

**Robert Lee Sutherland Seminar XV
Hogg Foundation for Mental Health**

**Integrated Health Care: What's In It For Me?
Summary Notes**

I. Garry Souffrant

- A. 1 of 4 Su Clinica patients were diabetic with cardiac complications
 - 1. 4 or 5 people seen per day were depressed
 - 2. Only 1.5 psychiatrists for whole city (Harlingen)
- B. First challenge to look at what you have in the clinic and what next to do
 - 1. Since started having team effort definitely see improvement with some of those patients
 - 2. By being able to educate doctors about mental healthcare, helped with improving populations
 - 3. Resources at the center instead of sending people out (referring) to get healthcare-danger of sending patient somewhere else, not able to coordinate the information

II. Lucius Ripley

- A. Unmet needs at Lone Star Circle because the community mental health center had limited capacity
 - 1. CEO said was going to hire psychiatrist even though didn't want to spend that much money
 - 2. Consult with primary care staff, work with 3 doctors day to day and provide consultations to referred patients and patients from the community because relative lack of psychiatric services in the area
 - 3. Originally more of a formal referral process and was co-located specialty provider
 - a. Over time go into exam rooms and see patient with primary care provider when patient comes in for a visit, do assessment, help expedite
 - 4. Reverse consultation-has issue, want to put on beta blocker for anxiety, not sure if going to fit with hypertension treatment, can talk to primary care provider (PCP) about that
 - 5. Mental health staff at clinic is himself and one mental health therapist
 - a. Major role is help PCP make more accurate diagnosis of anxiety disorders
- B. Fair amount of research showing that in PCP and psychiatric settings 25% with bipolar are inaccurately diagnosed, these patients don't do well on standard treatment like antidepressant
 - 1. Major role has been educating PCPs on this issue
 - 2. PCPs becoming adept at identifying bipolar and starting on treatment
 - a. Incorporated use of rating scales into treatment, everyone gets PHQ or questionnaire and do bipolar screening with MDQ (Mood Disorder Questionnaire)

b. Have made progress in collaborating but ways to go, so many barriers built into system, but substantial progress looking forward to full integration

III. Megan Zesati

A. Integrated behavioral health program 2 years ago

1. Moderate to severe levels of anxiety and depression in primary care setting,
2. Utilizing teamwork approach
3. Care manager and when necessary psychiatrist
4. Consult with psychiatrist 4 hours a week; currently have 3 care managers
5. Offers medical treatment for patients with anxiety and depression and/or counseling
6. Also utilize PHQ9 and the OASIS (depression and anxiety measures, respectively) how to gauge whether treatment is helpful or not

IV. Patricia Darden-been going there for 10 years, Dr. Peavey is my doctor. I was going through some health challenges and he saw that it was changing my emotions. He told me about Megan and that she was young and that I would like her and she had an old soul

-very comfortable with Megan in this setting

-Patricia says seeking mental health services in primary care makes it easier / more comfortable, doesn't want to be passed around like a bag of chips

-happy she was in the same place at the right time

V. Questions from Moderator/Audience

A. Referrals-typically primary care providers identify a mental health issue and at that point will connect them to Megan or other mental health provider

-sometimes the primary care provider will start someone on an antidepressant or some other medication

-usually at time care manager meets with someone, will determine if primarily phone contact or counseling sessions or both

-there's a lot of flexibility, not everyone is available to come in weekly, difficult to ask someone to come everytime, so phone contact has become important

-already having a hard time physically emotionally, asking them to take the next step where they don't know anybody, that's really difficult

B. What made your organization willing to change the way it practices to work in this different way and what was the hardest part of getting started?

1. Souffrant:

-early on, all under same roof but doing different things

-site visit from evaluation team early on helped

-now, everyone on same floor, discussing problem

-problem is having integrated team rather than having providers from different specialties doing parallel play

-not necessary to have psychiatrist on board, have one that consults only

2. Dr. Ripley:

-first challenge was getting reacquainted with view of PCP

- took a while to realize how different the culture in primary care is
- things that seemed obvious to him as psychiatrist didn't seem obvious to PCPs and vice versa
- mode of working is very different, PCP has hectic pace, psychiatrist have luxury of one patient at a time and lot more time to evaluate/interact
- amount of data hoped they would get from patient interview was not realistic for a primary care setting
- PCPs didn't have enough time to address mental health issues
- adjusting to their perspective was a challenge-another challenge was acceptance of psychiatrist
- myths/preconceptions (stigma) about psychiatrist
- typecasting / stigma re: psychiatric patient (likely to be unreasonable/irrational)

3. Zesati:

- how they started up was important, getting buy-in of PCPs
- terminology was new, treatment meant medication versus treatment plan and counseling
- shadowed providers for a day in their job and got to know them and to understand their worldview
- other thing they did was give us their top 5 hardest / most challenging patients with mental health issues, allowed her to get a sense what the challenges would be, what manageable caseload would be, what PCPs are dealing with
- really important for PCPs to feel like from the beginning that the program was important to them, instead of just something else to do
- providers feel responsibility for patients and not going to hand over unless it's someone that's going to work with them, collaborative approach
- provider buy in was a huge part of starting up

C. What have they gained?

1. Souffrant-impact in terms of total health care, from just the medical side, very important; #2, gained tremendous knowledge on what clinical care manager can bring to healthcare delivery
 - also, reduction in cost
2. Ripley-gains are numerous, but also changing patterns of doing care, needing to be more flexible,
3. Zesati-gain has been how they've been able to reach their patients-a lot of folks that would not be receiving integrated care otherwise
 - letting go of her ideas of what mental health treatment looked like, entering into medical system, meeting people where they need to be met
4. Darden says it's more comfortable to seek help in primary care

D. What do you wish you'd known then that you know now?

1. Souffrant:

- wish they'd had the concept of care; they were so focused on trying to do own things, thinking they could get different results with same way of doing things
- having a well-defined mission
- try to be innovative, may not have a grant but can achieve thing with a team approach to medical problem
- have to look at own environment and resources

E. Suggestions to the audience for how to start integrated care-

1. Darden: Need more people like Megan, that understand that people need a little bit, need to know which medicines are going to work with the others, need a place that's comfortable, that your doctor feels good about mental health treatment and knows the patient's environment
2. Ripley: planning process and try to get people to sit down at meetings
 - in healthcare provider world not enough meetings, lack of communication too often, lack of planning, changing of roles
 - all the complicated issues can start to be addressed, naively asked for 1 hour staff meeting each week
 - impossibility for that much time to be carved out of busy clinic schedule-differences in expectations in different organizations make it hard to have sufficient planning time
 - if we'd had more time to meet and discuss would've made faster progress, would've been shorter if there'd been more of a front-loaded process rather than stretched out over long period of time
3. Zesati: know who you're serving and then set expectations and parameters as part of front loading process

F. Question on Peer Support

1. Souffrant: need a staff to build what they do, only one person in team right now to do that (care manager) who is involved in clinical care

G. Do social workers make good care managers?

2. Zesati: congruent with values of social work, so yes, and that's what they do at People's Clinic
 - social workers advocate and link people with services, makes her job as social worker easier and helps things to flow easier