discussing feelings.
- • **Summarizing.** Reflect back to clients their ambivalence and accentuate any statements they make that indicate a willingness to change.

A successful referral

- Successful connections at 4th Street clinic
- Different agency 2 weeks in the future: 10-25%
- Different agency next 48 hours: 25-50%
- Within agency 1 week: 30-50%
- Within agency later same day: 50-75%
- In-visit introduction to the BH provider increases likelihood of kept BH appointment by 2-3x.



Facilitating successful referrals

- Consider the role of a "connector"
  - Can be clinician, MA, case manager, peer specialist, or other staff member
  - Open availability throughout the day
  - Discusses *with patient the screening* and available clinic resources
  - Schedules appointment and communicates needs to the clinician

- "[Latino patients experienced] *better treatment outcomes and lower probability of premature treatment termination when they were ethnically and linguistically matched with their therapist*."

Bridges et al., 2014

Here

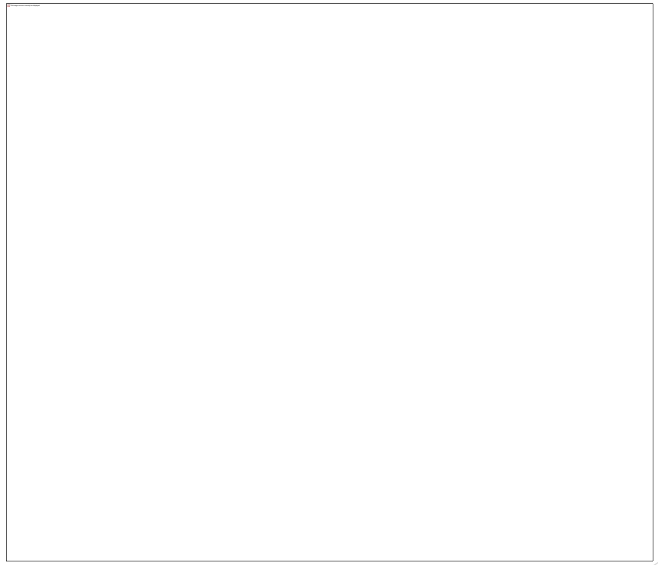
1. Shared exam room or neighboring therapy room
2. Same clinic
3. Nearby clinic
4. Satellite clinic
5. Outreach settings
6. Consider using connector (PSS) if referral to another site is necessary

Now

1. Collaborative session
2. Warm hand-off for immediate transition
3. Later in same day
4. If BH clinician not available, what can PCP do?
    1. Consultation
    2. Motivational Interviewing
    3. Telemedicine
5. Stalling tactics—worth the investment
6. Above all, be sensitive to the time path of the patient

Barriers to Integration

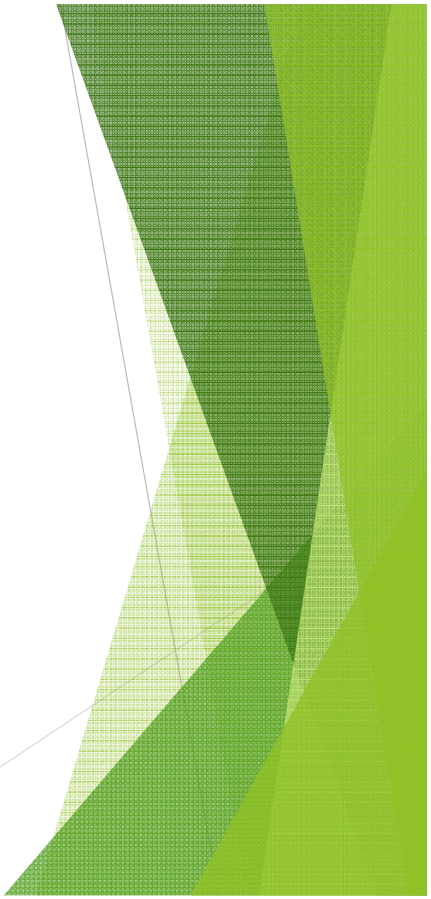
- Lack of coordination
  - Need for case managers
- Lack of available specialists
  - Consultant role
- Reimbursement
  - Grants vs billable
  - Separate payers
  - Pre-approval
  - Limits



Commonwealth Fund (2014): http://www.commonwealthfund.org/publications/newsletters/quality-matters/2014/august-september/in-focus

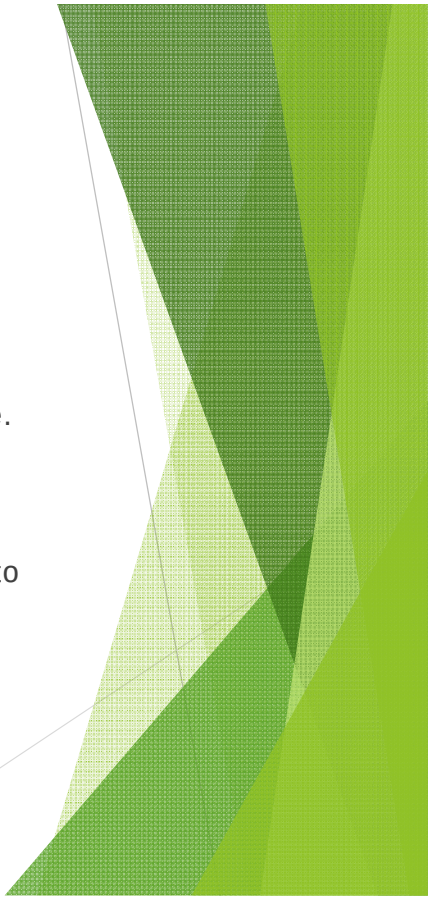
Barriers continued

- Privacy regulations
  - Use broad and inclusive ROI including 42CFR language
- Stigma
- Lack of cross-training between primary care and behavioral health clinicians
- Disagreement regarding most appropriate model
- Unrealistic expectations both ways.
- Resistance to change (inflexibility)
  - Scheduling, duration of encounters, sequence of events.



Barriers at Fourth Street Clinic

- Barriers to engagement:
  - Disaffiliation: from personal, community, social supports
    - Encourage engagement through outreach and warm hand-offs
  - Distrust and disenchantment: with service providers, systems, concern about confidentiality, fear that things could get even worse.
    - Deliver a result ASAP
  - Mobility
    - Clinic space close to target population. Bring outside services to the clinic (SUD assessments through FSH and ATR)
  - Hierarchy of needs
    - Skilled MI tying current struggles to BH disorders if appropriate



Zerger, 2002

Integration at 4th Street Clinic

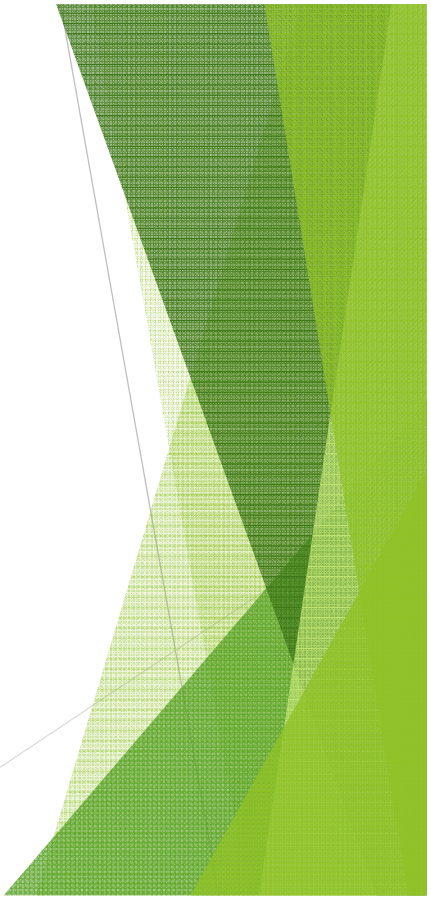
- Evolution:
  - Here is the address to Valley Mental Health, we will send over a referral
  - An appointment to see our Psych APRN in 3 weeks
  - Our psych APRN might be able to see you this week.
  - This is Sam, who practices mental health. He has experience with the kind of problems we were talking about and I think he can help you.

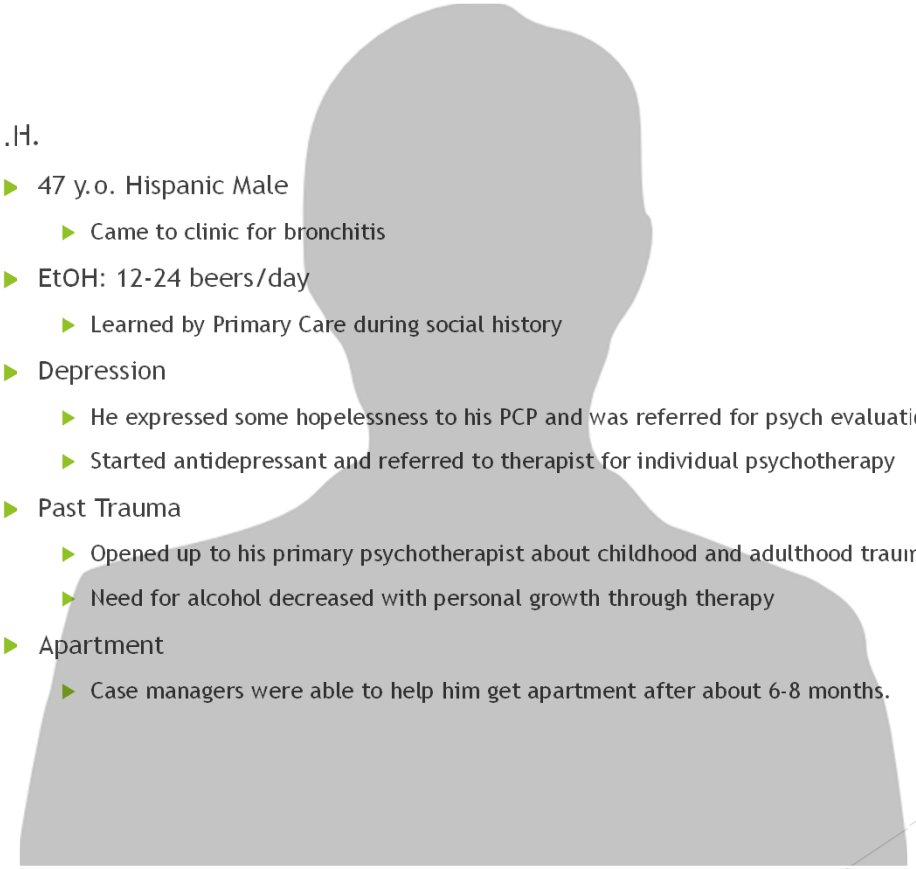
The extreme importance of flexibility.

- Setting the stage for acceptable interruptions
- Flexibility with duration of appointments for services
  - Divide a service into different parts
- Flexibility with who performs a service
  - Evaluation shared between different clinicians
- Flexibility with hours
  - Weekends and evenings to accommodate work
- The role of the BH specialist
  - Consultation is better than nothing!

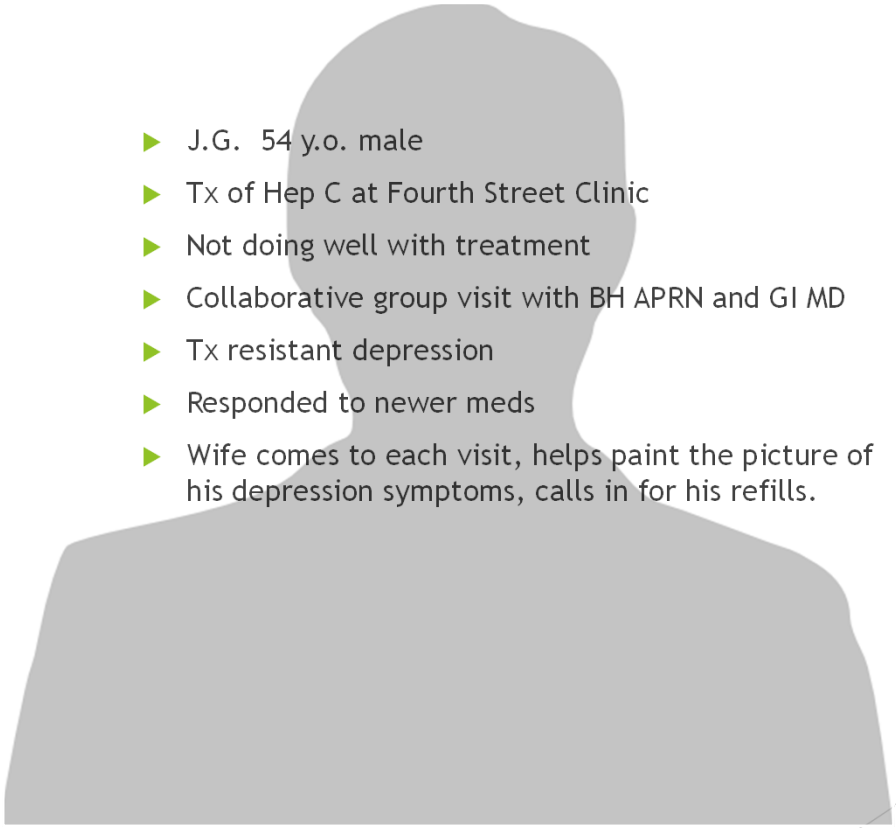
Medication Assisted Treatment

- Suboxone
  - In-House
  - Same-Day workup
  - Timing is everything in treatment of SUD
- Methadone
  - An important community partnership with Project Reality
  - Raised predictable issues
    - Allocation of resources from multiple agencies: Time, Staff
    - Reimbursement strategies
    - Communication
    - Respecting each others' culture and lessons learned

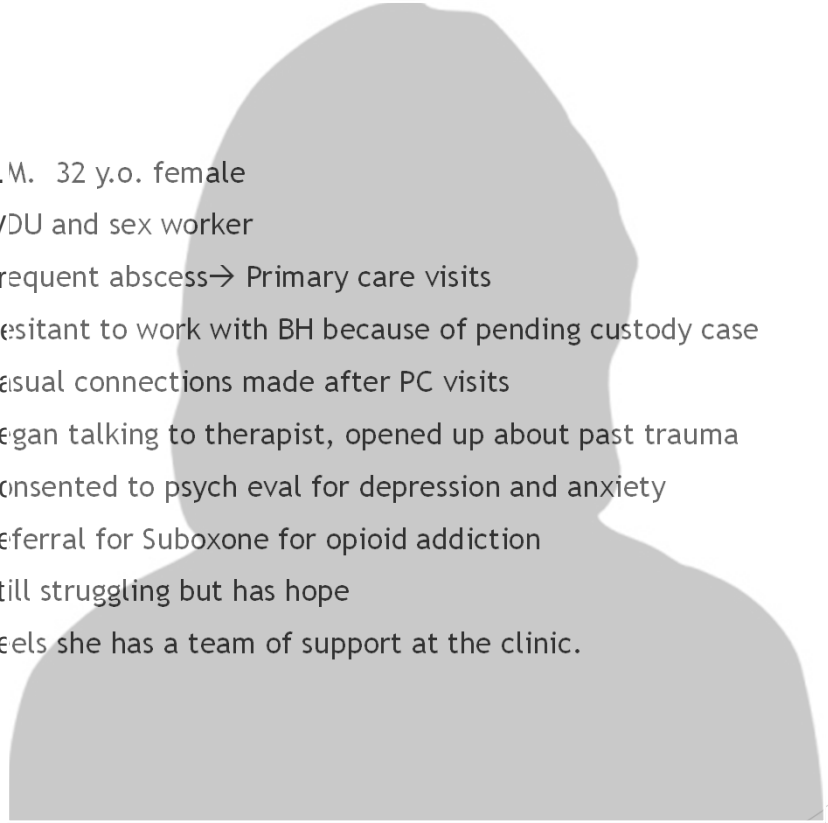




- J.H.
  - 47 y.o. Hispanic Male
    - Came to clinic for bronchitis
  - EtOH: 12-24 beers/day
    - Learned by Primary Care during social history
  - Depression
    - He expressed some hopelessness to his PCP and was referred for psych evaluation
    - Started antidepressant and referred to therapist for individual psychotherapy
  - Past Trauma
    - Opened up to his primary psychotherapist about childhood and adulthood trauma
    - Need for alcohol decreased with personal growth through therapy
  - Apartment
    - Case managers were able to help him get apartment after about 6-8 months.



- J.G. 54 y.o. male
- Tx of Hep C at Fourth Street Clinic
- Not doing well with treatment
- Collaborative group visit with BH APRN and GI MD
- Tx resistant depression
- Responded to newer meds
- Wife comes to each visit, helps paint the picture of his depression symptoms, calls in for his refills.



- L.M. 32 y.o. female
- IVDU and sex worker
- Frequent abscess→ Primary care visits
- Hesitant to work with BH because of pending custody case
- Casual connections made after PC visits
- Began talking to therapist, opened up about past trauma
- Consented to psych eval for depression and anxiety
- Referral for Suboxone for opioid addiction
- Still struggling but has hope
- Feels she has a team of support at the clinic.

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