Behavioral Health Integration into Primary Care: A Perspective from California

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Integration of Substance Use Disorders (SUD) and Primary Care Services

- Literature review
- California Forum on SUD/Primary Care Integration
- California County Integration Survey
- FQHC visits and case studies (17 sites)
- California Integration Learning Collaborative
- DDCHCS in 6 sites
Integration: Literature Review

- Integration models vary.
- One size does not fit all.
- Existing models tend to focus on mental health rather than SUD, and “SUD” usually = alcohol.
- Use of medications to treat SUDs in primary care is rare.
- Good examples of existing efforts (e.g. see Chalk, Dilonardo et al. 2010), but none have been implemented on a wide scale.
Integration:
California Forum on Integration

- December 8-9, 2010
- “One size does not fit all.”
- “Think big, start small, use data.”
- “Workforce and training issues loom large.”

Barriers:
- Resistance (real or perceived)
- Financing, e.g. Medi-Cal restrictions on same-day billing for medical & SUD services, only licensed behavioral health care staff can be reimbursed
- Sharing of information limited by 42 CFR

- There are many examples of programs that have moved beyond these barriers.
California Integration Survey

2010 County Participation in SUD-PC Integration Initiatives (n=43)

- Engaged in Initiatives: 12%
- Planning Initiatives: 16%
- Not Engaged in Initiatives: 44%
- Initial Communication: 21%
- Learning about Integration: 7%

SUD/primary care integration is underway but is still in its infancy.
Financing, documentation, and partnership barriers are common, but can be overcome.
Integration: Site Visits & Case Studies

Sites
- La Clínica de la Raza, Vallejo and Oakland: co-location
- Tarzana Treatment Center, Tarzana: reverse co-location
- Los Angeles Gay and Lesbian Center, Los Angeles: co-location
- Mountain Park Health Center, Phoenix, AZ: integrated MH/PC
- Saint John’s Well Child and Family Center, Los Angeles: co-location

Counties
- Kern County: screening, brief interventions in 6 primary care sites
- Los Angeles County: improve utilization of SUD services in PC site
- Orange County: co-location in 2 sites, SBIRT in emergency rooms
- San Francisco County: office-based opioid treatment
- San Bernardino County: MH/SUD/PC co-location, Comprehensive Pain Management Services
- Santa Clara County: Moorpark Medical Home, Alexian Integrated Care
- Marin County: SBIRT in multiple clinics
Integration: Learning Collaborative & Website

• The Integration Learning Collaborative aims to provide an interactive forum where county administrators, SUD provider organization representatives, and other key stakeholders can collaborate to identify successful models of integration and solutions to shared challenges.

• Website: most useful and up to date information related to Healthcare Reform and the SUD field: www.uclaisap.org/Affordable-Care-Act
Measuring Integration with DDCHCS

County project to implement + study integration in 6 primary care facilities:

– **Program A (1 Site)**
  - Federally Qualified Health Center
  - Co-located BH screening and brief intervention
  - Coordinated long-term, higher-severity services at BH specialty clinic off-site but close (half-mile)
  - telepsychiatry

– **Program B (4 Sites)**
  - Federally Qualified Health Center
  - Co-located BH services (screening, brief intervention and treatment)
  - telepsychiatry

– **Program C (1 Site)**
  - Family Medicine Residency Program
  - Co-located BH services (screening, brief intervention and treatment)
  - Collaborative specialty services offsite
DDCHCS Strengths

The DDCHCS was the best fit for the county’s needs

- Provides quantitative scoring for simplicity in follow up comparisons
- Provides clear, concrete suggestions for increased BH integration
- Flexibility in administration of the instrument allows for minimal impact on clinic flow
Challenges Encountered

• DDCHCS score initially received somewhat poorly by one organization. Hard to convey the concept that not every organization is expected or should be expected to be “DDE”
• “DDE” potential limited in some domains due billing restrictions
• Scoring, inter-rater reliability (a manual has since been released)
• Tendency to collect data more from behavioral health side
  – BH staff are leading the integration effort in PC settings
    • BH staff have more vested interest in integration
    • Perceived as the lesser value service or that PC staff’s time is premium
  – BH staff tend to be the contacts and liaisons for site visits
• Confusion regarding confidentiality in sharing BH information
DDCHCS Scores

- Standard scoring: Sites were rated as Health Care Only Services to Dual Diagnosis Capable
- Alternate numeric scoring (average of scores across domains): ranged from 3.0-3.8 (Dual Diagnosis Capable).
Thoughts for future instrument development

For some purposes it would be useful to have an instrument that scores integration between primary care, mental health, and substance use disorder services independently, i.e. scoring integration as a “triangle”:

[Diagram of a triangle with labels: Primary Care, Mental Health, Substance Use, numbers 3 and 4 representing connections]

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Next Steps

- Re-administer DDCHCS at the 6 sites, Summer 2012
- Small grant from the California Program on Access to Care to study integration in 3 California Counties (surveys, focus groups)
- Submitting R01 for a national study of integration in FQHCs. Surveys, administrative data analysis, site visits, focus groups, interviews.
Thank you!

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