NCIOM North Carolina Institute of Medicine
shaping policy for a healthier state

TASK FORCE ON MENTAL HEALTH AND SUBSTANCE ABUSE

NORTH CAROLINA INSTITUTE OF MEDICINE
630 DAVIS DRIVE, SUITE 100
MORRISVILLE, NC 27560

OCTOBER 16, 2015
10:00 am - 3:00 pm

Task Force members in attendance: Marilyn Pearson, Trish Hussey, Tana Hartman Thorn, Bert Bennett, Grant Baldwin, Theo Pikoulas, Bert Wood, Luke Smith, Glenn Field, Kim Young, Andrew Clendenin, Brandy Bynum

Co-Chairs in attendance: Senator Angela Bryant, Courtney Cantrell, John Santopietro,

Steering Committee members in attendance: Jehan Benton-Clark, Starleen Scott Robbins, Flo Stein

Guests/Speakers in attendance: Kristin Humphrey, Dennis Russo, Skip Cummings

NCIOM staff in attendance: Adam Zolotor, Berkeley Yorkery, Michelle Ries

10:00 - 10: **INTRODUCTION AND WELCOME TO THE TASK FORCE**

Our Task Force co-chairs will bring the meeting to order and facilitate member introductions. We ask that each Task Force member introduce him/herself with name, title, and organization.

Senator Angela Bryant
North Carolina General Assembly

Courtney Cantrell, PhD
Director
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
North Carolina Department of Health and Human Services

John Santopietro, MD, FAPA
Chief Clinical Officer of Behavioral Health
Carolinas Health System

10:10 – 11:00 **VA MODEL FOR PROVIDING INTEGRATED CARE**

Goal: To learn how the VA provides integrated care to a diverse population. Understand how the VA has developed various ways to try to meet veterans where they are through a number of different access points.

Kristin L. Humphrey, PhD, LP
SIPU/PCT Coordinator
Director of Training
Clinical Assistant Professor – Department of Psychiatry
Wake Forest School of Medicine

Dr. Humphrey presented on the work of the VA as the biggest HCC in state, providing outpatient and specialty care for all North Carolina veterans, with over 50% from Army, for a total of 46,627. New facilities will be opening in Salisbury and Charlotte in the coming year.

Veterans tend to experience large rates of substance abuse and many co-occurring disorders such as depression, schizophrenia, bipolar disorder, and post-traumatic stress disorder (PTSD). In recent years, rates of PTSD and substance use disorders (SUD) have been rising. Mental health disorders were among the three most common problems for veterans seeking support. In fact, 51.2% of diagnoses are for mental health issues. Via services provided at the VA, all returning veterans receive a post-deployment health assessment with their primary care provider in order to receive screening, HA, and referrals to specialty care. However, rates continue to rise for PTSD among the National Guard and Reserves, who receive less support and training. Concerns were risen surrounding eligibility and array of services offered to veterans. According to the Veterans Choice Act, veterans are eligible to receive services through the community as well.

This population is mostly male, with 45% born between the years 1980 and 1995. Many veterans have reintegration issues post-deployment, such as trust issues with the military and VA. “Moral injury” is a common issue, meaning that many veterans feel that their moral/value system contradicts what they had to do during deployment. This can serve as a barrier to mental health treatment among others, such as behavioral health issues, scheduling problems, basic living problems, and stigma associated with mental health.

The VA has designed a Telehealth program to reduce barriers to access, as the VA is limited to providing transportation, etc. Treatment options for mental health problems include symptom management and trauma-focused care. Symptom management often occurs within primary care, which is often more acceptable and easier for many veterans. Primary care services offer chronic disease management for issues from chronic pain to HIV support. Trauma focused treatment includes evidence-based psychotherapies targeted to symptoms followed by connection with peer support services.

Outpatient PTSD treatment includes assessment, education, coping skills, trauma processing, aftercare (including booster classes and peer/caregiver support). Moral injury therapy seeks to address the challenging "stuck points" of trauma, emphasizing achieve closure rather faith-based practices. Inpatient/residential PTSD treatment sees combat veterans through a 6-week program offering intensive trauma processing, coping skills, and alternative therapies. Many veterans come to this program after the outpatient program has either been ineffective or if they are seeking a faster, intensive program.

In May 2014, the VA opened a new model facility with a homelike atmosphere, recreation/exercise programs, shared rooms (max 2) with private bathrooms. This program was developed on an evidence-based model mandated by the federal government. Most patients leave treatment without full diagnostic criteria for PTSD, but are encouraged to stay engaged with aftercare treatment so progress is not lost. PTSD mobile apps help with follow up as well.

11:00 – 12:00 **INTEGRATED CARE IN EASTERN NORTH CAROLINA**

Goal: Understand how integrated care is being provided in rural communities in eastern North Carolina using both a traditional integrated care model and the TeleTEAM model.

Dennis C. Russo, PhD, ABPP
Clinical Professor
Departments of Family Medicine and Psychology
Head, Behavioral Medicine
Department of Family Medicine
Brody School of Medicine
East Carolina University

Dr. Russo discussed the integration of mental health care into the primary care setting in rural communities in eastern North Carolina. Because of the many comorbidities associated with mental health and chronic disease, there exists a need to focus on “upstream issues” in behavioral health, rather than waiting until they’re “downstream.” Primary care physicians here focus on medical management but need support on behavioral modification and access/insurance coverage issues. In this model, behavioral health providers are always available to meet with patients during primary care visits. Providers use PHQ-9 for screening as a system to clearly define the problem, gives a functional description, and drive treatment options. One problem that has arisen includes health care teams not looking at full patient health history, and rather focusing on only a point in time (HbA1C level example).

Another interesting example was presented in the connection between diabetes and depression: depression is twice as prevalent in people with diabetes than a normal patient. The disease is associated with more complications, and higher risk of premature mortality, medication adherence problems, etc. There also exist challenges with social interactions related to diabetes.

PRIMARY CARE AS FIRST STOP FOR BEHAVIORAL HEALTH ISSUES: Dr. Cummings

Dr. Cummings discussed the integral role of primary care in the behavioral health system. Most people with behavioral health problems are not in a specific care system; rather they are in the primary care system, and often undiagnosed. Mental health issues and the variety of associated comorbidities is more efficiently managed in primary care through a joint support care plan.

Discussion centered around the idea of universal screening and barriers to implementation, such finances, time, and push back from office staff. We should think about universal screening for patients with chronic disease, but maybe not all patients. Another barrier is that patients often answer according to expectations of what they perceive a physician wants to hear. Marilyn Pearson claimed that universal screening received good results, especially around reducing stigma. Jehan Benton-Clark explained that many rural communities are getting close to universal screening and many practices are improving in selecting the right tools according to a patient’s needs. Grant Baldwin emphasized that identifying

"ultra-brief" screenings can be very helpful for primary care physicians in terms of time constraints and eliminating necessary work.

Dr. Santropietro stressed the importance of the "warm hand off" in seeking to address stigma of behavioral health care, as this model introduces the value of care to a patient. In fact, research shoes that physicians lose more than 50% of patients if with a cold hand off vs. less than 10% with warm hand off. Most behavioral health encounters can be easily handled in less than 30 minutes. The TeleTEAM care offers brief integrated care through BH, nutrition, pharmacy services. Early results of the program show improved outcomes and patient satisfaction, as well as popularity as a rotation among behavioral health students.

Discussion of Potential Recommendations

Potential recommendations surrounded setting a vision for integration that is suited across practice sizes. While on-site screening is ideal, telehealth provides the opportunity to improve access to care, but also presents billing challenges. The biggest issue discussed was around workforce development and the need for provider education.