Behavioral Health and Primary Care Integration Consultation

Prepared for:
Monterey County Health Department

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Introduction

This consultation was initiated at the request of Mr. Ray Bullick, Health Director for Monterey County. It is meant to serve as a complement to the Monterey County Behavioral Health Review conducted by Mr. Ezequiel Vega and Dr. Kyle Titus in the past few months.

For the purpose of this project, I interviewed Mr. Bullick, David Soskin, MD (Behavioral Health Medical Director), and Caroline Kennedy, MD (Primary Care Medical Director). I also spoke with Mr. Vega and reviewed Quality Improvement reports and data that were supplied at my request by Dr. Soskin and Dr. Amie Miller, Quality Improvement (QI) Manager for Behavioral Health.

The QI review included the 2013-2014 “D3” and the IQ 2013 Reports; an analysis of 2014 Psychiatrist visits; a summary of psychiatric staffing distribution; data on the length of time from initial request for Behavioral Health Bureau services until actual first contact with a psychiatrist (Average 59.5 days); and the numbers of clients lost who do not receive any services after hospital discharge (40% in 2013). The Quality Improvement Reports are extremely well done and provide a superb overview of the services being provided by Monterey County Behavioral Health.

The overarching goal of the Monterey County Health Department is to develop a single system to provide integrative clinical collaboration between the Behavioral Health Bureau and primary care subsystems in order to achieve:

1. Improved and appropriate client / patient access to behavioral health services across the combined Behavioral Health and physical health subsystems.
2. Appropriate distribution of resources needed to provide individuals the combination of primary and behavioral health care they need across combined subsystems.
3. Appropriate utilization and distribution of behavioral health and primary care staff to attain maximum reasonable productivity across the combined system.
4. Improve coordination of needed client services within Behavioral Health.
5. Sufficient appropriate alcohol and drug services to meet the needs of the safety-net population served.
6. Improved overall client / patient health outcomes.

I also reviewed 60 client records that were provided for me by Ms. Elsa Jimenez. These randomly selected records include 30 hard copies of Behavioral Health Bureau charts, and 30 electronic health records for patients being seen in the primary care clinics that I was able to access online. All of these latter primary care clinic records were for patients being seen by dedicated behavioral health staff within primary care clinics, though it should be noted that there was evidence that primary care physicians are following some patients for high risk Serious Mental Illness for extended periods of time before they can access their internal clinic behavioral health services.
Chart Reviews

Overview of Chart Reviews

It should be noted that this review was limited in scope, based on key medical records elements identified beforehand with Dr. Soskin. These elements are believed to be fundamental to document the provision of good care. The review did not include the appropriateness or quality of medications prescribed – although in general medication treatment did seem appropriate and effective. For the Behavioral Health charts, review was of necessity limited to the pages copied and provided, so some elements may have been missed. In particular, an inference of assessment of Behavioral Health communication with primary care depended on included Progress Notes, lists of scanned documents (the documents themselves were not included in the copies) and lists of informed consent episodes. There were no Behavioral Health charts that clearly documented actual communication with primary care (i.e. no copies of notes sent back and forth and no progress notes documenting actual conversations).

All charts were reviewed for the following:

1. Is there a full, community standard psychosocial assessment, inclusive of risk factors (suicide/homicide/domestic violence) and an alcohol / substance abuse evaluation?
2. Is there a full behavioral health care plan that reflects #1?
3. Is there clear documentation of previous psychiatric hospitalizations?
4. Is there a clear safety assessment and safety plan, accessible to anyone who might look at the medical records in a crisis?
Is there, independent of mention in #1 or #2, a clear Substance Use Disorder evaluation and related care plan?

Is there a reasonable DSM diagnosis reflecting the actual evaluation and treatment?

Is there a single, easy to identify problem list, inclusive of both behavioral health and medical health needs?

Is there evidence of communication and timely referral WITHIN either the Behavioral Health or primary care systems, demonstrating best internal utilization of resources?

Is there evidence of cross-communication and timely referral between Behavioral Health Bureau providers and primary care clinic providers?

Behavioral Health Bureau Charts

Overall, it appears that clients are getting good care, within California community standards for county behavioral health systems. The notes reflect a positive working relationship with provider staff. However, there are significant deficiencies in charting. It is possible that necessary information was obtained by clinicians but not charted. Also, it is noted that although the vast majority of the 30 clients began treatment when they had acute, complicated and/or risky behavioral health conditions, at least 15 of the 30 clients continued to be followed in Behavioral Health long after (at least 3 months) these conditions stabilized. It is hard to assess the number who might have safely been transferred for further medication care either to a psychiatrist within a primary care clinic, or to a primary care provider directly, because there were no formal risk assessments. Based on Progress Note documentation of ongoing client endorsement of "no suicide ideation / homicide ideation / substance abuse," it appears that at least 10 of the 30 clients could have been transferred to a primary care setting. Many of these might easily be treatable by primary care providers themselves, should adequate support be available to PCPs to allow them to feel comfortable doing so.

Primary Care Clinic Charts

Again, overall care seems good, well within California community standards. In fact, the electronic medical record lends itself to improved documentation, especially the maintenance of a single problem list inclusive of both psychiatric and non-psychiatric medical problems in one location. Furthermore, the behavioral health assessments, though only partially structured by the EMR itself, tended to be much more thorough than those done in the Behavioral Health clinics. Attempts to transfer at least 3 out of the 30 patients to Behavioral Health were documented, the majority of those demonstrating significant risk based on either PHQ9 scores or clinical description – yet none of those referrals seems to have materialized into an actual intake at a Behavioral Health Bureau site.
Detailed Chart Findings

Behavioral Health Bureau Charts

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Evidence of a Safety Assessment and Safety Plan

Of 30 charts, only 2 had a thorough safety assessment and plan in the psychosocial assessment, one of which had no plan for domestic violence although the client had been a victim. One additional chart had ongoing assessment and planning exhibited in Progress Notes.

There was no documentation of suicidal or homicidal ideation after the initial psychosocial assessment in 11 of 30 charts. In several charts there was documentation of domestic violence in the assessment or progress notes, but no plan. There was evidence of past suicide attempts (several had multiple attempts) and/or recent suicidal ideation in 7 of the charts without a plan. There was a history of aggressive or assaultive behavior in 4 charts of clients without a plan. In one instance, the client had recently been fired for threatening other employees.

In one instance, the psychosocial assessment described a client with agitated Bipolar Disorder who had a history of 2 siblings who suicided. The client also had previously written a suicide note but did not then attempt suicide. There was no evidence that the client was asked about the presence of suicidal ideation in subsequent visits and there was no safety plan.

Substance Abuse Evaluation and Plan

In 10 of 30 charts there was no evidence that the client had been asked about substance abuse at all, either in the psychosocial assessment or in subsequent progress notes. In most of the remainder, the client was asked once at the time of initial assessment whether there had been "illegal drug use" or a substance abuse problem. In fewer than 5 assessments was there a complete evaluation grid listing all the various categories of alcohol and drugs subject to abuse. Their initial endorsements or denials were relied upon as accurate throughout their courses of treatment.

Of 30 charts, there were 14 clients demonstrating either ongoing or previous history of significant alcohol or substance abuse. In no instance was there a plan for Behavioral Health to address these substance abuse problems. Several clients had histories of DUI convictions, yet none of these had any plan for maintenance of sobriety. Several others had histories of alcohol, stimulant or marijuana abuse, yet were treated with benzodiazepines or stimulant drugs.

Of the 14 clients with significant substance or alcohol abuse history - or ongoing usage - only 3 had any indication of an effort to achieve or maintain sobriety, generally found somewhere in the progress notes. In several instances there was notation in the progress notes that clients had been or were going to go to recovery programs on their own, but apparently this was done entirely at the client's own initiative. Several other progress notes mentioned that clients were attending AA meetings.
All of the reviewed charts maintained DSM IV or DSM V nomenclature and format. Of 30 charts, 29 had at least one DSM IV or DSM V Axis I and/or Axis II diagnosis, and all were consistent with the treatment and medications being used. Of these, 14 did not include mention of any medical conditions, although some of those cases had very significant medical conditions. The medical diagnoses, when listed as part of the formal diagnosis, were sometimes conflicting over time so that one would have to rely on an accurate and current Problem List to understand the entirety of the client's medical problems.

As noted above (#1) the possibility of substance abuse was not investigated at all in many cases. In 3 charts clients who did have documented, significant substance abuse there was no mention of these in the diagnostic formulation. In 2 of these instances, the client was also being prescribed stimulant drugs despite a history of stimulant abuse.

Problem List
No chart had a single problem list including known medical and behavioral health problems. In 14 of the 30 charts, a list could only be surmised from combing the psychosocial assessment, the progress notes, and the DSM diagnostic formulation. In the other charts, it did not appear possible to derive a complete list anywhere, often because there was no evidence that medical or substance abuse histories had been solicited from the client. Even for those charts where problems could be combined from different sources to deduce a single list, there were frequently conflicting accounts of medical or substance abuse conditions.

Communication and Referral Within Behavioral Health
In only 3 of 30 charts, were there indications that clients were getting other services within the Behavioral Health Bureau besides medication clinic. Two charts mentioned case managers coming to appointments with clients. Another noted that the client was in a skills group but there was no documentation of communication with the leader of that group. There was no documentation of consideration of referral for any other clients to other Behavioral Health resources.

Cross-communication with Primary Care and Referral
It is impossible to be certain that there was communication regarding any of the 30 charts reviewed, as there is no documentation of actual communication in the progress notes. However, in 10 of the 30 charts there was evidence of scans having been either sent or received, or consents for communication with primary care having been signed by clients. It is unclear whether these were utilized to send information such as lab data to PCPs, or...
to receive information, although it may be safer to assume the former since nothing in the charts reflected any information that may have been received from PCPs. In several other charts there was documentation in the progress notes that laboratory results were being given to clients or family members “to take to their PCP’s.” In another instance, there was a reference to a referral being planned to a PCP—however there was no subsequent documentation to demonstrate that the referral had actually taken place.

There was no instance in which an initial assessment note stated that a client had been referred from primary care.

Physical Health Charts

1. Psychosocial Evaluations

Out of 30 charts, 20 had reasonably complete assessments, inclusive of both suicidal / homicidal ideation as well as substance abuse history. None had screening for domestic violence. As is the case for the Behavioral Health Bureau charts, accounts seemed based entirely on patients’ own endorsement or denial. While substance abuse histories were detailed, it is not clear that patients were asked about all potentially abused substances. When seen only by the LCSW, patients had no formal or complete psychosocial assessments of any sort in their charts. All 30 assessments included a description of patients’ medical problems.

2. Behavioral Health Care Plans

In 28 of 30 charts there was a clear plan starting from the assessment. The plans addressed only those items identified in the assessments (#1, above). In no instance did initial treatment plans address safety or substance abuse issues.

3. Documentation of Previous Psychiatric Hospitalizations

In 19 of 30 charts there was evidence that full psychiatric hospitalization history was obtained. In most of the others, the patient was fairly young and clearly had either no psychiatric hospital records, or only the one recent hospitalization that may have been noted in the narrative.

4. Evidence of a Safety Assessment and Safety Plan

Only 2 of the 30 charts contained a safety plan, although one psychiatrist intermittently noted, “safety protocols reviewed.” There was no documentation of the protocol to which he referred. In one chart there was a progress note that stated that a “contract for safety” was made at that point in time. In another case there was documentation that the
At the majority of MD, NP, and PA visits, there was documentation that the patient had been asked if they had suicidal or homicidal ideation, but in 3 of 30 charts there was no evidence the patient had ever been asked at all during the course of assessment and treatment. There was no documentation of domestic violence risk assessment on an ongoing basis, though a history of domestic violence was mentioned in several assessments.

One patient had a history of "rage attacks" and blackouts, with auditory hallucinations. Another had a history of cocaine, amphetamine and other substance abuse, as well as ongoing cocaine use combined with aggressive behavior. Still another had a history of "violence problems from benzos." In none of these cases there was any ongoing follow-up of these risk issues after they were noted in the assessment.

Two patients had ongoing intermittent suicidal ideation and there was no safety plan for either although they were asked about this in most of their encounters.

5. Substance Abuse Evaluation and Plan

Of 30 charts, approximately half had a thorough screening for substance abuse and alcoholism, and from the narrative it seems that at least 12 of the patients did have significant alcohol and/or substance abuse in their histories. Some were actively using cocaine, methamphetamine, and/or alcohol. In all cases, there was notation that SBIRT screening was to take place (Screening, Brief Intervention and Referral to Treatment—a SAMHSA best practice), but this has not been implemented by the clinics as of yet.

Of the 12 with identifiable substance disorder, only 3 had plans: 1 was on Antabuse, another in a court ordered program, and a third was referred by the clinic to a residential program. Of the others, several had urine toxicology screens periodically, but the majority had no targeted approach. Several of them were being treated with narcotics, Tramadol, or benzodiazepines. One woman had a long history of substance abuse and a DUI conviction approximately 2 years earlier, but she had no plan apparently because she said she had been abstaining—though one progress note mentioned that she was nonetheless continuing at least to use marijuana.

6) DSM Diagnosis

Of 30 charts, 25 had DSM diagnoses for their behavioral disorders, though they were often not given in the DSM IV Axis format, which has in any case been dropped with DSM V. Diagnoses were generally consistent with assessment and treatment, though substance abuse disorders were omitted approximately half the time despite documentation in the narrative. This was especially true when the patient claimed the substance abuse was inactive, even if recent. For example, in the instance of a woman who had been arrested 8 months earlier for drugs, her diagnosis of a substance disorder was dropped for unknown reasons after having been given to her at the time of assessment.
It did not appear that the lack of DSM format in some cases adversely affected care in any way, though the lack of any score for function may have made it harder to communicate the patient's functional level for referral purposes.

Problem List
All 30 charts had Problem Lists and these included both behavioral and medical problems. Of the 30, 4 showed a history of significant substance abuse that was not listed as a problem, and 2 showed current abuse that was not listed. In no instance was domestic violence listed.

Communication and Referral Within the Primary Care System
Of 30 cases receiving behavioral health services within the primary care clinics, 29 were referred from clinic primary care providers and one was a referral from an outside primary care provider. The amount of time from referral to first behavioral health visit varied a great deal, from 1 day to 5½ months. During these intervals, patients did receive appropriate care directly from their primary care provider. Most cases were seen within 2-6 weeks.

In several instances of very high risk patients (one with a PHQ of 29), there were significant delays in being seen by behaviorists within the clinics. In these cases, though there were no adverse outcomes, rapid assessment by a behavioral health specialist would have been especially useful. Ideally, these patients should have been referred to, and seen within the Behavioral Health Bureau system very quickly to minimize risk.

Cross-communication with Behavioral Health System and Referral
In 10 of 30 cases, there was evidence of communication with or referral to outside behavioral health resources. Reviewing the notes, it is impossible to know if the Behavioral Health Bureau operated these resources, or if they were services provided by other local agencies. Of these charts, 1 was a case in which a Case Manager came to the appointment with the patient, 1 was a patient referred for homeless services, 1 was referred to a substance abuse program, and 2 were referred for counseling.

There were 3 patients who the clinic attempted to refer to the Behavioral Health Bureau system for overall behavioral health care. Of these, none of the referrals was successful and the patients continued to be seen in the primary care clinic behavioral health setting. Two cases were referred more than 3 months prior to this review, and one was referred 9 months prior. All 3 cases could be considered both high complexity and high risk.
A man with psychotic depression was referred on October 27. He had a history of alcohol and substance abuse, and episodes of suicidal ideation. He has also been on methadone and various narcotics for pain.

Another case is a homeless woman referred on October 11, with a recent methamphetamine related arrest, being treated for episodes of "mania," who also had a "violence problem." Her situation represents a complex diagnostic and treatment dilemma that arguably may require a comprehensive treatment plan beyond the capabilities of a primary care clinic, including case management and substance abuse counseling. While she denied current substance abuse, she was not monitored for her drug use and her substance abuse disorder was somehow dropped both from the diagnostic and problem lists though she was being treated with a narcotic for pain.

A man with a diagnosis of depression was referred March 14. He seemed to become psychotic during the course of treatment in the clinic. He also had a history of "rage attacks or blackouts," as well as intermittent auditory hallucinations. He denied substance abuse at assessment but was never asked again.

Summary

1. Clients are being maintained on medication visits within the Behavioral Health Bureau clinics for an extended period of time, arguably beyond their need for this scarce medical specialty resource. There do not appear to be clear standards for when to discharge a client, even though discharge and "mainstreaming" to outside treatment may be important in promoting recovery. There also does not seem to be a robust program to provide group therapies that may help clients in their recovery and help move them to ward "graduation" from treatment.

2. At the same time, some patients with very acute, complex, and high risk needs are being treated in the primary care clinics, with unsuccessful attempts to transfer them to Behavioral Health Bureau clinics.

3. There may be additional evidence of Behavioral Health Bureau access problems suggested by a review of the "IQ 2013" QA Report, which showed that of the 772 individual patients discharged from the hospital that year, 12% were seen in the outpatient system only after 30 days, and 40% were never seen for follow-up. This population arguably represents the greatest concentration of risk among populations served. Further, data provided by Behavioral Health QI shows that the average wait for services in the Adult system is 52.52 days, with a range up to 321 days. The Behavioral Health Bureau does not seem to have a method to prioritize clients on a risk basis in order to assure that those most in need get seen right away.

4. While high risk patients within primary care clinics are being referred to behaviorists within those clinics, it is clear that primary care providers themselves are providing direct treatment to some of these higher risk patients by necessity until their...
behavioral health providers can make time for their referrals. It is likely that PCPs are also maintaining other psychiatric treatment candidates without any referral being made at all, since the medical providers must be aware of the difficulty accessing their own behaviorists.

5. Given the variety of levels of severity and acuity being seen throughout both Behavioral Health Bureau and primary care systems, there do not appear to be clear “screening in” standards to define eligibility for behavioral health services in the two different venues.

6. There is negligible communication documented between the Behavioral Health and primary care systems, so it must be assumed this is not occurring.

7. With a few exceptions, clients of the Behavioral Health Bureau are not having their physical health needs addressed by that system in any way. Problem lists do not address significant medical needs that, in many cases, may present greater risks to life and quality of life than do the clients’ behavioral health needs.

8. Risk assessment is spotty throughout both sets of clinics, and is seldom thorough. While suicidal and homicidal ideation are solicited from patients, there is little evidence that specific additional risk factors are investigated, e.g. presence of weapons in home, family history of suicides, lack of significant other, any catastrophic losses, etc. There is no assessment of domestic violence risk. In the majority of cases, there is limited information about prior psychiatric hospitalizations, although such information can aid in understanding a patient’s potential risk.

9. Neither system has been doing safety plans for at-risk patients, though one psychiatrist in a primary care clinic refers to reviewing a “safety protocol.” It is likely that patients and their families may be unaware of resources available to them in the event of a crisis, and it would be impossible for a third party to advise patients and families of their options in that event.

10. Alcohol and substance abuse are being addressed in a casual manner when addressed at all. There are no comprehensive evaluations of the extent of patients’ abuse patterns, and sometimes patients are not even asked about the issue. No chart had a formal plan to address known substance abuse issues, although there were occasional progress notes suggesting that patients were being referred for treatment.

11. The majority of the time, even known substance abuse (by history or current) is omitted from problem lists and diagnostic formulations.

12. In the Behavioral Health Bureau clinics, the electronic template for psychosocial assessments is being ignored by at least some staff. The document is long and complex, with some data field elements not applicable to all clients.

Preliminary Recommendations

1. Clear criteria can be adopted for client/patient exit through the “back door” of behavioral health care in both systems, i.e. “graduation” from specialty behavioral health. This can be framed as an expectation consistent with principles of Recovery
and Resilience, encouraging consumers to become more reliant on natural community resources over time. This approach would open space for behaviorists to see those for whom only they can provide needed care. Several tools have been utilized elsewhere to assist in identifying candidates for graduation from specialty behavioral health care. These include both the more medically oriented LOCUS (Level of Care Utilization System) and the MORS (Milestones of Recovery Scale). The latter is used by several other counties in California and is especially useful as it promotes a focus on principles of Recovery. Further, peer recovery resources can be included in thinking about the graduation process, as they can have an important role to play in assisting consumers in the graduation and mainstreaming process. In particular, peers can be helpful in assisting clients to develop “WRAP Plans” (Wellness Recovery Action Plans), to help prepare for greater independence. Lastly, many counties provide group therapies such as CBT and DBT, to assist clients in mastering symptoms so they can progress to lower levels of care.

2. At the same time, supports can be provided for primary care providers to take increasing responsibility over time, for increasing degrees of severity, acuity and complexity of behavioral illness. In fact, the chart review suggests that many of them are already assuming care of seriously ill persons until and unless scarce behavioral health resources become available—without assistance. In order to feel and become competent and comfortable treating this population, they need the same support from behavioral specialists that is provided by other scarce medical specialties: reliable access to specialists to take over care when needed, heretofore-unprecedented access to consultation, and education. In San Diego County it was found that, with such supports, PCPs can indeed become much more comfortable with treating lesser degrees of serious and persistent psychiatric illness, just as they now feel comfortable treating lesser degrees of renal failure, heart failure, etc.

3. Clients of the Behavioral Health Bureau can graduate and move to primary care clinics to enjoy all the health benefits of having a single medical home for their comprehensive health needs. As the population of less need behavioral health patients shifts gradually over to the primary care setting, with the least in need going to supported PCPs for all their treatment needs, scarce resources in the Behavioral Health Bureau should open up for improved access.

4. In order to facilitate access to Behavioral Health Bureau clinics, walk-ins can be accepted to assure consumers get what they need when they need it. Tools exist that can assist staff in screening walk-ins, to assure that those with highest risk can be seen immediately as needed, e.g. recent hospital discharges needing medication, referrals of patients with sudden higher acuity who have been seen by PCPs, others with suicidal or homicidal ideation, etc.

5. To facilitate this on-demand and as-really-needed access, Behavioral Health Bureau psychiatrists need to have the expectation that they will have flexibility in their daily schedule, with some time set aside, perhaps just a half hour to start, to be available on demand in order to provide services to walk-ins and consultation to primary care. The dedication of time for these activities represents an important symbolic institutional commitment to the new access paradigm and demonstrates that it’s not “just another uncompensated demand” being added to already busy schedules.
Behaviorists within the primary care clinics need to have the expectation that they will provide flexible consultation, brief assessment, and treatment. This requires that they maintain large pieces of their day to be available to their PCP colleagues for curbside consultation and "over the shoulder" visits with PCPs' patients, i.e. coming into the PCP's office briefly to "eyeball" a patient occasionally, so that they can step outside with the PCP and offer some quick advice. They also need to be able to take "warm handoffs" from PCPs, where they can at least greet a referred patient right away in order to establish rapport and better assure patient follow through.

A culture change is needed in which both primary care and Behavioral Health providers begin to see themselves as sharing responsibility for the single population they serve, a population with complex medical and behavioral health needs. The implication for providers is that everyone shares responsibility to be sure that all medical needs are met by "going the extra mile" to assure access when people need it. It is helpful to remind everyone of the recent finding that nationally, those with serious mental illness being treated in public health systems die on average at least 25 years early—and that people with behavioral illness deserve a comprehensive approach to their complex needs in order to address that serious health disparity.

All providers need to share concern for the patient's total well being, which requires that Behavioral Health Bureau providers do more to assure that their clients get the medical attention they need. There can be an expectation that all Behavioral Health problem lists and care plans include all significant medical problems, and, if there is no such problem already identified the problem can be "needs ongoing primary care." This can help focus interactions of clinical staff so that there is ongoing attention to the patient's totality of medical needs. Many Behavioral Health consumers will simply not follow through on needed primary care appointments unless clinical staff continually reiterate the importance of doing so.

A template can be developed or borrowed from another County, or both electronic medical records systems, to allow more thorough risk assessment. Similarly, there are major provider organizations that have developed Risk Plans, and these can be borrowed and adapted. Ideally, screening and planning for domestic violence can be included as the problem is now recognized as a more frequent occurrence than once thought.

It is clear that current screening for alcohol and substance abuse and referral for treatment are inadequate; even when identified as problems they are often not included in treatment planning or on problem lists. A major reason providers fail to investigate and address these problems is often a sense of helplessness if they do identify a problem—especially if they are unaware of recovery resources or these resources do not exist. A first step may be to add a staff member to either the Behavioral Health system or primary care, or both, whose job would be to identify current resources and then to broker services for specific referred patients. Because it has been demonstrated that repetitive admonition alone is better than no treatment in addressing substance abuse, it would be important in any case to develop a template for substance abuse screening and treatment planning. Again, there are existing tools that can be borrowed and adapted to the electronic medical records systems in both the Behavioral Health Bureau and the primary care clinics. Planned implementation...
11. As attention is given to developing additional alcohol and substance abuse treatment resources, it will be important to focus on the more acute end of the services spectrum, to provide a program that can provide assessment and initiate referral and/or treatment when referrals are made from the clinics, without danger of developing further access problems. It is suggested that residential treatment can be developed to initiate sobriety, but then length of stay in residential treatment needs to be relatively brief and flexible to assure that front door access can be maintained. Following brief residential treatment, counselors can be utilized to serve a case management function, assisting clients to remain involved with community recovery resources such as AA.

12. The broad issue of communication between the Behavioral Health Bureau and primary care systems is problematic because they do not share electronic medical records. Nonetheless, workarounds have been used elsewhere and could be encouraged in Monterey County until such time as their software can communicate. These include use of encrypted emails or instant messaging, or using a separate web-based database to store (necessarily re-entered) information for mutual reference. None of these are particularly suited to a physician’s busy schedule, however, and nothing really replaces a phone call, so long as the physician calling has a reasonable expectation that the other physician can come to the phone quickly. Per #5, above, Behavioral Health psychiatrists need to have the expectation that, even during their medication visits, they will take the rare, quick phone call from a PCP, stepping outside their office if necessary. As a quid pro quo, PCPs need to have a similar expectation. If the process works well, physicians in general will find it satisfying despite time constraints, and this interaction can help build a culture of shared population responsibility as well as mutual trust. Dr. Kennedy has also proposed an interesting system where PCPs could send records to Behavioral Health for a psychiatric review. While not real-time, this could certainly support PCP confidence in prescribing psychotropic medications.

13. As the patient population redistributes so that the most seriously ill and highest risk are concentrated in the Behavioral Health Bureau clinics, with the clinics taking walk-ins, it’s important to recognize that this will change working conditions. Leadership must recognize this fact overtly from the start and prepare the entire staff at the affected clinics, because there are ramifications for all. Staff need to hear that other counties and other clinics have made this transition and still thrive. Waiting rooms will become busier and more intense, general activity level will increase, and there may be more clients with potential for violence. Providers will be giving up their “nice” clients, with whom they’ve had longstanding relationships. Staff will need ongoing emotional support and attention to their further needs for administrative support as acuity and activity level build.

14. Lastly, it is suggested that the psychosocial assessment tool in the Behavioral Health Bureau electronic medical record be revised, preferably through a stakeholder process so that staff will “buy into” an improved version—especially since many are not using the current one. As a stakeholder, clinical leadership needs to be clear about what is needed, but if data fields are being ignored now, that data isn’t being collected...
in any case. Staff need to participate in the development of a format that meets their workflow needs in order to have a tool that they will use.

The Monterey County Health Department has many hard-working and dedicated staff who have been providing good care. In all likelihood they, themselves, have been frustrated with some of the structural issues noted in this report. It is hoped that these recommendations may support structural changes that will allow the citizens of Monterey greater access to services and even better, more comprehensive and more integrated care.