

Audience Notes
1st Annual
Primary Care and Behavioral Health Integration Summit
June 22, 2010
San Diego, CA

Problems, Barriers and Obstacles

- An expectation that we all have to be experts in all fields – feels overwhelming – worried about burn out and lack of self care.
- Lack of funds
- Lack of Personnel – leading to burn out
- Organizing the time to get better educated in a integrative model – needs to be a balance of strict structure of how this will be done and a fluidity in changing the model as we go.
- Expectation of Reciprocity BH and PC and ADD
- Need to establish familiar relationships BH/PC
- Difficulty by PCP's to take any MH clients
- Fear of Pt/\$ funding "overload" PC/BH
- All the time spent talking about problems
- PCP's having difficulty with our clients (stigma or clients being a disturbance to other patients) – NEED education in Medical School
- Overall stigma of mental health or clients of
- Difficulty getting a hold of PCP's – TIME is Limited
 - For collaboration
 - Or enough time with clients/patients
- Clients with no PCP
- Different "goals" between PCP and clinic and treatment methods/requirements
- When patient is stable on psychotropic medication and ready to move to primary care site – primary site PCP's want patient tapered off current med to generic.
- Insufficient funding
 - Payment differences
 - Funding streams are different and they don't integrate (even in vocabulary they don't integrate)
- Too much time in admin paperwork and not enough in patient care
- Communication
 - Confidentiality constraints
 - Access to M.H. providers (psychiatry)
 - Unfamiliarity with other systems/protocols/resources
 - Access to clinical data
- Case Management Resource
 - Time, staff
 - Focus of case plan
- Funding
 - Staffing deficits
 - Education in cross systems issues

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- Client – Centric Focus vs. Institutional Silo
 - System Requirements
 - Provider Education
 - Client Education and Support needs
- Advocacy Deficits
 - Comprehensive
 - Persistent need for education, training, and policy development.
 - Flexibility in staff time to collaborate.
 - Navigating through confidentiality and HIPAA. “Need to know.”
 - Work-flow operations between programs rarely mesh is not currently.
- Misinterpretation of HIPAA.
- Disconnect between physical health and mental health w/PCP’s.
- Lack of trainings among PCP’s.
- Lack of client/patient ownership
- Communications.
- Time Management
- Lack of ability to see parent for mental health issues.
- Too much paperwork – mandates
- Provider admin time
- Expertise
- Varying levels of comfort
- Lack of information sharing (how does HIPAA effect integration)
- Motivation to integrate
- Capacity of primary care
- Big Pharma dictating care
- BH Provider on site in PC
- Paperwork req’s
- Funding indigent and other related issues
- Zero PAP’s in PC
- Providers comfortable with own disciplines
- Decreasing safety net for MH consumers by decreasing MH consumers from MHS when stable.
- Communication between providers
- Increasing demand for services and unwillingness to fund
- Increasing service need and decreasing fund taxes and funding
- Lack of access to services
- Too many barriers
- Communication and PCP
- Medication Management and follow-up
- Medi-Care clients – access to PCP (transportation, homebound)
- Gaps between services
- Language barriers
- Too busy to plan and implement change
- Impact on funding (not able to bill)

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- Role confusion/productivity expectations
- Lack of training for new roles
- Dependent on client self-management
- Cultural differences – professional
- Funding – existing funding structure doesn't allow to have a medical and MH visit on the same day. (You can't have 2 physical health visits in a day)
- Behavioral Health Culture
 - Need right mix of right person since cultures are different.
- Disconnect not having the same collegial connection.
- Too much paperwork.
- Access to care
- Lack of coordination of services
- Lack of one on one case management
- Lack of culturally competent providers
- Lack of access to comprehensive services
- Training for Primary Care Providers
- Funding
- Fear and mistrust (providers)
- Time to coordinate and consult
- Lack of client education about importance of physical health
- Integration is under development and many parts are misunderstood/not understood by all stakeholders, and parts of the system of care.
- Funding – decrease in funding (limited MH sessions, PCP ending services, falling on therapist to manage having to justify treatment.
- What is the willingness of PCP to integrate?
- Funding source restrictions: many not lined-up for integration – billing collaboration/coordinate time.
- Will PCP do proactive engagement/outreach to clients?
- Client lacks a PCP
- Getting through PC gatekeeper
- Philosophical “cultures” of treatment, recovery and physical health.
- Rural and regional access for complex needs.
- Stigma of patients to follow-through on MH referrals
- Resources for unfunded clients
- PCP reluctance to make “social work” referrals
- Misunderstanding by professionals (underutilizations of peer/parent supports)
- Lack of time for PCP to effectively identify and/or follow-through on referrals.
- PCP limitations on who they will accept
- Lack of shared decision making.

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Solutions

- Less stringent CMS requirements
- Give patient generics
- Get rid of late policies
- Need flexibility with eligibility requirements and timelines
- Use more peer support specialists to get clients started and facilitate “warm hand offs”
- Get people on entitlements
- Collaborate among clinics (ex. CCC grant)
- Focus on how to change the culture (change agents), maybe a county-wide, centralized training series with on-going support
- Include ancillary staff, including nurses in behavioral health training
- Billing codes need to be amenable to integration
- Search for solutions among people who are already doing integration
- On-site linkage (psychiatrist within primary care clinic)
- Take existing BH staff and co-locate them in clinics
- Have more forums, broaden the audience/stakeholders
- Cross-training both formal and informal
- Use telepsychiatry on-site with primary care physicians and outside populations
- Better case management and care coordination will lead to better client outcomes
- Community-based outreach
- Become more patient-centric
- Regional resource fair
- Develop family support- especially for the adult mentally ill
- Assess organizations to determine capabilities
- Use peers more effectively

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TOPIC GROUPINGS

Lack of Resources

- lack of money
- lack of personnel
- different funding streams that don't allow for integrated approach
- current funding structure doesn't allow for a medical and MH visit on the same day
- lack of case management
- increasing demand and decreasing funding

Lack of Time

- more time needed to learn about integration and integrated structure
- PCPs are difficult to contact
- Not enough time to spend with clients
- Too much time required for administrative paperwork takes away from client time
- Need more time to plan, coordinate, consult and implement changes
- Need time for PCP to effectively identify and follow through on referrals

Lack of Communication/Relationships

- Need for familiar relationships between BH and PC
- Confusion/misinterpretation regarding HIPPA requirements and confidentiality
- Unfamiliar with other systems/protocols and resources
- Need access to clinical data
- Lack of information sharing and shared decision making
- Disconnect- not having the same collegial connection
- Lack of coordination of services
- Lack of understanding and communication of what "integration" really is and what it means
- Need to know how to get through the PC gatekeeper
- Underutilization of parents and peer supports
- PCP limitations on what referrals they will accept

Lack of Training/Expertise

- overwhelmed at expectation to be an expert in all fields
- resistance by PCP to take any MH clients
- Education needed in cross-systems issues
- Client education and support needed, particularly regarding importance of physical health
- Need education, training and policy development
- Varying levels of comfort in treating

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- Role confusion/productivity expectations
- Training needed for new roles
- Philosophical “cultures” of treatment, recovery and physical health are different
- PCP reluctance to make “social work” referrals

Stigma

- PCPs fear clients will be a disturbance to other patients
- Generalized stigma of MH clients
- Stigma related to primary care clients following through with MH referrals

END