Addressing Mental Health Issues in Primary Care: An Overview

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Why integrate physical and behavioral health care?

- Most people seek help for MH problems in PC settings
- ~1/2 of all care for common psychiatric disorders happens in PC settings
- Populations of color are even more likely to seek or receive care in PC than in specialty MH settings

MH problems in primary care

- Mild to moderate psychiatric disorders are common in PC settings
  - Anxiety, depression, substance use in adults
  - Anxiety, ADHD, behavioral problems in children
    - Prevention and early intervention opportunity
- People with common medical disorders have high rates of MH problems
  - Diabetes, heart disease, & asthma + depression
    - Worse outcomes & higher costs if both problems aren’t addressed

Why go to PC for MH care?

- Uninsured or underinsured
- Limited access to public MH services
- Cultural beliefs and attitudes
- Availability of MH services, especially in rural areas
**Current reality**
- MH problems often go undetected and untreated in PC
- When PCPs do detect MH problems, they tend to undertreat them
- Populations of color, children and adolescents, older adults, uninsured, and low-income patients are especially unlikely to receive adequate care for MH problems

*PCP = primary care provider

**Challenges**
- Patient factors (e.g., unwillingness to discuss MH problems or participate in treatment due to stigma)
- PCP factors (e.g., lack of training and time, fears re: prescribing for children)
- System factors (e.g., limited insurance benefits for MH conditions, limitations on PCPs’ ability to bill for MH services) – Variations by state, payer, etc.

**Key opportunity**
- Integrating care offers:
  - Chance to reach groups who cannot or will not access specialty care
  - Prevention and early intervention opportunities

**How do we improve MH care in PC settings?**

**Helpful, but not sufficient**
- Physician training
- Screening
- Referrals
- Co-location of services

**Strongest evidence base**
- Collaborative care
  - >25 years of research
  - >38 randomized controlled trials, including IMPACT (a collaborative care implementation)
- Adaptation of Wagner’s chronic care model
- Collaborative care is a set of basic principles and core components
  - Workable for settings with limited financial and/or workforce resources (e.g., rural areas) as well as those with more
Active ingredients

- Care management
  - Ensuring patients don’t “fall through the cracks”
- Evidence-based treatments
  - Effective medication management
  - Counseling / psychotherapy
- Psychiatric consultation for patients who are not improving as expected

Ref: Gilbody S, et al. Arch Internal Medicine 2006: 37 randomized controlled trials show collaborative care substantially more effective than care as usual.

IMPACT

- 1,801 participants in 18 clinics / 5 states
- 2 key processes
  - Systematic diagnosis and outcome tracking
  - Stepped care
- 2 key team members
  - Care manager
  - Consulting psychiatrist

Findings from IMPACT

- Doubled effectiveness of depression care
- Improved physical functioning
- Long-term cost savings
- Greatest gains seen in most disadvantaged populations

Ref: J. Unutzer, 2010

Real-world implementation

- AIMS Center – Research and training center
  - Training, consultation
    - Over 4,000 clinicians trained on IMPACT
  - Resources
    - http://uwaims.org/index.html

Putting it together

- Map core functions on to staffing resources
  - What are the basic activities your center needs to accomplish?
  - Who is doing them currently? If no one, who could take them on?
  - What additional resources are necessary, if any?
- AIMS Center planning tools
  - http://uwaims.org/implementation_tools.html

What does integration look like in the “real world”?
Lifelong Medical Care
Berkeley, CA
Brenda Goldstein, MPH
Director of Psychosocial Services

- Community Health Center (FQHC) serving Oakland and Berkeley
  - 6 primary care clinics
  - 2 adult day health centers
  - Dental clinic
  - Supportive housing program
  - Frequent Users of Health Services program
- Serving >20,000 low income patients
- 75% at or below 100% of federal poverty level
  - 53% MediCal
  - 28% Uninsured
  - 11% Private
  - 8% Medicare
- Integrated primary care/behavioral health

Special Populations/Programs
- Older Adults
- Frequent Users of Hospital Emergency Departments
- Homeless/Residents of Supportive Housing
- Disabled (physical, mental health and substance use disabilities)
- Primary care providers embedded in MHSA funded treatment teams serving the seriously mentally ill
- Centering Pregnancy/Centering Parenting
- Adult Day Health Care

Ethnicity

Age and Insurance Coverage

- 14% Uninsured
- 21% Hispanic
- 9% Asian/Pacific Islander
- 20% African American
- 21% Caucasian

- 24% Medicare
- 31% Medi-Cal
- 11% Private
- 31% Uninsured

Project Vida Health Center
El Paso, TX
Bill Schlesinger, DMin
Chief Executive Officer
Rachel Quintanilla, LMSW
Care Manager
The word “vida” means “life” in Spanish, and it is that broad definition that provides the parameters of what we do.

- Multiple social service agency
  - Sponsored by the Presbyterian Church (USA) and the Cumberland Presbyterian Church
  - Established as a Community Clinic in 1990
  - Programs and priorities developed in response to community concerns and issues
  - Located immediately on the USA/Mexico border
    - 99% of service area is Hispanic
    - Federally designated Medically Underserved (MUA) and a Health Professional Shortage Area (HPSA)

- Project Vida Health Center
  - Roger Naftzger Clinic
    - South Central El Paso
  - Northeast Family Practice
    - Northeast El Paso
  - Northeast Dental Clinic
  - Montana Vista Clinic
    - Far East El Paso
  - Project Vida Sparks Clinic
    - East El Paso
  - Culberson / Hudspeth Counties
    - Van Horn
    - Sierra Blanca
    - Dell City

- Project Vida Health Center
- Panel Discussion: Digging into Lifelong and Project Vida’s Integration Experiences
- How did your program start?
**Project Vida Start**
- Concern about chronic disease management
- History of high no-show in counseling.
- Partnerships with LMH Authority and community Counseling agency.
- Hogg Foundation grant – Care Manager function.
- Primary care – MD/PA/NP with contracted psychiatric consultation.

**Project Vida & IMPACT**
- **What worked?**
  - Team-based Depression care
    - Patient, PCP, Counselor, Consulting Psychiatrist, CM
    - 100% Staff buy-in, 100% Partnering Agency cooperation
  - Adaptable to our care setting
  - Systematic follow-up and outcomes tracking
    - Web-based Patient Registry
    - PHQ-9 / OASIS screeners
- **What didn’t work?**
  - Integration of Registry with EMR
  - Co-morbid conditions (substance abuse; chronic pain)

**IMPACT – LifeLong’s Lessons Learned**
- **Pros:**
  - Heightened attention to integration of mental health – increased staff involvement at all levels (providers, support staff, administrators, IT)
  - Promotes systematic adoption of practices that further integration – screening, multi-disciplinary planning and treatment, stepped care, evaluation of patient improvement
  - Identified patients not currently treated
- **Cons**
  - Model developed exclusively for depression and the population served has a heavy burden of anxiety, PTSD, substance use, and domestic violence issues
  - Difficult for behavioral health staff to keep up with referrals – all clinics ended up with waiting list.
  - Standalone data collection was burdensome
  - Did not inherently promote integration regarding chronic disease or other primary care issues
  - Staff felt that it was a lot of work but didn’t result in large numbers of clients getting treatment and missed a lot of folks who did need treatment

**What do you consider to be the “active ingredients” of your current integration approach?**
**LifeLong**

**Key Elements to Integrated Care**

- Co-location of staff, preferably sharing offices
- Multi-disciplinary team meetings
- Warm hand-offs between primary care and behavioral health providers
- Flexibility (scheduling, interventions etc.)
- Use of non-licensed staff
- Patient centeredness/recovery focus
- Removing stigma – packaging the services as part of the primary care experience and not as mental health
- Identify behavioral health needs on a spectrum that includes health education, case management, social work, therapy and medication
- Training of and acceptance by providers of integration
- Address mental health, substance use and physical health issues

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**Project Vida ‘Active Ingredients’**

- Care Manager
- Psychiatrist consultant accessibility to clinic staff & educating primary care providers.
- Trained Promotora team.
- CBT taught as method in group settings.
- Web-based Patient Registry Function.

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**Project Vida services not as traditional Mental Health**

- Oriented to maintain basic life functions.
- Address stigma issues.
- Short therapy with medical management as needed.
- Refer out bi-polar, schizophrenia, major depression.

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**LifeLong - A Spectrum of Care**

- We provide traditional mental health services – psychiatry, psychotherapy, long term treatment
- We also provide:
  - Short term interventions (1 – 3 sessions)
  - ½ hour visits
  - Includes case management
  - Focus on working with people with chronic physical health conditions (e.g. diabetes, hypertension)
  - Stages of change and motivation focused

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**How do the services you provide now differ from traditional mental health services?**

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**How do your programs address prevention and early intervention?**
### LifeLong Prevention & Early Intervention

- Using annual screening tool for all adult diabetics to identify depression, PTSD, anxiety and substance use
- Identify when physical symptoms are potentially signs of early onset of a mental health issue
- Refer primary care patients to behavioral health staff when there are changes in health status, when behavioral issues are impacting health status or when it seems like a patient needs additional psychosocial support
- Case management is often the door through which mental health issues are identified — primary care patients may identify immediate needs as resources. Once a relationship is developed with a case manager other issues surface

### Project Vida Prevention & Early Intervention

- Screening at all clinical encounters — same as height, weight, BP
- Group orientation with families and individuals at risk with CBT as method of thinking.
- ‘Warm hand-off’ in clinical setting to care manager.
- Clinic-sponsored health fairs address physical, emotional, and nutritional health

### Project Vida Promotoras & Care Managers

- Diabetes Empowerment Education Program — many similarities to CBT methods.
- Promotoras provide basic information on depression, anxiety.
- Promotoras lead group activities for secondary prevention as well.
- Care managers not licensed providers in FQHC setting.

### LifeLong Non-Licensed Staff: Essential Team Members

- MAs — screening, facilitating warm hand off
- Case Managers — intensive services for the highest risk/highest need clients. Conduct outreach and assessment, provide education, service brokerage, outreach, harm reduction interventions.
- Clinical Care Assistants — panel management, referrals, education and support, triage
- Health Educators — provide group and individual interventions focused on behavior change and chronic disease
- Students — psychology and social work students who extend our capacity and provide many services that aren’t billable

### How do you tailor your services to fit the diversity of the populations you serve?
**Project Vida population diversity**
- 98% Hispanic population so far
- Providers bi-lingual
- Promotoras provide culturally and linguistically appropriate services.
- Counseling and CBT Group classes are culturally adapted for Hispanic population

**LifeLong Serving a Diverse Population**
- Hire diverse staff – language, culture, approach, experience, perspective
- Client centered care – promotes attention to individual perspectives and needs
- Groups
- Non-licensed staff – easier to recruit a diverse staff reflective of clients served
- Primary care is a non threatening entry point for mental health services because of lack of stigma associated with seeking medical services, especially for communities which have traditionally stayed away from mental health centers

**Project Vida challenges**
- Funding as services expand –
- Bringing new providers into the system.
- Dealing with state Department of State Health Services on coordination/integration with Local Mental Health Authority.

**Challenges - LifeLong**
- Changing staff roles – challenging to those who’ve been doing it one way for a long time
- Funding – pressure to increase visits
- FQHC financing structure limits model – no reimbursement for groups, MFTs, MSWs, same day visits, telephone support
- Evaluation and documenting positive impact of integrated services
- Creating efficient screening and triage processes
- Recruiting mental health professionals from the diverse communities which we serve
- Demand for services exceeds capacity
- Serving extremely high risk clients requires an intensive, wrap around model

**What are the biggest challenges you face at present?**

**What are some of your key lessons learned?**
Key Lessons Learned - LifeLong

- Integrating services, like other change, is a gradual process which can meet resistance along the way – be prepared to create culture change.
- Engaging leadership staff in integration efforts is critical.
- Hiring staff who believe in and support integration is key – build into recruitment and interview process.
- Integration is achieved when all staff are trained and buy into the model.
- Integration needs to be embedded in strategic planning efforts and a critical element in clinical priorities and development of tools (e.g. electronic health records).

Project Vida lessons & advice

- PCP and support staff champions are critical.
- Psychiatrist and care manager need to establish trust with PCPs.
- Once implemented, PCPs quickly see the benefits, and late adopters come on board.
- Care managers’ personality may be equally important to credentials.
- Collaborative care approach reduces stigma as a barrier to treatment seeking.
- Co-morbid conditions (especially substance abuse and chronic pain) must be addressed.
- Creative partnerships facilitate model.

Where can you learn more?

- Collaborative Family Healthcare Association.
- Patient-Centered Primary Care Collaborative.
- AIMS Center – University of Washington.
- IBHP - CA Endowment/Tides Center.
- Hogg Foundation for Mental Health.

Primary Care, Mental Health, and Substance Use Integration Webinar Series

- Bridging Differences in the “Cultures” of Primary Care, Mental Health, & Substance Use June 10, 2010.
- Paying for Integrated Services: FQHC, Medi-Cal, and Other Funding Strategies June 24, 2010.

Q&A