La Clínica℠

La Clínica de La Raza Behavioral Health Integration Project:

Planning, Pilot and Implementation in Contra Costa County

Funded by

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Introduction

In 1971, a group of concerned students, health professionals and community activists came together to establish La Clínica de La Raza as a volunteer-run free clinic in Oakland, California. Since then, La Clínica has grown into one of the largest community health centers in California – a sophisticated provider of primary health care and other health-related services across 25 locations in Alameda, Contra Costa, and Solano counties. The organization provides culturally appropriate, high quality and accessible care to its patients. Most La Clínica patients speak Spanish as their primary language, 93% of are uninsured or have public health insurance, and 68% of all La Clínica patients have incomes at or below the federal poverty line.

For over a decade, La Clínica has worked closely with the John Muir-Mt. Diablo Community Health Fund to first enter and then expand its presence in Contra Costa County, where the number of Spanish-speaking, low-income residents has been on the rise. Since 1999, through its clinics in Pittsburg, CA and Monument (Concord, CA), La Clínica's services and capacity in Contra Costa County have grown steadily. Today, La Clínica offers a full array of primary health care services to approximately 10,200 Contra Costa residents each year, and provides a link between those residents and the county's hospitals and specialty service providers.

The Behavioral Health Integration Project

Of the John Muir-Mt. Diablo Community Health Fund's $3.3 million in grants to La Clínica since 1999, nearly $875,000 – provided over three years – supported development of the Behavioral Health Integration Project (BHIP), which integrates behavioral health services into primary care visits at La Clínica's Pittsburg and Monument clinics. The project emerged in response to longstanding concerns among La Clínica medical providers that, while there is mental health care available for patients with severe and persistent mental illness, patients with symptoms of mild-to-moderate severity did not have adequate access to mental health services.

To better address La Clínica's patients' full range of mental health needs, BHIP has two primary components:

1. **A tailored, culturally sensitive behavioral health screen that enables medical providers and other La Clínica staff to better identify patients who can benefit from behavioral health interventions.**

2. **An on-site behavioral medicine specialist (BMS), who can be available *during* primary care visits. The BMS provides behavioral health interventions for mild-to-moderate mental health symptoms, as well as consultation to the medical providers around mental health diagnoses. The BMS is also available for follow-up appointments or to make referrals to social workers and specialty mental health providers.**

The John Muir-Mt. Diablo Community Health Fund's BHIP grants supported a planning year (2007), a two-year pilot implementation (2008 and 2009), and an evaluation process throughout the three years. In 2008, La Clínica hired The Avisa Group – a policy research, evaluation and consulting firm – to conduct the evaluation. This report draws on The Avisa Group's work, as well as on background materials and interviews with La Clínica staff and patients.

Race/Ethnicity of La Clínica Patients in Contra Costa County in 2009

Race/Ethnicity	
White (Latino)	85%
White (Non-Latino)	8%
Black	4%
Asian/API	3%
Other (Native American, Multi-ethnic)	<1%
Total	**100%**

Income of La Clínica Patients in Contra Costa County in 2009

Poverty Level	
100% and below	73%
100 - 150%	19%
150 - 200%	6%
Over 200%	2%
Total	**100%**

La Clínica

Program Logic Model

GOALS

Increase patient access to culturally and linguistically appropriate behavioral health services

Improved physical and behavioral clinical health outcomes

Improved medical provider ability to address patients' behavioral health

Increased efficiency and cost effectiveness of health care delivery

STRATEGIES

SCREENING ALL PATIENTS ANNUALLY FOR MENTAL HEALTH SYMPTOMS

CO-LOCATION OF BEHAVIORAL MEDICINE SPECIALIST (BMS) WITH MEDICAL PROVIDERS PROMOTES:

"Warm hand-off" ↔ Consultation with Medical Providers ↔ Appointment with BMS

BRIEF ASSESSMENT AND CONSULTATION

- Assess patients who answered positively for mental health concerns on screen
- Assess patients with mental health issues identified by medical provider
- Assess mental health issues underlying poor chronic disease management

BRIEF INTERVENTION

- Early Intervention to prevent mental health problems
- Cognitive and/or behavioral strategies for symptom reduction and chronic disease management
- External referral to specialty Mental Health Agencies
- Internal referral to Medical Social Workers for brief counseling

OUTCOMES

Individual Patient Outcomes

- Immediate access to behavioral health consultation
- Increased identification of behavioral health problems
- Symptom reduction
- Increased adherence to treatment plan
- Improved management of chronic diseases

La Clínica Outcomes

- Increased quality of care
- Improved chronic disease outcomes
- Increased patient and provider satisfaction
- Reduction in medical visits from underlying psychosocial issues

Community Outcomes

- Reduction of barriers to mental health consultation
- Improved community health outcomes
- Reduction in severity and incidence of preventable mental health disorders
- Reduction of use of Emergency Room and hospital

Planning and Implementation

La Clínica's behavioral health integration planning efforts began with a review of existing research. The studies confirmed that Latinos do not get their mental health needs met as consistently as Caucasian patients[1,2] and that Latinos tend to have higher rates of depression or distress than Caucasians.[3,4,5,6]

Many speculate that the higher rates are attributable to the stresses of acculturation. Moreover, the stigma attached to mental illness within segments of the Latino community and documented disparities in mental health care access likely contribute to the finding that fewer than one in 20 Latinos contact mental health specialists when they have mental health needs[7]. Integration appears to offer Latinos greater access to mental health services, primarily for two reasons. First, many Latinos express their emotional distress through physical symptoms[8,9] and thus tend to seek help through primary care. And, second, Latinos tend to trust and have more access to primary care services than mental health services.

[1] Young, A.S., Klap, R., Sherbourne, C.D., & Wells, K.B. (2001). The quality of care for depressive and anxiety disorders in the United States. Archives of General Psychiatry.
[2] United States Public Health Service Office of the Surgeon General (2001), "Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General." Rockville, M.D: Department of Health and Human Services, U.S. Public Health Service.
[3] Frerichs, R.R., Aneshensel, C.S., & Clark, V.A. (1981). Prevalence of depression in Los Angeles County. American Journal of Epidemiology.
[4] Roberts, R.E. (1981). Prevalence of depressive symptoms among Mexican Americans. Journal of Nervous and Mental Disease.
[5] Vernon, S.W., & Roberts, R.E. (1982). Prevelance of treated and untreated psychiatric disorders in three ethnic groups. Social Science and Medicine
[6] Vega, W., Warheit, G. , Buhl-Auth, J. & Meinhardt, K. (1984). The prevalence of depressive symptoms among Mexican Americans and Anglos. American Journal of Epidemiology.
[7] Young, et al, op. cit.
[8] Escobar, J.I., Rubio-Stipec, M., Canino, G. & Karno, M. (1989). Somatic Symptom Index (SSI): A new and abridged somatization construct: Prevalence and epidemiological correlates in two large community samples. Journal of Nervous and Mental Disease.
[9] Escobar, J.I., Hoyos Nervi, C., & Gara, M.A. (2000). Immigration and mental health: Mexican Americans in the United States. Harvard Review of Psychiatry.

These phenomena are not unique to Latinos, but they almost surely occur more frequently in Latino communities. La Clínica providers were concerned that a primary care appointment is rarely an adequate mental health solution, given that a 15-minute primary care visit is barely enough time to address physical symptoms. According to clinical psychologist Kirk Strosahl, PhD, of the Mountainview Consulting Group, mental health outcomes in primary care patients are only slightly better than spontaneous recovery. Even if primary care providers do identify a mental health need, it is usually difficult to convince mildly afflicted patients to follow up with an unfamiliar mental health provider, particularly if insurance does not cover the follow-up visit and there is a cultural unwillingness to acknowledge emotional or mental distress. In fact, says Strosahl, only one in four patients referred to specialty mental health or treatment for chemical dependency even make their first appointment.

Finally, the research indicates that one solution to these challenges is integrating behavioral health into the primary care setting. When implemented effectively, this approach has resulted in significant improvements in access, patient outcomes and provider satisfaction, as well as more efficient delivery of services.

Convinced by its own experience with Latino patients, and supported by the literature, La Clínica decided to plan for integration. Recognizing that successfully adapting behavioral health integration models to La Clínica's unique population would require considerable planning, The John Muir-Mt. Diablo Community Health Fund agreed to support this planning process. Now, three years later, staff members believe the year of planning was absolutely essential to the program's success.

Choosing the Model

Prior to BHIP, La Clínica had relied on medical social work and external specialty mental health services to address patient mental health concerns. The key difference among the approaches is that behavioral health integration aims to be "population-based," while the other two modalities are "patient-based." A population-based approach uses interventions designed to quickly give patients self-management skills for times when their own coping resources are overwhelmed, serves more patients and, thus, can improve the health of the community. In contrast, patient-based approaches generally are designed to meet more severe mental health needs, but serve fewer patients.

La Clínica believed that a population-based behavioral health approach would best address the needs of its large patient population with mild-to-moderate mental health symptoms. A planning group chose a model pioneered by Strosahl. The model has five key elements:

1. **A behavioral health clinician, called a Behavioral Medicine Specialist (BMS) at La Clínica, is physically "nested" in the medicine practice area. The goal is to achieve a "warm handoff" from the medical provider to the BMS.**
2. **The BMS is integral to the primary care team, in which the medical provider is the lead.**
3. **There is seamless patient flow between the medical provider and the BMS to address the full spectrum of physical and mental health needs.**
4. **Behavioral health care is a routine component of medical care.**
5. **Behavioral health care promotes rapid diagnosis, goal achievement, and enhanced self-efficacy through simple, solution-focused interventions compatible with 15-minute health care visits.**

Operational Planning

Once they had chosen the model, the planning group expanded and began speaking with other programs to better understand the operational challenges involved. La Clínica then devised processes to address how a fully integrated behavioral health program might affect current systems related to:

- **Patient registration**
- **Appointment scheduling**
- **Patient flow**
- **Billing**
- **Information Technology**
- **Documentation**
- **Program oversight**
- **Medical provider practices addressing behavioral health issues and chronic disease management**

It became clear that to optimize the chances for success, La Clínica would have to conduct more staff trainings than initially anticipated.

Goal Selection

Because program evaluation was a key piece of the grant, La Clínica also spent the planning year determining on what basis it would evaluate its program. It decided to look at the three key areas:

- **Clinical Outcomes: To what degree could BHIP reduce mild-to-moderate mental health symptoms?**
- **Fiscal Outcomes: Could BHIP reduce emergency room use, hospital use, and functional impairment?**
- **Provider Satisfaction: Would the integration increase provider satisfaction and confidence in their ability to address mental health issues?**

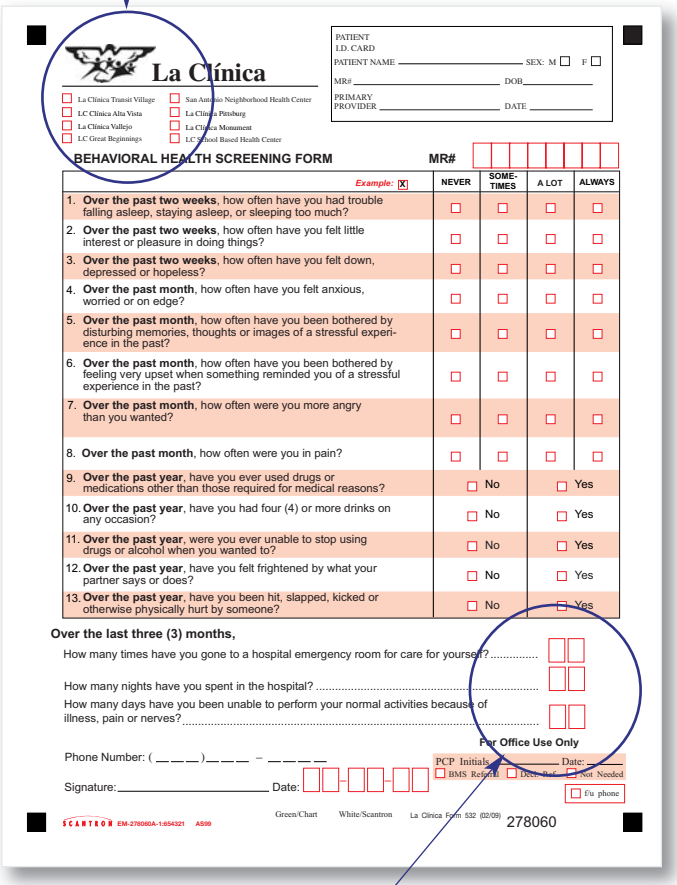
After considerable discussion, the planning group decided that it would be hard to accurately evaluate the true fiscal benefit of BHIP. In California, billing for a behavioral health visit that is the result of a "warm hand-off" is not allowed, because it is viewed as billing for two services in the course of one visit. While La Clínica is involved in a statewide effort to have this regulation changed, under the current circumstances, measuring the direct fiscal impact on clinic revenue did not make sense. La Clínica decided, therefore, to measure if the program could reduce health care costs generally (reduced hospital and emergency room use), as well as patient costs (less time away from work and less out-of-pocket costs for self-pay patients).

Behavioral Health Screening Tool

Though there were already validated screening tools available, La Clínica felt it needed a broad, bilingual, culturally appropriate tool tailored to its population. The team wanted a screening instrument that would be simple enough for patients to quickly fill out in a busy waiting room, but also robust enough to help medical providers quickly identify mental health concerns. The tool also needed to be usable by patients with a variety of literacy levels and able to screen for a range of symptoms that might present in a variety of ways, with particular attention paid to the ways in which Latinos tend to experience and express emotional distress. A final concern was striking a balance between identifying areas providers were already good at identifying (and using the screen as a reminder to make a referral) and those they may be under-identifying.

The team developed a 16-question form. Thirteen of the questions are clinical and screen for depression, anxiety, trauma, domestic violence, alcohol/drug abuse, sleep problems, and pain. Three additional questions address emergency room (ER) and hospital utilization as well as impairment in role function. The plan called for every adult La Clínica patient (age 18 and above) to fill out the screen once a year. La Clínica also purchased Scantron software and a scanner to ease data entry and more quickly reveal patterns obtained from the data.

Discussion
1. All La Clínica sites are listed here, with the hope of expansion to those sites in the 'future'.



La Clínica

☐ La Clínica Transit Village ☐ San Antonio Neighborhood Health Center
☐ LC Clínica Alta Vista ☐ La Clínica Pittsburg
☐ La Clínica Vallejo ☐ La Clínica Monument
☐ LC Great Beginnings ☐ LC School Based Health Center

PATIENT I.D. CARD
PATIENT NAME _____ SEX: M ☐ F ☐
MR# _____ DOB _____
PRIMARY PROVIDER _____ DATE _____

BEHAVIORAL HEALTH SCREENING FORM MR#

	NEVER	SOME-TIMES	A LOT	ALWAYS
Example: ☒				
1. **Over the past two weeks**, how often have you had trouble falling asleep, staying asleep, or sleeping too much?	☐	☐	☐	☐
2. **Over the past two weeks**, how often have you felt little interest or pleasure in doing things?	☐	☐	☐	☐
3. **Over the past two weeks**, how often have you felt down, depressed or hopeless?	☐	☐	☐	☐
4. **Over the past month**, how often have you felt anxious, worried or on edge?	☐	☐	☐	☐
5. **Over the past month**, how often have you been bothered by disturbing memories, thoughts or images of a stressful experience in the past?	☐	☐	☐	☐
6. **Over the past month**, how often have you been bothered by feeling very upset when something reminded you of a stressful experience in the past?	☐	☐	☐	☐
7. **Over the past month**, how often were you more angry than you wanted?	☐	☐	☐	☐
8. **Over the past month**, how often were you in pain?	☐	☐	☐	☐
9. **Over the past year**, have you ever used drugs or medications other than those required for medical reasons?	☐ No		☐ Yes	
10. **Over the past year**, have you had four (4) or more drinks on any occasion?	☐ No		☐ Yes	
11. **Over the past year**, were you ever unable to stop using drugs or alcohol when you wanted to?	☐ No		☐ Yes	
12. **Over the past year**, have you felt frightened by what your partner says or does?	☐ No		☐ Yes	
13. **Over the past year**, have you been hit, slapped, kicked or otherwise physically hurt by someone?	☐ No		☐ Yes	

Over the last three (3) months,
How many times have you gone to a hospital emergency room for care for yourself? ☐☐
How many nights have you spent in the hospital? ☐☐
How many days have you been unable to perform your normal activities because of illness, pain or nerves? ☐☐

For Office Use Only
Phone Number: (___) ___ – ____
PCP Initials _____ Date: _____
☐ BMS Referral ☐ Dietary Ref. ☐ Not Needed
☐ F/u phone
Signature: _____ Date: ☐☐-☐☐-☐☐

SCANTRON EM-278060A-1:654321 AS99 Green/Chart White/Scantron La Clínica Form 532 (02/09) 278060

Discussion
2. Some patients had difficulty filling out the numeric values. Please see lessons learned for more discussion.

Implementation

Implementation occurred in stages. Early implementation involved piloting and revising the screening form.

In addition, La Clínica spent had difficulty finding licensed, bilingual clinicians willing to work according to the integrated model. Few licensed mental health providers are trained in behavioral health integration, and the search was complicated by the strong belief that to be effective at La Clínica, the clinician should be bilingual and, preferably, bicultural. La Clínica hired a bilingual clinician for its Monument clinic, but struggled to find a qualified clinician for Pittsburg. After six months of a vacant position, La Clínica hired an experienced English-speaking clinician on a temporary basis while the search continued. A bilingual medical assistant provided translation assistance. Provider enthusiasm and patient response improved measurably when a bilingual provider came aboard, and improved even further when, finally, a bilingual, bicultural clinician was hired.

In practice, the BMS conducts a brief assessment guided by the medical providers' referral. Clinical interventions include teaching patients how to recognize signs of deteriorating mental health and giving them tools that enable them to set achievable goals and return quickly to prior levels of activity and functioning. Methods include supportive counseling, psycho-education, motivational enhancement, behavior change strategies, and patient "homework."

Initial visits are approximately 30 minutes, although warm hand-offs may be briefer. Follow-up visits range from 15 – 30 minutes. After the BMS does a brief assessment, intervention and consultation, s/he can schedule a follow-up visit with the patient or refer the patient to the case managers (medical social workers) at La Clínica to either provide counseling of longer duration or link the patients to specialty mental health services.

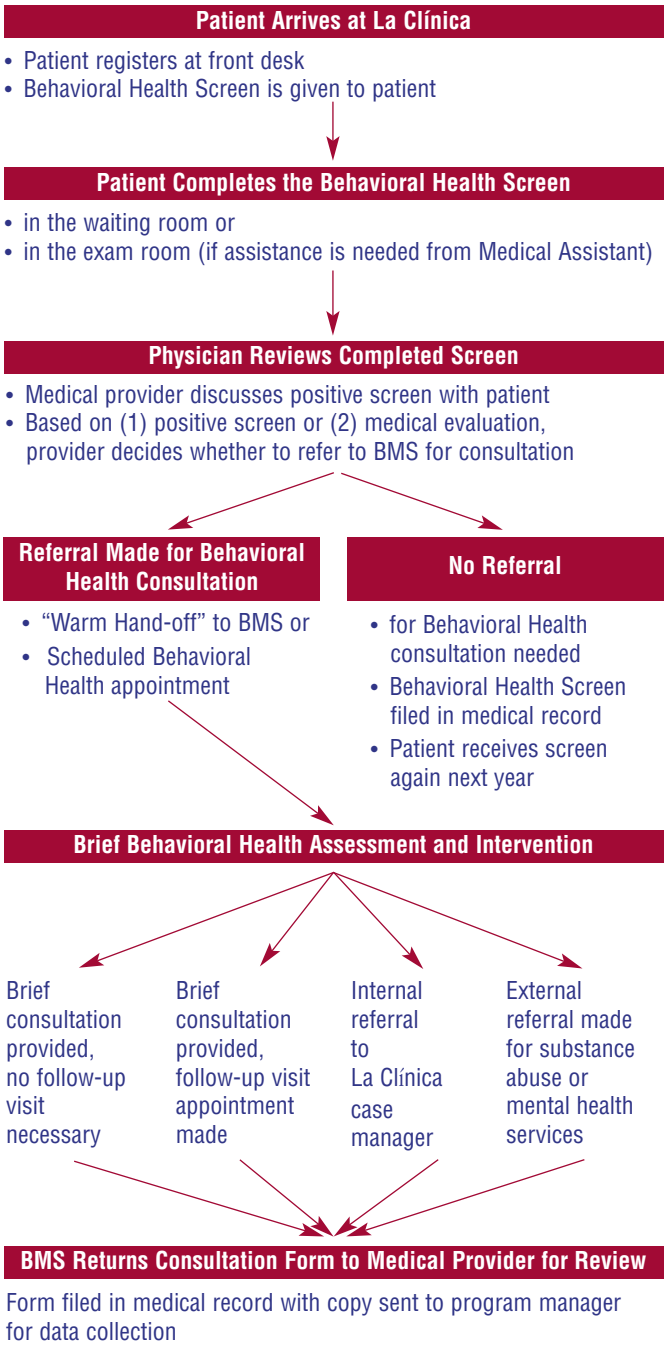
Exhibit One illustrates the process used from patient entry in the clinic through BMS intervention and data entry and follow-up.

Screening and Prevalence of Mental Health Needs

In 2008, 644 patients at Pittsburg and Monument had visits with the BMS. In 2009, the program served 875 patients. The U.S. Department of Health and Human Services' Federal Partners Senior Workgroup on Mental Health recognized La Clínica as a "Best Practice Setting."

The end of 2009 brought the end of John Muir-Mt. Diablo Community Health Fund implementation funding, and the end of Phase One of BHIP. In Phase Two, which a Mental Health Services Act grant through Contra Costa Mental Health will support, La Clínica will use what they learned during the pilot implementation to expand and evolve its service with enhanced screening and interventions, as well as with groups for children, adolescents, adults and seniors.

Exhibit One



Evaluation Results

According to The Avisa Group's evaluation, the Behavioral Health Integration Project successfully improved access to mental health services for La Clínica patients with mild-to-moderate mental health symptoms and reduced symptom severity. Provider satisfaction with the program was high, including increased confidence in helping patients with their mental health symptoms. Interviews with La Clínica staff appeared to confirm those findings and there is considerable enthusiasm for the program.

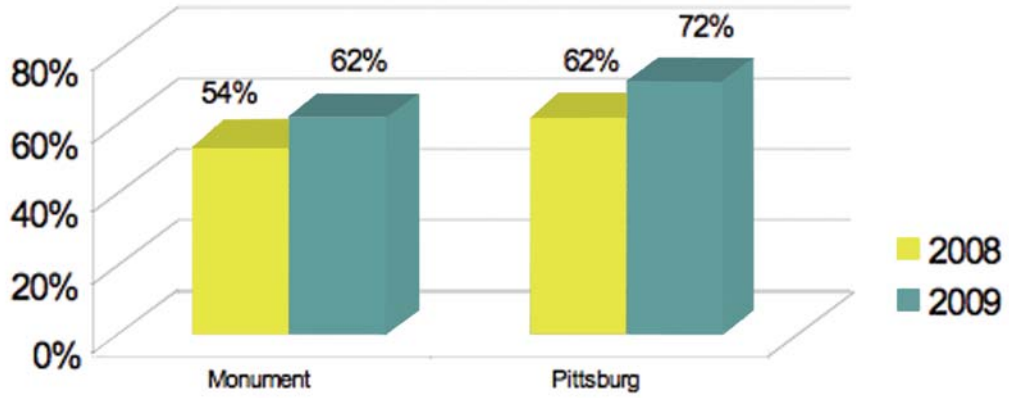
What follows is a snapshot of the key findings for Monument and Pittsburg from the Avisa evaluation, which examined the data from January through October 2009.

Screening and Prevalence of Mental Health Needs

In 2009, 62% of those screened in Monument and 72% of those screened in Pittsburg generated a positive response to at least one of the thirteen clinical screening questions. Of those with a positive response, about 2/3 generated a referral to the BMS. There are several reasons that the other 1/3 of patients did not generate a referral, including assessment by the medical provider that the patient could effectively manage the symptom without consultation, as well as the need for further training of medical providers. The latter is not a surprising finding for a new program, but the goal is to eventually refer close to 100% of those who generate a positive response to a screening question.

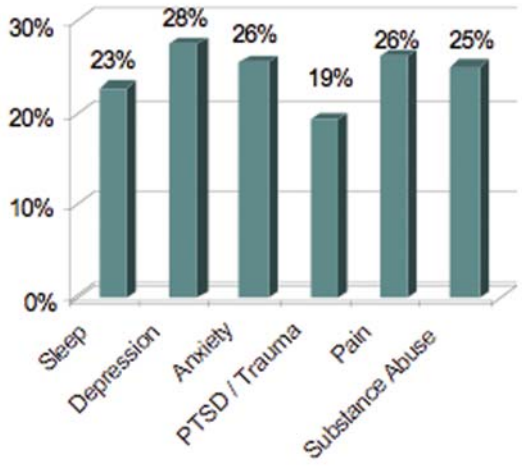
Of all patients screened in 2009 at the Monument and Pittsburg clinics, depression was the most prevalent positive screen (28%), but it was closely followed by anxiety and pain (26% each), substance abuse (25%), sleep disturbance (23%), and trauma symptoms (19%).

Percentage of Positive Screen Results by Site and Year
The percentage of positive results increased in Monument and Pittsburg in 2009. Pittsburg had the highest percentage of positive results, 72%.



2009 Screen Results by Clinical Area
The Behavioral Health Screen succesfully identified significant percentages of patients who experienced behavioral health symptoms.

Monument and Pittsburg



Case Study Number One: Culturally Competent Care

A 32-year-old man was referred to La Clínica from a county emergency room, having been diagnosed as having had a "psychotic" episode, because he spoke of *embrujado*, which literally translates to being bewitched. After a warm hand-off, the BMS evaluated the man and did not find evidence of psychosis, in part because she knew that *embrujado* is a common belief among some Latinos. The BMS offered supportive counseling, referred the patient to county mental health for a full psychiatric evaluation, and scheduled a follow-up visit. At the same time, the medical provider prescribed anti-depressants for his significant depressive symptoms, and the BMS explained their use in a way that made sense to the patient.

The patient did not attend his appointment with county mental health, but did arrive for his follow-up appointment with the BMS, two weeks after the first meeting. In the appointment, the BMS found low-to -moderate depressive symptoms, tied to acculturation challenges; the patient said the anti-depressants had helped ease his depression. The BMS reinforced her prior recommendation that the patient contact county mental health services, provided more supportive counseling, and set-up another appointment to monitor the patient.

Left, Nancy Facher, Integrated Behavioral Health Program Manager
Luzia Camarillo-Daley, Behavioral Medicine Specialist, Pittsburg
Erica Murillo, Medical Assistant, Pittsburg

Case Study Number Two: Rapid Response

A medical provider referred a 14-year-old girl to the BMS, because the girl was distraught after a falling out with her best friend since second grade. Her grades in school had fallen from A's to D's and F's, she had developed migraine headaches, and she reported a deteriorating relationship with her mother.

At her initial appointment, the girl spoke of the social pressures her ruptured friendship was causing. Assessment found moderate depressive symptoms, no suicidal ideation, and relatively low anxiety. After supportive counseling and psycho-education regarding developmental stages and the managing of conflict among friends, the BMS taught the girl some cognitive strategies to overcome the criticism she was hearing from her peers, with the primary goal of reducing her depressive symptoms including improving her self-esteem.

When the girl returned, her depressive symptoms had significantly decreased and her anxiety remained low. Her grades had improved and she appeared happier. The BMS praised the girl for the work she had done implementing the plan, and offered additional cognitive strategies to reduce her worries and improve her relationship with her mother. She told the patient that she was free to return as needed, but the patient was satisfied that, at that moment, she was feeling sufficient improvement and relief.

Left, Marixa Escalante, Medical Assistant, Monument
Leslie Lessenger, Behavioral Medicine Specialist, Monument
Ana Vega, Monument Clinic Manager

Case Study Number Three: Integrated Care

A 41-year-old male complained to his medical provider of stress, anxiety, insomnia, and tearfulness without provocation. He reported a history of depression and anxiety; the physician prescribed an anti-depressant medication and made a warm hand-off to the BMS.

The patient described financial and social stressors (including unemployment) that were leading to increased social withdrawal, fatigue and a depressed mood. A simple assessment tool indicated moderate-to-severe depressive symptoms. The BMS offered possible strategies to reduce the symptoms, and from these, the patient agreed to increase his daily exercise. The BMS also reviewed the effective use of anti-depressants with him.

At a return visit two weeks later, the patient's depressive symptoms had decreased. After discussion about the importance of continuing medication even though his symptoms had begun to improve, the patient agreed to continue the medication until his next medical appointment, to increase his exercise, and to consider volunteer work while seeking full-time employment. After two more weeks, his depressive symptoms had continued to decrease, although he was still having difficulty staying asleep. The BMS taught him specific behaviors that would promote healthy sleep and asked the physician to review the patient's medication. Two weeks later, the patient's depression scores were even lower, his sleep had improved, he had secured temporary employment, and was staying active. The BMS reviewed strategies to maintain his improved mood and functioning, and to prevent relapse.

Clinical Results

Improved Access: "Warm hand-offs" – face-to-face introductions and an initial clinical encounter with the BMS at the time of that medical visit, usually as a precursor to a follow-up visit – virtually eliminated no-shows and ensured more patients received a brief assessment and intervention who otherwise might have gone without. Providers also believe the screening and enhanced awareness among the providers themselves helped identify a broader range of mental health concerns and increased appropriate referrals to medical social workers and specialty mental health providers for patients with more severe symptoms.

Improved Outcomes: Based partly on pre/post scores from assessment tools for anxiety, depression, and insomnia – and partly on patient self-report and clinician assessment – the severity of patient symptoms lessened in response to a brief behavioral intervention with the BMS. As the chart below demonstrates, evaluators found improvements between the first visit and last BMS visit (on average about three visits), including reductions in symptom severity for anxiety, depression and pain.

Anecdotally, behavioral medicine specialists were struck with how quickly patients responded and believe that many of the interventions work well as preventive care by averting patterns that worsen mental and physical health.

Fiscal Results

The absence of baseline measures makes it impossible to accurately compare fiscal outcomes pre- and post-intervention, but the behavioral health screen seems to be a useful tool in predicting high utilizers of expensive medical services; therefore, behavioral health interventions in this population could significantly reduce ER and hospital use, as well as functional limitations that cause people to miss work. In addition, warm hand-offs appeared to virtually eliminate no-shows, which are costly to clinics. Unfortunately, it is very difficult to attribute causality, because there are multiple factors that could have contributed to the no-show rate. Both areas would be good candidates for further research.

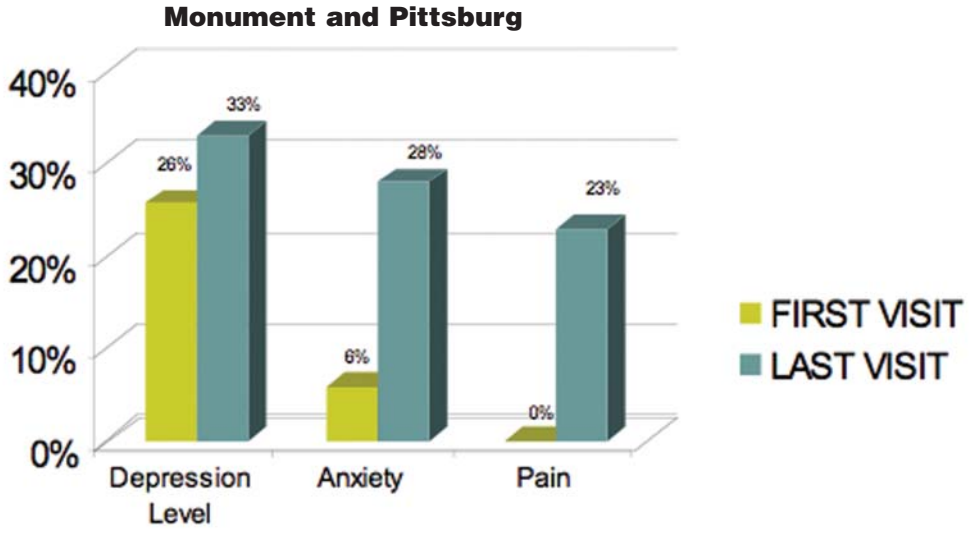
Provider Satisfaction Results

The Avisa evaluation found that BHIP has had a positive and statistically significant effect on provider confidence and satisfaction, with provider satisfaction increasing steadily over the three years of the project.

This was borne out in interviews with providers. Pittsburg Medical Director Gustavo Curbelo, MD noted: "It's a big relief…once it began, we knew we had an option for treatment. It is a help for the patients and for us."

Physician Assistant Lupe Ochoa, said, "I can't picture doing my job without what (BMS) Luzia brings. I call her or speak with her about a patient two to four times a day."

Percentage of Patients with Low Severity of Symptoms at First and Last Visits in 2009
Patients reported a reduction in the severity of their symptoms after consultation from the Behavioral Medicine Specialist.



Continued success depends on careful evaluation of successes and areas for continued development. Below is a compilation of lessons learned from the three-year Behavioral Health Integration pilot.

Conclusion: Lessons Learned and Beyond

Plan and Train: Universally, staff felt having a year to plan was a significant factor in this successful pilot. Training was part of that process and remains a key to success.

Providers need ongoing training in all of the ways that even one consultation with a BMS can benefit their patients. Staff members need ongoing training in a variety of process and communication issues, including: how to recognize all who can benefit; how to discuss behavioral issues with the patients; how to introduce the BMS; and how to speak with patients about follow-up appointments without raising red flags associated with cultural stigma around mental illness. For example, La Clínica trained staff to avoid the word "psychologist" and, instead, to speak with patients about seeing a "specialist" who can help with the patient's specific concern.

Use a Bilingual, Bicultural Clinician, if Possible: Translation should be an option of last resort. When La Clínica moved from a non-Spanish speaking BMS to a bicultural, bilingual BMS in Pittsburg, referrals skyrocketed. The cultural knowledge and direct linguistic access are important factors in high quality patient care.

Patients are Responsive: Despite some concern that Latino patients would not feel comfortable disclosing behavioral issues, most patients have responded well to behavioral health interventions in the primary care setting. This may indicate the level of trust engendered by the providers, as well as the value of this integrated model.

Be Flexible to Accommodate High Patient Volume: Space and time coordination can be difficult. New Behavioral Medicine Specialists start with approximately 10 patients a day, but as they gain experience and familiarity with the model, they eventually can handle up to 18 patients a day. The schedule is challenging and the warm hand-offs also engender a good deal of unpredictability. The BMS must be flexible enough to accommodate the interruptions, as well as varied appointment times and visit lengths.

As for space, freeing up exam rooms for warm hand-offs is difficult because of how it affects patient flow in busy clinics. Both Pittsburg and Monument have found alternatives – such as a Medical Assistant or the BMS walking patients to another office – but this compromises the number and nature of the warm hand-offs that can take place. At Pittsburg, the clinic manager has surrendered her office for the 2 1/2 days a week the BMS is there. At Monument, the BMS does most of her direct work with patients in what used to be a computer closet.

The Medical Assistant Plays a Critical Role: When a clinic has a dedicated medical assistant (MA), the BMS can use his/her time more efficiently, because the MA prepares the charts, administers the screens, calls the primary care providers' attention to positive screening responses, handles all paperwork, moves patients quickly in and out of exam rooms, and makes follow-up appointments.

Be Patient: Despite high levels of provider acceptance and satisfaction and good patient results, there were certainly patients who slipped through the cracks. This is disappointing, but to be expected. After all, change is incremental and this project was a starting point; it takes time to reach the level of integration where all providers are referring for all possible mental health and chronic disease issues.

Reimbursement Restrictions Must Be Overcome: Limits on reimbursement constrain this program from meeting its full potential. Not having a full-time BMS makes it hard to optimize the warm hand-off and can create confusion about patient flow (who goes to the BMS on what days, and to the medical social worker on what days, etc.).

If billing for two services in the same day becomes allowable in California, a program like BHIP could theoretically generate income and be self-sustaining, which could allow for a full-time role if the logistics work. At the moment, however, BHIP must rely on philanthropic or grant support.

Consider the Whole System: True integration depends on the integration of all departments, including Information Technology and Management Information Systems. The support of these departments is critical to the successful delivery of behavioral health services.

Universal Screening Requires Commitment: Universal screening in a fast-paced primary care settings requires a significant investment of time and resources. For example, time spent developing the screening tool was worthwhile, because the tool played a substantial role in helping La Clínica reach one of its key goals: improving access for families in need of mental health services.

Based on the pilot, however, there are aspects of the screening process that require adjustment. For example, patients struggled with the questions on the screen that went beyond selected yes/no or none/sometimes/often/always answers. La Clínica providers also were concerned that the tool seemed to under-identify some mental health problems, especially domestic violence, where the numbers were considerably below national data. In addition, the system occasionally broke down: not all entering patients filled out the form annually and Dr. Curbelo noted that the screen did not always pick up concerns that he knew existed from his knowledge of the patient.

Data Collection Requires Commitment: Data collection and entry proved to be a significant challenge that continues to take substantial time and effort to resolve. The demands of collecting data – both from an efficiency and regulatory standpoint – will only increase, so understanding the challenges ahead of time is critical.

La Clínica staff hoped that entering information on the forms, running them through a scanner, and using Scantron software would enable them to closely and easily track the efficacy of the screening tool, the rate of referrals, and the patients' progress. But this proved to be much more difficult than anticipated. While patient response to yes/no or never/sometimes/often/always was effective, writing numbers into boxes posed a challenge for some. Additionally, computer recognition of handwritten numbers and letters on the screening forms has been inconsistent.

Then there were the logistics. At Pittsburg, initially, the Medical Assistant responsible for entering information and sending it on did not have a desk or computer from which to work. More importantly, merging the behavioral health data stream from the Scantron with La Clínica's practice management system proved to be a challenge. Medical record numbers in the two systems didn't always match, forcing manual links that were both time-consuming and imperfect; this compromised the ability to confidently track patient progress. In addition, the scanner and its software were flawed: the machine would jam or need servicing, or a number would be misread and require correction.

Minimize the Paperwork: Paperwork for those working in primary care should be kept to a minimum. One form that combines the referral, the assessment, the intervention, and feedback to the medical provider seems to work best.

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The Future

La Clínica's securing of a Mental Health Services Act grant through Contra Costa Mental Health enables it to use what it learned during its pilot implementation to expand and evolve the behavioral health integration concept.

In Phase Two, rather than confine itself to adult screening, La Clínica is tailoring its screening processes to five distinct age categories: infants and toddlers (0-5), children (6-12), adolescents (13-17), adults (18-59), and older adults (60 and over), with follow-up assessments and consultations in all of these age categories. In addition, the program is going beyond screening for signs and symptoms of mental illness to also screening for risk factors, such as isolation, cultural adjustment, and parenting problems. Social workers will conduct groups to help patients deal with many of these risk factors. The John Muir-Mt. Diablo Community Health Fund is funding an evaluation of the services La Clínica will provide in 2010.

Beyond the specifics of these implementations, the successful BHIP pilot appears to be on the vanguard of change at La Clínica and beyond. Providers at many other La Clínica sites have asked to have their own version of BHIP. San Francisco County's mental health program is adopting the Strosahl model. Nationally, BHIP seems to be consistent with a strong federal push for more closely coordinated care all along the health care continuum.

Having been given resources by the John Muir-Mt. Diablo Community Health Fund to successfully plan and test the behavioral health integration concept, La Clínica appears well positioned to expand and refine the integrated behavioral health services it provides to its patients.

La Clínica℠

Mission

The mission of La Clínica is to improve the quality of life of the diverse communities we serve by providing culturally appropriate, high quality, and accessible health care for all.

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