A Summary of the Integration Summit: Strengthening the Continuum of Care Focusing on Adults with Co-occurring Behavioral Health and Medical Disorders

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November, 2004

November 17, 2004
Grappone Conference Center
Concord, New Hampshire

Sponsored by: Anthem Blue Cross & Blue Shield, Behavioral Health Network, Bi-State Primary Care Association, Center for Life Management, National Alliance for the Mentally Ill NH, New Hampshire Academy of Family Physicians, New Hampshire Community Behavioral Health Association, New Hampshire Medical Society, New Hampshire Psychiatric Society, and New Hampshire Psychological Association.

Introduction:

According to the New Freedom Commission Report on Mental health, 2003: "From a clinical perspective mental and medical conditions are highly interconnected, yet a chasm exists between the medical and mental health care systems that must be understood and bridged. Consumers, family members, caregivers, and employers experience unnecessary suffering, functional impairment, mortality, economic losses and health care costs as a result of ineffective care at the interface between mental health and general medicine."

On November 17, 2004, Summit took place with the objective of "Strengthening the Continuum of Care, Focusing on Adults with Co-occurring Behavioral Health and Medical Disorders." The summit, sponsored by ten significant organizations ranging the combined fields of behavioral medicine, was attended by physicians, behavioral health providers, administrators, social workers, nurses, family members, consumers, mental health advocates, representatives of insurance and pharmaceutical companies. In seven breakout sessions this heterogeneous group reconfigured in a variety of contexts to further collaborate, sharing knowledge, frustrations, experiences and ideas, according to a structure that would hopefully yield not only mutual understanding but suggest steps toward action. The structure was presented by Charles (C.J.) Peek, PhD, LP and Macaran (Mac) Baird, MD, MS, during an opening plenary session. There were four smaller sessions before lunch and three after lunch. Following lunch was a sobering presentation by Stephen Bartels, MD, MS, on "Medical Issues and Costs," highlighting the expense of not coordinating mental health and medicine. After a full day of learning, discussion, and collaboration, everyone returned into one large group for summarizing comments by Drs. Peek and Baird, covering "Top Themes, Next Steps and Questions for Moving Collaborative Care Forward in New Hampshire." Certainly all the problems had not been solved but for many the ice had been broken, and possibly even some ground in bringing integrated care to New Hampshire.

Opening Plenary Session:
Collaborative Care is Many Things to many People: How to Put Your own Work in Context

The opening session was about establishing a common framework so that so many representatives of different kinds of work could find better ways to collaborate. The framework would include: "common language in use, levels or kinds of collaboration desired, stages of program 'maturation,' harmonizing clinical, operational and financial goals at each stage, and how to articulate your own challenges or 'next steps' in collaborative care."

C.J. Peek, a consulting psychologist, opened the session with examples of the many kinds of language we use to describe our work, the term "collaborative care" being the most general. We have integrated care, biopsychosocial care, collaborative family healthcare, citizen healthcare and, last but not least, patient-centered care (where the patients are regarded as people!). The implications of language are subtle and revealing. They tell us something about focus and whose needs are being primarily considered. In collaboration, it helps if language is unifying and encompasses a variety of perspectives.

To facilitate this kind of talk, C.J, Peek and Macaran Baird proposed a more global vocabulary designed to address the wider world of collaborative care, which then could be applied to viewing more local and specific contexts, as would be addressed in the seven breakout sessions: "Latitude" and "Longitude." Latitude meant the range of personal goals for collaborative practice. Longitude would express stages of development for moving forward in the real world. Handouts were provided to all Summit participants to aid them in finding their bearings and charting their course. See Handout

To further aid in this process, Macaran Baird articulated five levels of collaboration which could be summarized as: 1) Minimal; 2) Basic from a distance; 3) Basic on-site; 4) Close collaboration in a partly integrated system; and 5) Close collaboration. Summit participants were urged to grasp the gestalt or big picture, greater than its parts. Details of specific contexts could be explored in breakout sessions. This would be Latitude.

For Longitude, or stages of development, another evaluatory grid was provided, (see grid) suggesting three basic stages: Stage 1: "Pilot"; Stage 2: "Project"; and Stage 3: "Mainstream". In different language, these stages could also be articulated as: 1) Idea, 2) Invention, 3) Innovation (Peek & Heinrich, 1995), or, perhaps most concretely: 1) Build commitment, 2) support big dreams with small success, 3) Implement the model across agencies (Mauksch & Cameron, 2002).

The framework established, Summit participants were then challenged to consider their "own Latitude and Longitude", using the five levels of collaboration and the three stages of development. This would initially be the work of the breakout sessions, to serve as a model for work beyond the Integration Summit. The ultimate short range goal would be to establish a sense of "My Next Developmental Step" in moving the work forward in the real world. As part of the next step, what would be important observations and questions to ask?

For the success of this work, as recommended by Drs. Peek and Baird, would be that whatever paths and solutions were developed, they would have to meet Clinical, Operational and Financial requirements. If a program were to fail in any one of these

dimensions, it was likely to fail altogether, as a table needs at least three legs to stand upon.
Breakout Sessions:

1. *Therapists from Venus, Doctors from Mars? One Practice's Experience with Integration of Services*:

In this session, Rick Pollak, MD, and Carol Sobelson, MSW, of Concord Family Medicine discussed their experience with primary care and mental health co-location. The question asked in the title focuses on the concern that behavioral health and medicine may seem to exist on and focus from the concerns of entirely different planets. What is described here from the point of view of Latitude is basic collaboration on site (or level 3) in which the two separate worlds are in close proximity and functioning moderately well. Longitudinally or developmentally, this would place their program at the Stage 2 or "Project" level of something working fairly well within its own context.

2: *A Commercial Health Plan's View of Medical-Behavioral Health Integration: the Anthem NH Experience*:

In this session, John Robinson, MD, Robert Feder, MD, and Kenneth Cohen, MD, presented several current and proposed projects of Behavioral Health Network and Anthem NH. They discussed initiatives for universal practice guidelines for the treatment of depression in primary care settings, identification of depression in post-partum mothers and patients with cardiac disease, high risk case management for patients with medical and behavioral disorders, medication compliance, and treatment of behavioral disorders with self-directed computer-based interventions. According to their own evaluation, this group saw itself engaged in "pilot" programs, functioning at level 1 of minimal collaboration with wide-reaching "mainstream" objectives. Observations and questions were in the realm of 1) looking for things that don't take extra time for providers, like the electronic submission of treatment plans; 2) expanding the possibility of getting behavioral services elsewhere in the community or state; 3) ways to get immediate referrals for behavioral health from PCPs; and 4) examining barriers in processes, for example: "treatment denied due to a medical problem." Next steps for this group were to: 1) address "cultural differences" across the state, and 2) take a collaborative approach respectful of contributions of everyone.

3. *Mind and Body Medicine: Vital Connection, Frequent Disconnect*:

This session began with a hearing of the personal experiences of Alison Tompkins, Dan Bailey and Andrea Tinkham, all of whom had co-occurring behavioral and medical ordeals and could testify first-hand to the need for greater collaboration between fields of treatment. Because of the personal nature of their disclosures, the tone of the discussion was emotional, but the context was appropriate if it be considered that behavioral and medical health delivery systems originated out of the need to provide care for patients. Their position is not merely a matter of what works clinically, operationally or financially but relates to their very well-being and mortality. The patients' plea for better

collaborative treatment was intense in their questions. Some of their questions were: 1) How do we bring education about mind-body connection/benefits/ treatment into medical training? 2) How do we help consumers advocate for themselves and ask pertinent questions? 3) How do we get providers to accept/believe somatic complaints from people who have mental illness? 4) How can we help providers see advocacy as a positive quality? Some next steps articulated were: 1) Have private insurers pay for care management/integrated care; 2) Have private insurance and state/federal insurance pay for medical care in the mental health system; 3) Allow for more time for medical providers to conduct thorough evaluations; 4) Separate the entitlement of health care from employment (collapse the 2-tiered system); 5) Train consumers to ask the questions they need to ask providers; 6) Teach consumers Wellness/Recovery (WRAP model); 7) Promote peer support centers (14 in NH) that help educate and promote self-advocacy; 8) Consumers eventually become providers and take over/change the mental health system; 9) Continue collaboration between mental health providers, consumers and families to integrate with other providers and bring legislators on board.

4. *Integrating Community Mental Health & General Medicine in a Culturally Competent Manner*:

In this session, presenters Kendall Snow, MSW, ACSW, Peter Janelle, MBA, Daniel Potenza, MD, Anna Pousland, BSN, RN and Jeffrey Sager, ND of the Mental Health Center of Greater Manchester discussed their experience with the emerging partnership between a general hospital and a community mental health center, working to facilitate the integration of general medicine and mental health. This collaboration seemed particularly comprehensive and highly motivated in its efforts to coordinate many different aspects of the field, especially in their emphasis on cultural competency, accessibility, and responsiveness to community needs. Additionally striking was the willingness to consider naturopathic medicine as a meaningful complement to traditional medical care. Unsure of their Latitude, this group seemed very active Longitudinally, both at the "pilot" and "project" levels, seeking to promote increased citizen involvement, developing funding, and focusing on existing gaps such as with the elderly, the mentally ill, and bringing addiction treatment into the community. They seemed to be moving quickly toward establishing a model for the "mainstream". Their idea to "magnify the choices that mental health consumers have received — what worked well", is a cognitive-behavioral prescription for project growth and development.

Medical Issues and Costs:
Care for Persons with Mental Illness in the Public Mental Health System

Stephen Bartels, MD, MS, presented an impressive array of statistics related to the financial impact of mental illness on overall health care. The general picture is that, across the board, the co-occurrence of mental illness with medical conditions (in particular depression) uniformly drives up the cost of medical care for everyone involved and, if untreated, results predictably in poorer outcomes. Costs to be considered would be emergency room, primary care, cost of prescriptions, and protracted illness. There is apparently a higher suicide rate for those with multidiagnoses; and persons with

schizophrenia statistically live ten years less, on average, than the general population, related to comorbidity of disorders and poor self-care. Smoking, use of substances, unsafe sex, poor diet and lack of exercise, all associated with mental illness, consistently interfere with positive outcomes and increase the cost of health care. Research recommends that co-location and the concurrent, collaborative approach is more effective than discrete specialized treatment. An integrated model is more likely to engage patients in their own treatment and recovery. Dr. Bartels recommended having a clinical depression specialist on hand at medical treatment sites. At the present time, insurance reimbursement seems to be one of the biggest obstacles. But the bottom line, as Dr. Bartels said more than once, based on numerous replicated studies, is that integrated behavioral and medical care would give "more bang for your buck" and result consistently in better outcomes.

Breakout Sessions:

5. *Patient Centered Disease Management: Integrating Behavioral and Physical health Care Strategies*:

In this session, Doris Lotz, MD of NH Dept. of Health and Human Services and Stephen Bartels, MD, MS of NH-Dartmouth Psychiatric Research Center, focused on what has been learned thus far regarding the optimization of health outcomes for patients with chronic behavioral and physical diseases. One interesting theme brought out was the use of nurses as educators, case managers and go-betweens. Education and better case management seemed critical to this group. Different systems would not depend so heavily on nurses, and it would depend on the culture of the organizations and communities involved who played this role. But ultimately, consumers should be educated in how to self-manage their conditions. In general, those patients who can advocate and manage for themselves have the best outcomes. However, when this is not happening, mental health clinicians and medical support staff need to compensate. A next step for this group would be "to have community mental health center clinical staff see integration with personal care as part of their role." Another step, ideally, would be to train a "new breed of case managers" with knowledge and skills to deal with both medical and psychological issues.

6. *Are Physicians Trainable? The Three I's of integration: Information, "Iducation" and Implementation*:

In this breakout session, Rodger Kessler, PhD of Fletcher Allen Healthcare, Berlin Family Health and Central Vermont Medical reviewed four different models of training physicians and psychologists in integrated care. What was essential, the presenters believe, was the implementation and sustainability of specific strategies within specific health care settings. This session generated many next steps and pertinent questions; 1) Multiple practices need to work on a project; 2) People suffer consequences of no integration; 3) Have everyone looking at the same outcomes to establish robust data; 4) Sometimes solutions are worse than the problems, too many people looking at too many things, too much bureaucracy; 5) Is there a good way to measure integration? 6)

Overfunctioning/underfunctioning partners creates imbalance and dysfunction of services; 7) Can administrators help find funding for projects? 8) There are cultural/language differences between professions and organizations that inhibit collaboration; 9) How do we get patients more involved in their treatment? 10) Electronic medical records will be important;
11) Who needs to make the move to integrate? 12) There are community-based training programs training masters-level clinicians with an new awareness of the need for collaboration; 13) Private practices may be isolated and resistant to integration. The last word seemed to be that we need new doctors and new behavioral health practitioners learning to be peers from the start.

7. *The "Odd Couple" — Primary Care and Behavioral Health*:

Stephen Noys, MSW and Philip Lawson, MD of Ammonoosuc Community Health Center presented the primary care model in relation to the traditional model of behavioral care. The implication of the title of their session would be that Primary Care and Behavioral Care are opposite but complementary and inseparable. This group was seeming highly developed in their Latitude, placing themselves at level 5 (close collaboration in a fully integrated system). They also see themselves Longitudinally as ready to go "mainstream." For next steps, this group felt that it could present to other clinics and mental health centers their working system. Other steps would be: 1) to ensure adequate treatment and ability to refer out; 2) make communication two-way between providers, referrals going both ways; and 3) move to electronic (shared, secure) records for efficiency and rapid communication. Questions posed by this group were: 1) What would it take to implement this model in other parts of New Hampshire? 2) How do we make it reimbursable? 3) How do we move to a holistic approach?

Closing Plenary Session:
From the Summit: Top Themes, Next Steps and Questions for Moving Collaborative Care Forward in New England

Participants returned to one assembly and Drs. Peek and Baird having circulated through the breakout sessions, with ears trained for top themes, next steps and questions, they proposed the following "News Headlines," along with some guiding wisdom and anecdotes:
1) Culture on the ground: This refers to the working culture of the different professions and agencies, learning to speak each others' languages so we can work better with each other and get the desired results. What is the difference, for example, between a patient, a client and a consumer? Different vocabulary suggests different implications. Knowing some of the assumptions, the rules, customs and expectations of the different providers will help pave the way for smoother collaboration.
2) Patient Role — Family/Community self-management: Here the patient/client/consumer becomes an active member of the treatment team. Instead of simply being consumers of services, individuals and families can learn to advocate for themselves, communicate their needs and seek out what they need. Providers can help in this process by meeting the patient in his/her own culture and level of understanding.

Here is where peer education and support have been beneficial. The hope was expressed in several of the breakout sessions that a new breed of providers might rise out of the ranks of consumers that would be sensitive to these issues and help to facilitate better self-care.

3) Care system improvement: Here we are talking about improvement of operations, better modes of communication and record keeping, and more reliable, friendlier, more efficient service. Drs. Peek and Baird stressed that close proximity of behavioral and medical services does not guarantee better integration of services. "Cohabitation does not equal collaboration." Collaboration needs to be worked out in a systems way, on a daily basis over time, so things work well all the time and not just some of the time.

4) Dialogue for Cooperation across delivery/financial boundaries: Suggested here is the idea that there ought to be a safe place where health care systems can talk through the boundaries to resolve bigger problems, seeing it as a community matter instead of collusion or antitrust. Organizations should seek to establish workable guidelines across systems that everyone can appreciate and meet instead of "dualing guidelines" working at cross purposes. There should be an effort through dialogue to "See the world through the other person's eyes to the satisfaction of the other person."

5) What's a useful policy question? A universal approach would be to blend the picture and call it "Health Care" instead of Behavioral Health Care and Medical Care. More realistically, we could all become policy shapers by our actions within our sphere of influence. Considering our sphere of influence, we could start with our own practice. Then we could consider our own practice in the context of our town or community. We could still have meaningful influence on that level. Then there is our influence at the state level, in all of New Hampshire. The Integration Summit seems an example of that kind of policy work. Beyond that is the national sphere, but our influence might be pretty thinly spread at that level. Best to spend our energies in the community and at state level, and of course in our own practices.

6) Training: Training is helpful and necessary but it does not guarantee change. However sophisticated and forward-thinking, however collaborative and multicultural the training is, the system must support it, implement it and sustain it. And the changes must meet clinical, operational and financial needs. In other words, good training is just one important piece of the picture. Let's teach physicians behavioral kinds of things so that, within their practice, they can make better referrals. Let the therapist be there to assist with behavioral aspects of medical treatment, for example the depression that often follows coronary interventions or any kind of serious surgery, issues of compliance, follow-up, chronic illness and chronic pain. The therapist can be there to take over the job when the physician has done his or her best work, because the therapist has likely spent months with the client and knows that person pretty well. And if the physician has seen a patient ten times and still does not have a clear sense of a diagnosis, maybe it's time to consult the mental health professional. It's a matter of balancing and complementing each other. And cross-validation is important, feeling good about your work and helping your partners feel good about their work.

Charles Peek concluded with a story about an encounter with Carl Whitaker, the well-known family therapist who worked from the experiential model, which has a lot to do with intuition and is mostly unteachable. A therapist was complaining about having sent a patient to the cardiologist and the neurologist and "all the other -ologists", and she kept

coming back to him, and Whitaker said: “Well, sir, if you’re not having fun, why are you doing this?” And Dr. Peek turned this around as: “If you’re having a good time in your practice and it’s valuable to the community — and I know it is because I’ve seen it — that’s contagious. The best thing we can do is find a colleague...” Find partners and form partnerships, and there is your collaboration. Drs. Peek and Baird urged everyone to keep up the good work, at whatever Latitude or Longitude we may find ourselves, one patient at a time, one collaboration at a time.

Closing comment by Michael J. Cohen, MA, CAGS, Chair, Planning Committee: “In my listening to people during the day and participating in discussions, there was clearly a genuine sense that everyone wants to do something and make something better for New Hampshire, and that’s a wonderful place to be. And I hope that all of you leave with that kind of recognition that whatever you do from here is something you take forward that has meaning.”