AVOIDING PITFALLS WHEN BLENDING CULTURES: PRIMARY AND BEHAVIORAL HEALTHCARE

The Challenge

Entering a foreign country where you do not speak the language and finding a culture unlike your own leads to considerable stress and unease. The growing sense of "what am I doing here and how am I going to get along" dominates your mind. Over time primary care and behavioral health have developed languages and cultures that are quite divergent. The delivery model is viewed as foreign. Time is viewed differently, styles of professional-client interaction are divergent, patient records are distinct, and behavioral expectations in the office are unrecognizable as both coming from similar traditions. For the primary care practitioner, the notion of a fifty minute hour and a process that seeks exposure of myriad thoughts unrelated to symptomatology seem a luxury to say the least. With the average patient-physician contact being 12 minutes, practitioners need instant access to each other and "hallway handoffs" become the norm.

WORLDS APART

PRIMARY CARE	*BEHAVIORAL HEALTH CARE*
12 Minute intervention; presenting problem and treatment plan both exposed	50 Minute assessment on presenting problem(s), developmental background, strengths, and current life situation
Treatment plan determined, medications prescribed as needed (75% of time), and referral made if necessary within assessment appointment (less than 10% of time)	Tentative treatment plan presented, additional appointment set for continued assessment and planning, and referral for medication evaluation made if necessary
Fewer than half leave with return visit scheduled	Patient scheduled for next evaluation and planning appointment. Discussion of treatment options initiated
Physician sees over 100 patients per week	Mental health professional sees less than 30 clients per week
Medical record entry checks type of appointment for billing and one sentence statement on diagnosis and plan of care	Medical record a summary of patient strengths, challenges, and current life situation. Tentative diagnosis and rational for plan of care noted.

So what do you need to do when you enter a foreign country? Put simply, learn the language, study the culture, visit the service exchange, and explore and practice living in a new and interesting culture. It doesn't mean you give up being you; it means finding your way with a growing understanding of your new environment and finding ways to participate.

THE CHALLENGE OF AN INTEGRATED WORLD

Some notions for guiding efforts at incorporating primary medicine into a behavioral health organization to achieve successful integration:

Service Scheduling, Planning, Delivery, & Recording	A provider organization may develop an integrated service system either on its own or in partnership with another complementary organization or a group of practitioners to ensure timely access to needed knowledge and skill sets, and Service capacity.
Health Screening	Routine, validated screening tools for both medical and behavioral health problems must be embedded throughout multiple and continuing points of the patient experience and be available to all practitioners for easy review.
Referral, Information Sharing and Exchange	Based on screening results, routine involvement and sharing of information by members of the service team (typically comprised of physicians, nurses, psychologists, social workers, etc.) supporting the development of either coordinated or integrated service plan(s) and record(s). Such methods should be increasingly electronic and may include such solutions as • Electronic Health Record (EHR) to Electronic Health Record (EHR) direct data transfer • Encrypted, HIPAA-Compliant Email/Fax communications • Use of Personal Health Records in a "Smart Card" format
Health Services	Demonstrated and consistent use of: • Coordinated and complementary service strategies responsive to identified co-morbid conditions and accompanying dynamics —Planned Coordination of Care between Medicaid HMOs and CMHSPs —Bi-Directional Care Agreements between FQHCs and CMHSPs —Participation in Hospital-based Service continuum for specific populations (e.g., those who are aging or cognitively-impaired) • Practice service delivery protocols such as: —Disease Management Protocols —Risk Behavior Reduction Protocols • Integrated Healthcare Service Delivery Infrastructure —Health Care Home/Patient-Centered Medical Home —Health Care Team —Stepped Care according to Acuity Algorithms
Outcomes	Consistent reporting of data that demonstrates • Significant Reduction in —No show rates for behavioral health specific services, and —Patient non-compliance rates relative to physical health specific services • Improved system change as measured by —Access to service through efficient differential use of existing service practitioner time, and —Quality and efficiency of care provided reflected in improved health outcomes.

This model raises the bar of expectation on both the sponsoring provider organization(s) and practitioners to create a new culture of integrated service. It takes a concerted effort and a high level of commitment on the part of the sponsoring organization(s) to be successful. Besides the "micro" levels of interorganizational coordination of care for shared patients/beneficiaries, there is also the "macro" levels of external drivers that must be continually negotiated within the integration process and would include

- Differing requirements between medical and behavioral health organizations regarding Confidentiality Laws
- Conflicting (or mutually exclusive) Service Reimbursement pathways
- Varying solutions vis a vis Parity Issues
- Regulatory Oversight by multiple and differing bodies
- Workforce Shortages (primary care physicians; mid-level providers, etc.)
- Chronic Disease Management Strategies (differing disease focus; differing strategies)
- Use of differing Objective Measures of Services Outcomes (e.g., HEDIS v. MMBPIS)

FINDINGS FROM THE BLOCK GRANT

There were several solutions we adopted to ensure a greater blending of primary care and behavioral health provider elements. Some of these solutions included the following:

- The primary care physician (PCP) received an "immersion" experience in our Assertive Community Treatment team. He became part of the ACT daily planning group and provided direct input on managing the multiple chronic conditions presented by ACT patients. There were several benefits to this approach: (a) the PCP learned the intimate challenges of managing the care of a person with a serious mental illness); (b) given that many PCPs are at the very least "uncomfortable" with SMI patients, the process allowed a period of "desensitization" for the PCP and a time for becoming accustomed to their challenges; (c) the PCP was able to understand the differing roles—and the necessity of mutual reliance—in providing holistic behavioral healthcare.
- The Psychiatric Staff was renamed the Medical Staff. The PCP was then integrated into the Medical Staff as an equal member. The PCP participates in peer review, policy and procedure development, system linkage development, and mutual consultation.
- Behavioral Health Nursing personnel were refocus to incorporate more attention, documentation, and follow-up to medical elements during psychiatric visits, including tracking HgA1c, BMI, hypertension, COPD, linkages and follow-up with PCPs, and so on.
- Case Managers and Peer Support specialists were trained in multiple approaches to chronic care management and wellness programs
- The role of the Peer Support Specialists has "morphed" from one of support for behavioral healthcare primarily to that of "healthcare navigator." throughout the system. They have been trained by nursing instructors (and equipped) to take blood pressures; monitor blood sugar; provide wellness information; and offer referral information.
- There is a continuing effort organizationally to "retrofit" ourselves as a holistic health center geared to address all aspects of a patient's care. Functionally, the agency is moving towards performance as a Health Home or Patient-Centered Medical Home.

PLEASE STRAP ON YOUR SEAT BELTS

There are three prerequisites for a successful journey.

One is a ***commitment to make it work***. It takes time, energy, and willingness to engage with other practitioners. And it takes even more of the same to be open to changing or revising ones cherished practices to support an integrated approach to care.

The second is ***leadership commitment*** of the sponsoring organizations to make it work. Clear objectives with targeted practice outcomes help the individual practitioners sustain their efforts and ride out the rough spots.

The third is a ***change in the expectations for care of the patient***. "Fortunately, there is a growing movement of researchers and healthcare providers that now recognize the need to change not only the method of service delivery but also the very notion of the patients' activity on their own behalf. Patients, especially those with chronic conditions, are increasingly being seen as active partners in their care. Treatment and rehabilitation for these patients do not happen passively in the doctor's office; rather, both the patient and the health care staff create a treatment plan and share in the patient's implementation of it."**

When it all comes together patients will have a better journey, experience increased support in managing their disease, and achieve a level of health that exceeds their prior experiences.

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