

La Clínica de la Raza

Behavioral Health Integration

Five-Year Evaluation



La ClínicaSM

Introduction

In 1971, a group of concerned students, health professionals and community activists came together to establish La Clínica de La Raza (La Clínica) as a volunteer-run free clinic in Oakland, California. Since then, La Clínica has grown into one of the largest community health centers in the state – a sophisticated provider of accessible, high quality and culturally appropriate primary health care and health-related services across 31 locations in Alameda, Contra Costa, and Solano counties.

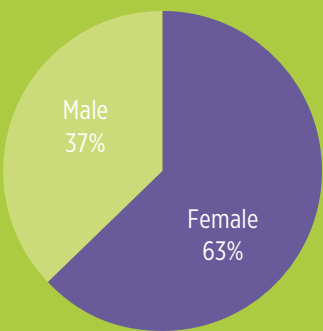
Through its clinics in Pittsburg, Concord (Monument) and Oakley, La Clínica now serves approximately 16,000 Contra Costa County residents each year. It provides a link between those residents and the county’s hospitals and specialty service providers and is uniquely skilled at serving Spanish-speaking, low-income patients, an underserved group that continues to grow rapidly in Contra Costa County

The John Muir-Mt. Diablo Community Health Fund (CHF) has been an essential partner for La Clínica since it arrived in Contra Costa County in 1999. One important piece of support the CHF has provided is for the integration of behavioral health services into primary care.

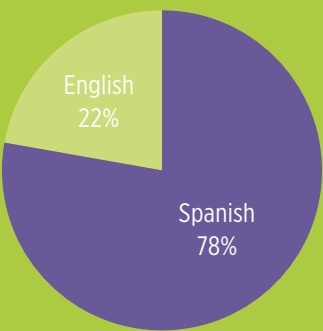
Since 2007, La Clínica has used CHF funding totaling over \$1 million to plan, pilot, evaluate and strengthen behavioral health integration at the Pittsburg and Monument clinics. This effort – originally called the Behavioral Health Integration Project (BHIP) – emerged in response to concerns among La Clínica medical providers that patients with mild to moderate mental health symptoms did not have adequate access to mental health services, which tend to be available only for those with the most severe symptoms.

During Phase One of BHIP, CHF grants supported a planning year and a two-year pilot implementation. In Phase Two, which was funded by a Mental Health Service Act grant through Contra Costa Mental Health, La Clínica expanded on previous adult-only screening to include pediatric, adolescent and geriatric patients. Additionally, during both phases, the CHF funded capacity building to guide and standardize clinical practice, as well as annual evaluations by the Avisa Group – a policy research, evaluation and consulting firm. This report draws on the Avisa Group’s work, background materials and interviews with La Clínica staff and patients.

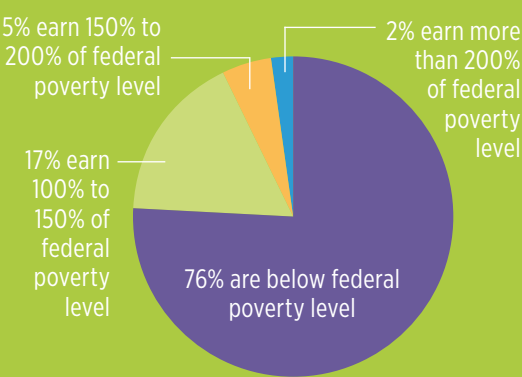
2012 Patient Demographics at Pittsburg and Monument Clinics



GENDER



LANGUAGE



POVERTY LEVEL

Timeline of the Behavioral Health Integration in Contra Costa





What is Behavioral Health Integration?

Behavioral health integration is a team-based, care delivery model where medical and mental health providers partner to identify, intervene and follow-up on psychosocial, mental health, substance use, and psychiatric symptoms in the medical setting. It is a proven model for: identifying behavioral health issues; providing brief, behaviorally oriented interventions that enhance coping for those affected by mild to moderate symptoms and; monitoring stabilized patients with more severe psychiatric disorders. In the integrated behavioral health (IBH) model, behavioral health clinicians also support the medical management of patients with chronic diseases.

Today, in La Clínica’s IBH program, on-site behavioral health providers see conditions that include:

- Depression
- Anxiety
- Parenting concerns
- Relationship problems
- Stress
- Substance abuse
- Chronic pain
- Post-Traumatic Stress Disorder
- Cognitive impairment and dementia
- Attention Deficit Hyperactivity Disorder

The clinicians intervene if they assess the condition as mild to moderate or if a patient has more severe symptoms but is stable enough to be helped within primary care. They refer or link externally for treatment if the patient’s condition is both severe and unstable and requires treatment other than what can be addressed by a series of brief, outpatient visits or ongoing monitoring.

A True Success Story

Much of this report discusses the results and lessons learned over the five years of implementation to date. In brief, the IBH program has:

- Identified behavioral health concerns and improved access to behavioral health services for La Clínica’s patients
- Eased symptoms for many patients with mild to moderate mental health conditions
- Provided psycho-education and skill-building to help patients effectively self-manage their symptoms
- Identified new areas to improve the care and case management of these patients
- Achieved solid levels of staff satisfaction

The evaluations and experience also highlight a number of ongoing challenges, but La Clínica staff believe IBH’s “whole patient approach” helps La Clínica improve the overall health of its patient population. Medical providers have come to rely on the behavioral health perspective to improve their care and appreciate being able to offer their patients the expertise of a behavioral health professional.

Expansion Project/Integrated Behavioral Health and Other Sites



Planning

Planning efforts began with a review of existing research, which confirmed that Latinos do not get their mental health needs met as consistently as Caucasian patients. 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. Behavioral health integration appears to offer Latinos greater access to mental health services, because: 1) Latinos tend to trust and have more access to primary care than to mental health services and 2) many Latinos express emotional distress through physical symptoms, and tend to seek help through primary care.

But a 15-minute primary care (medical) appointment is rarely an adequate mental health solution and it can be difficult to convince patients who struggle with mental health issues to follow up with an unfamiliar mental health provider, particularly if insurance does not cover the follow-up visit. Additionally, due to stigma and cultural bias regarding mental health issues, there is often an unwillingness to acknowledge emotional or mental distress. The research indicated that integrating behavioral health into the primary care setting is one solution. Convinced of the need – and supported by a planning grant from the CHF – La Clínica began exploring how to provide IBH services designed for its unique population.

Choosing the Model

Prior to the BHIP project, La Clínica had relied on case management, medical social work and external specialty mental health services to help a small subset of patients with the most acute mental health needs. La Clínica felt it needed to adopt a “population health” approach, which seeks to reach a broader set of patients along the continuum of severity. Such an approach would also enhance the service medical providers could offer all their patients.

The planning group chose an IBH model that 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 might benefit from behavioral health interventions.
2. An on-site behavioral medicine specialist (BMS), who can be available during primary care visits to provide behavioral health interventions for mild-to-moderate mental health symptoms; this is known as a “warm handoff”. The BMS also provides consultation to the medical provider around mental health diagnoses and is available for follow-up appointments or to make referrals to social workers and specialty mental health providers for additional therapy.

Operational Planning

Once the model was selected, the planning group began speaking with other clinics to better understand the operational challenges of integrating behavioral health services. The group eventually developed an operational flow chart (*See page 7*) and recognized that specific staff training would be essential for a successful implementation.

Goal Selection

La Clínica had to determine on what basis it would evaluate its program. Originally it decided to look at:

Access: Impact on access to mental health services.

Clinical Outcomes: Impact on mental health symptoms.

Fiscal Outcomes: Because billing for a behavioral health visit in the context of a primary care visit is not allowed in California, La Clínica decided to see if IBH could reduce health care costs generally (reduced hospital days, emergency room use, or overuse of medical services), and reduce patient costs (less time away from work and less out-of-pocket costs for self-pay patients).

Provider Satisfaction: Assessment of medical provider’s satisfaction with and confidence in the quality of care they provide their patients.

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 Young, et al, op. cit.

⁴ 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*.

⁵ Escobar, J.I., Hoyo Nervi, C., & Gara, M.A. (2000). Immigration and mental health: Mexican Americans in the United States. *Harvard Review of Psychiatry*.

The Behavioral Health Screening Tool

Though validated screening tools existed, La Clínica needed a broad, bilingual, culturally appropriate tool tailored to its population that would identify patients who might benefit from prevention, early behavioral health interventions and a behavioral health consultation. The screen is not intended for diagnosis, but to identify patients who might benefit from further assessment. As such, the screen needed to be:

- Simple enough for patients to fill out quickly in a busy waiting room
- Robust enough to help medical providers quickly identify a range of mental health concerns
- Usable by patients with low literacy levels
- Offer a reminder for providers to refer for known conditions
- Identify conditions that might not have been identified yet

The original form – developed in Phase One for La Clínica’s adult population (age 18 and above) – contained 13 clinical questions that screen for depression, anxiety, anger, trauma, domestic violence, alcohol/drug abuse, sleep problems, and pain. Three additional questions address emergency room (ER) and hospital utilization as well as functional impairment. During Phase Two (2010-2012), La Clínica adapted this form for a range of pediatric and adolescent patients, as well as for seniors.

TRIAL IN ERROR IN DATA COLLECTION

La Clínica

PATIENT ID CARD
 PATIENT NAME: _____ SEX: M ☐ F ☐
 MR#: _____ DOB: _____
 PRIMARY PROVIDER: _____ DATE: _____

☐ La Clínica Tama Valley ☐ San Antonio Neighborhood Health Center
☐ La Clínica Alta Vista ☐ La Clínica Pinar
☐ La Clínica Valero ☐ La Clínica Monument
☐ La Clínica Grandview ☐ La Clínica School Based Health Center

BEHAVIORAL HEALTH SCREENING FORM MR# _____

	NEVER	SOME-TIMES	A LOT	ALWAYS
1. Over the past two weeks, how often have you had trouble falling asleep, staying asleep, or sleeping too much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Over the past two weeks, how often have you felt little interest or pleasure in doing things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Over the past two weeks, how often have you felt down, depressed or hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Over the past month, how often have you felt anxious, worried or on edge?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Over the past month, how often have you been bothered by disturbing memories, thoughts or images of a stressful experience in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Over the past month, how often were you more angry than you wanted?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Over the past month, how often were you in pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Over the past year, have you ever used drugs or medications other than those required for medical reasons?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
10. Over the past year, have you had four (4) or more drinks on any occasion?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
11. Over the past year, were you ever unable to stop using drugs or alcohol when you wanted to?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
12. Over the past year, have you felt frightened by what your partner says or does?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
13. Over the past year, have you been hit, slapped, kicked or otherwise physically hurt by someone?	<input type="checkbox"/> No	<input type="checkbox"/> 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: () - - - - -
 Signature: _____ Date: _____
☐ RNS Referral ☐ Ref. ☐ Not Needed ☐ Via phone

Green/Chart White/Scantron La Clínica Form 532 (02/06) 278060

La Clínica

PATIENT ID CARD
 PATIENT NAME: _____ SEX: M ☐ F ☐
 MR#: _____ DOB: _____
 PRIMARY PROVIDER: _____ DATE: _____

☐ La Clínica Tama Valley ☐ San Antonio Neighborhood Health Center
☐ La Clínica Alta Vista ☐ La Clínica Pinar
☐ La Clínica Valero ☐ La Clínica Monument
☐ La Clínica Grandview ☐ La Clínica School Based Health Center

BEHAVIORAL HEALTH SCREENING FORM MR# _____

	NEVER	SOME-TIMES	A LOT	ALWAYS
1. Over the past two weeks, how often have you had trouble falling asleep, staying asleep, or sleeping too much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Over the past two weeks, how often have you felt little interest or pleasure in doing things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Over the past two weeks, how often have you felt down, depressed or hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Over the past month, how often have you felt anxious, worried or on edge?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Over the past month, how often have you been bothered by disturbing memories, thoughts or images of a stressful experience in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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13. Over the past year, have you been hit, slapped, kicked or otherwise physically hurt by someone?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		

Over the last three (3) months,
 How many times have you gone to a hospital emergency room for care for yourself? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6+
 How many nights have you spent in the hospital? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6+
 How many days have you been unable to perform your normal activities because of illness, pain or nerves? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6+

For Office Use Only
 Phone Number: () - - - - -
 Signature: _____ Date: _____
☐ RNS Referral ☐ Ref. ☐ Not Needed ☐ Via phone

Green/Chart White/Scantron La Clínica Form 532 (02/11) 278060

Patients were not clear that these boxes were designed to capture two numerical digits:

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? ☐ ☐

Patients found the check boxes to be much easier to use than writing in the numbers themselves:

Over the last three (3) months,

How many times have you gone to a hospital emergency room for care for yourself? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6+
 How many nights have you spent in the hospital? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6+
 How many days have you been unable to perform your normal activities because of illness, pain or nerves? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6+

Implementation

Early implementation began with piloting and revising the adult screening form. The early days also involved a search for licensed, bilingual mental health clinicians willing to work within the integrated model, but such providers are few and far between. Eventually, La Clínica successfully found bilingual psychologists to fill the role in both Contra Costa County clinics and initiated services.

In Phase Two, La Clínica introduced screening forms and interventions for pediatric, adolescent and senior populations, as well as therapeutic groups for specific conditions. In addition, mental health professionals have begun to incorporate more interventions than originally anticipated and to incorporate more flexible appointment times to facilitate longer sessions for geriatric patients and for specific clinical presentations, such as ADHD and chronic pain.



How it Works

When medical providers refer, preferably via a warm handoff during the medical appointment, the Behavioral Medicine Specialist (BMS) conducts a brief assessment. Clinical interventions include teaching patients how to recognize signs of depression, anxiety, substance abuse and other behavioral health conditions and giving them tools 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 during a primary care visit may be shorter. Follow-up visits typically range from 15–30 minutes. Exhibit One illustrates the referral process used from patient entry in the clinic through BMS intervention, data entry and follow-up. After the BMS does a brief assessment, intervention and consultation, if the patient needs a higher level of care or more than 1-3 follow-up sessions, the BMS refers the patient to La Clínica social workers who either provide counseling of longer duration or link the patients to specialty mental health services.

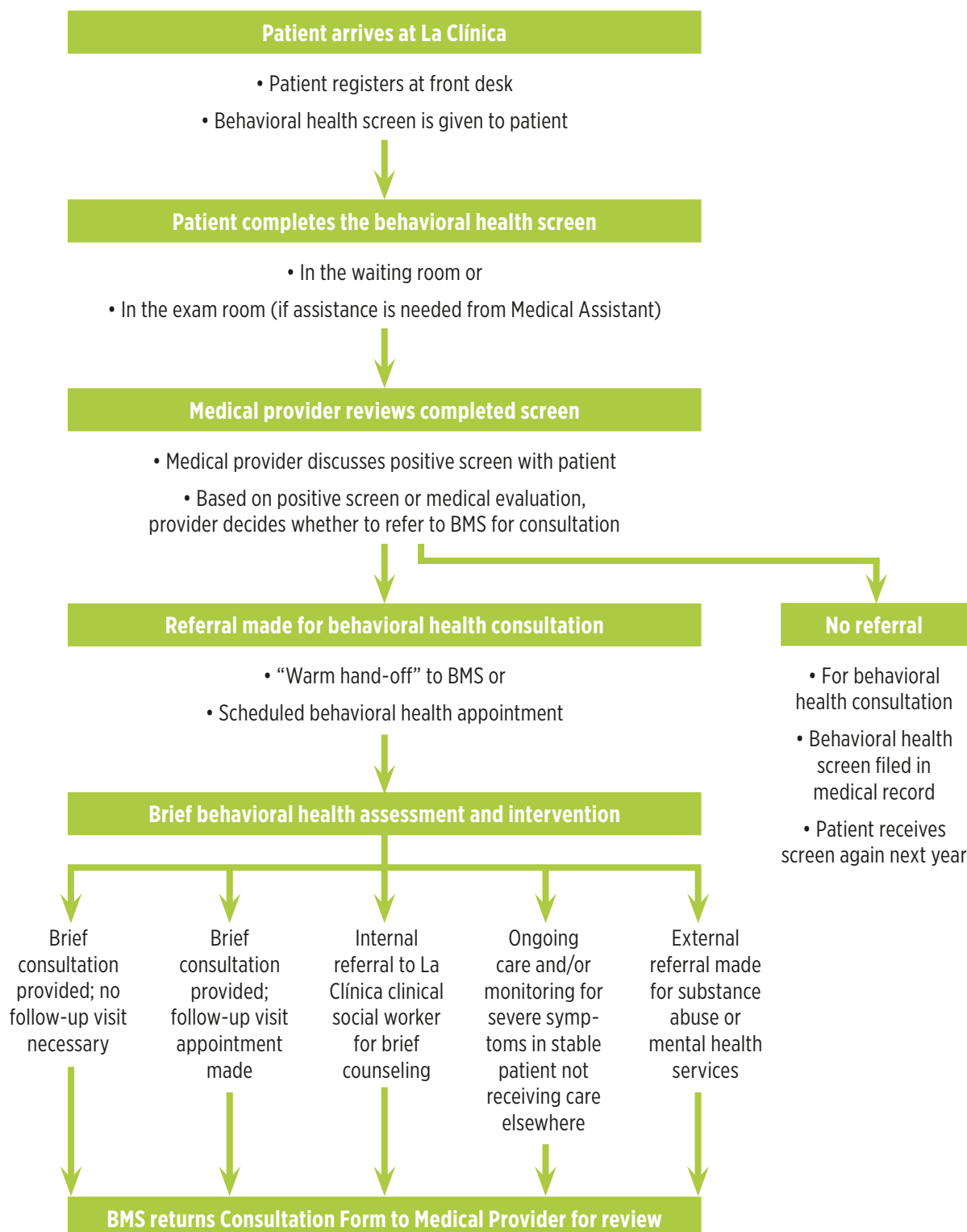
Expanding the Program

At the Pittsburg and Monument clinics, the number of patients screened had jumped from 550 in 2008 to 4,822 in 2012. In addition to identifying and serving increasing numbers of patients and making the screening process more precise by age, La Clínica has expanded the model by:

- Adding a chronic pain group, facilitated by a BMS
- Developing geriatric protocols for identifying and working with those who are experiencing cognitive loss
- Providing groups on topics such as anxiety and depression, mindfulness, grief, and parenting led by social workers
- Piloting an ADHD clinic, which enables the BMS to more efficiently provide assessment and counseling to youth and families affected by ADHD
- Incorporating additional clinical techniques derived from Dialectical Behavior Therapy to expand the range of approaches used in the brief interventions

Funding from the Mental Health Services Act enabled the implementation of these new IBH services.

HOW IT WORKS: FROM WAITING ROOM TO ASSESSMENT



Evaluation Findings

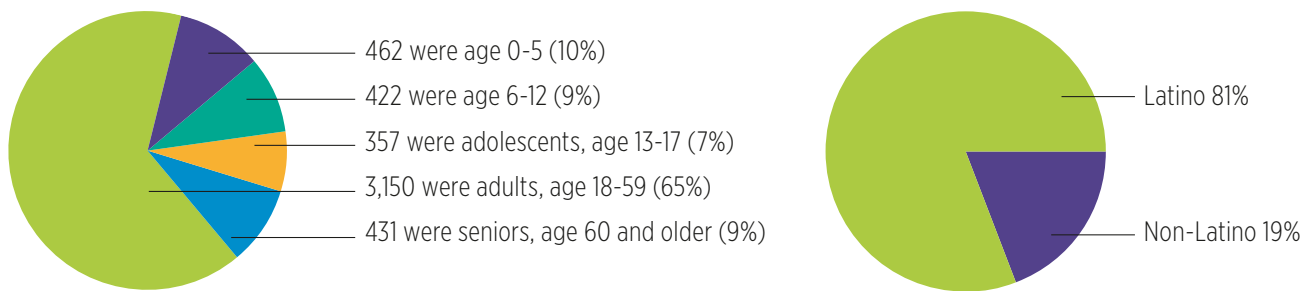
During its first two years of implementation, IBH services successfully improved access to mental health services for La Clínica patients with mild-to-moderate mental health symptoms and reduced symptom severity. The U.S. Department of Health and Human Services' Federal Partners Senior Workgroup on Mental Health recognized La Clínica as a "Best Practice Setting." Provider satisfaction with the program was high, including increased confidence in helping patients with their mental health symptoms.

In the ensuing three years, the program continued to improve access and reduce symptom severity as La Clínica adapted and expanded its IBH screening and interventions. What follows is a snapshot of the key findings from the Avisa evaluations from 2009 - 2012.

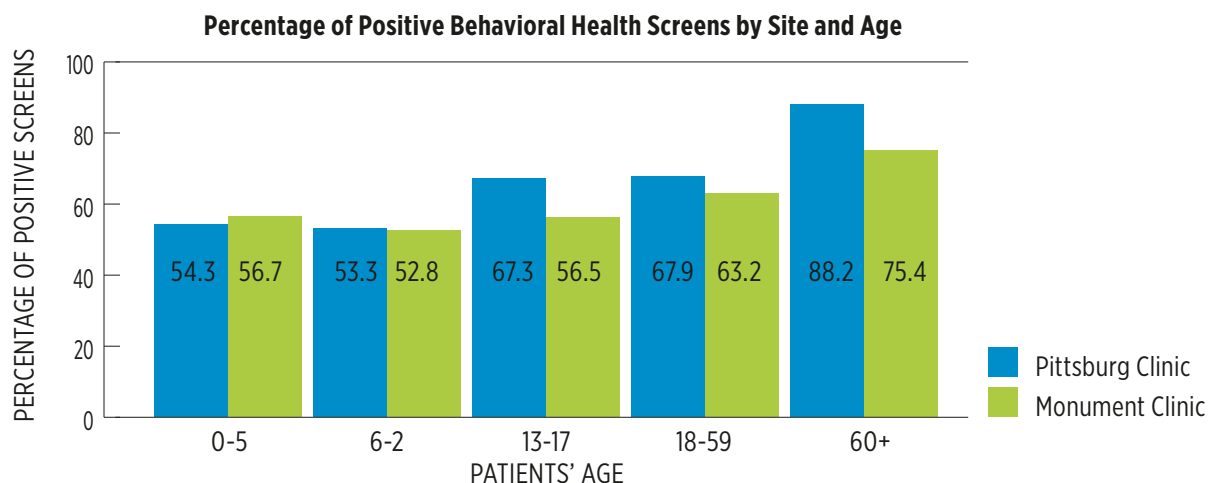


Demographics

Of the 4,822 patients screened in 2012 – the year to date with the highest number of screens administered – 81% were Latino, which mirrors both La Clínica’s patient population and the changing demographics in Contra Costa. 65% were between 18 and 59 years of age.

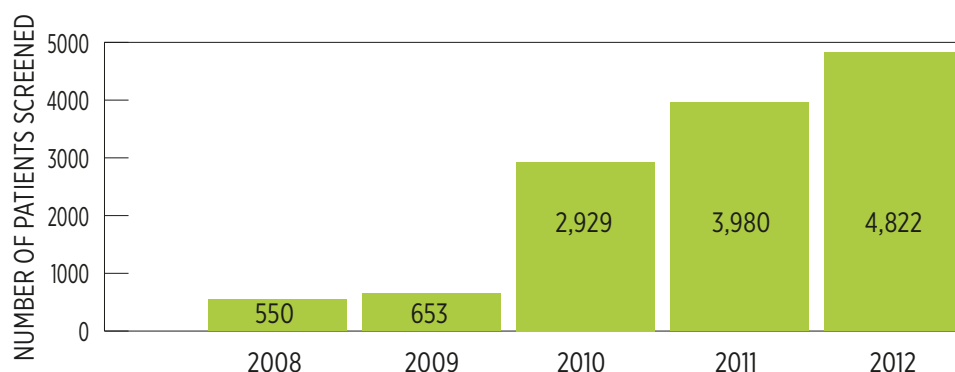


As the figure below makes clear, the screens pick up more behavioral health concerns as patients age.



Access Outcomes

The number of patients screened each year, at each of the two sites has increased steadily:



The Utility of the Screens

The screens proved to be effective in a number of ways.

▶ **The screening questions appear to be sound.** Those who answered yes to one question didn't consistently answer yes to another question, which indicates that each individual question identifies a separate and important behavioral health concern. This confirms the original decision to screen comprehensively – rather than just for depression and anxiety. In addition, answers to screening questions enable La Clínica to effectively track trends over time and to identify areas such as substance abuse that medical providers do not always pick up as part of their regular examination.

▶ **Increased screening and increased availability of the BMS has led to increases in the number of patients receiving brief assessments and interventions.** La Clínica providers can now address a wider array of previously unidentified concerns.

▶ **Screening provides important information about care utilization.** In 2012, patients with a positive screen result were 56% more likely to “No Show” (fail to show up) for their scheduled medical appointment than patients with a negative screen. This delays individual patients' access to medical and behavioral health care, but also affects all of La Clínica's patients, because of the impact no-shows have on scheduling. Thus the screens help La Clínica strategize about how to minimize no-shows over time – and, in turn, further improve the health of its patient population.

▶ **Screening provides important information about differences among clinics, provider practice patterns, and the various age groups.** This information helps La Clínica respond more effectively to patients needs, provide education and information to providers, and more effectively standardize provider practice. They also reveal age-specific concerns, including:

- For children, ages 0-5, parents' most prevalent concern was perceived over-activity. The high positive response rate (30–40%) could indicate a flawed question, but it may also indicate a role for helping parents better understand early child development.
- For children, ages 6-12, over half of parents had a positive response to one or more of the questions. The positive responses, spread fairly evenly among eight questions, indicated a fair degree of concern about all of the topics screened, ranging from anxiety and hyperactivity to behavior problems.
- For adolescents, ages 13-17, the most frequent symptoms experienced were sleep problems, worry, and anger. Between 10 and 20% reported witnessing violence.
- For patients ages 60 and older, the high rates of positive responses to six screening questions heightened awareness among providers to assess for the following conditions:
 - Cognitive impairment/Dementia (42%)
 - Sleep deprivation (40%)
 - Chronic pain (31%)
 - Anxiety (29%)
 - Social isolation (28%)
 - Depression (27%)

Clinical Outcomes

There is both quantitative and anecdotal evidence that the interventions help patients.

In 2012, the Avisa Group studied 610 patient records to understand the interventions' effect on patients with depression and anxiety. Using validated questionnaires to rate depression (PHQ-9) and generalized anxiety (GAD-7) symptoms, 42.3 % of patients with two or more visits had a statistically significant decline in their depression and anxiety scores between their first and last visits – even though most patients had three visits or less.

More generally, BMS Leslie Lessenger, PhD, of the Monument clinic notes, “I’ve been quite amazed at the amount of improvement with some conditions. When patients do what we suggest – which works best when patients hear it from the medical provider and me – they get results and are very appreciative. For example, panic symptoms are very treatable, once patients have the tools.”

“Warm hand-offs have been very helpful,” says BMS Janira Gonzalez-Cunningham, PhD. “One example is when the screen identifies someone as drinking and we do additional screening that identifies likely alcoholism. We then do a brief educational intervention about potential harm to the person’s body from their specific levels of use and use motivational interviewing to encourage the patient to think of his/her own motivation for reducing the use. If the patient is interested in continuing the conversation, we schedule a follow-up appointment. The motivational interviewing has also been helpful for patients with diabetes, depression or those who are having a difficult time adhering to their medication schedule. After discussing the patients’ own unique reasons for taking care of their health, their motivation for self-care increases.”

Staff Satisfaction

During the first two years, the Avisa Group evaluation conducted staff interviews and administered pre/post surveys and found staff satisfaction with the program to be high. No formal measurements have been taken since, but anecdotally, enthusiasm remains.

Chika Akera, MD, the Associate Medical Director at Monument, says, “Having Leslie [Lessenger] there takes one thing off my plate. If I have a patient who has headaches that I believe are from stress, there is someone she can speak with; and Leslie is doing a lot to help collaboratively assess and manage depression patients from the get-go.”

“I like the preventive work that we do,” says Gonzalez-Cunningham. “I like that we provide skills to patients, rather than having them accumulating stress where their mental health gets more compromised.”

Lessenger says: “I like the variety, never knowing what you’ll see next. I also enjoy the collegiality with [medical] providers.”

Fiscal impact

Because it depends on self-reporting – and because finding a format on the screening forms to which patients can accurately respond has been a challenge – assessing fiscal outcomes has remained elusive. There is speculation that because the screens seem to predict high utilizers of expensive medical services, they could significantly reduce ER and hospital use as well as functional limitations that cause people to miss work. But at this point, La Clínica is still revising this aspect of the form to see if it can garner reliable measures that can be fairly attributed to the screening process.

ANXIETY

Case Study

1

SITUATION: The primary care provider referred a 16 year-old Hispanic male to the BMS for “anxiety.” The teen had been out of school for almost three months because of a feeling of a lump in his throat and heart palpitations. His mother accompanied him to the appointment and was very concerned about a summons to the Student Attendance Review Board because of his unexcused absences. The patient denied problems at home or at school and stated a desire to return to school, but the school case manager requested a form from the

primary care provider excusing the patient from school for the rest of the year and enrolling the patient in what is known as the Home and Hospital program.

INTERVENTION: The BMS contacted the school to explain that avoidance of an anxiety-provoking situation will reinforce the maladaptive response. Instead, she instituted cognitive behavioral interventions, including instruction in diaphragmatic breathing, relaxation and monitoring of dysfunctional thoughts. She explained his physical symptoms and the patient agreed to gradual exposure to anxiety-provoking situations. He has been seen weekly for three weeks to monitor his progress.

OUTCOME: The school agreed to allow the patient to attend one low-pressure class for one week, to be increased to two classes after one successful week. He will continue in Home and Hospital as well to make up lost credits. The goal is to return to school full time in the fall and, possibly, to attend summer school.

SUBSTANCE ABUSE

Case Study

2

SITUATION: The screen identified potential alcohol abuse in a 54 year-old Latino male, prompting a warm handoff from the medical provider to the BMS.

INTERVENTION: The BMS implemented a brief intervention based on the widely used approach SBIRT (Screening, Brief Intervention, and Referral to Treatment.) Four follow-up sessions included the use of motivational interviewing and harm reduction strategies, as well as collaboration with the medical provider for ongoing monitoring of the patient.

OUTCOME: The patient decreased his alcohol intake from an average of 13 drinks a day to 2-3 drinks per day, 5 or 6 days per week; the other 1-2 days, he did not drink at all. The patient has scheduled another follow-up appointment with the BMS.

OBESITY

Case Study

3

SITUATION: The medical provider referred a 27 year-old Latina female to the BMS due to obesity and a history of bulimia and anorexia. Binging behaviors included both food and alcohol. There was no history of abuse or trauma, but the patient has been disappointed in not reaching some of her life goals. The diagnosis was mild depression and disordered eating.

INTERVENTION: Patient was seen twice by the BMS. At the first appointment the patient and the BMS explored eating and exercise behavior changes, as well as medication under the medical provider’s supervision. The patient chose to focus on healthy eating. Together they set additional behavioral objectives, including attending Overeaters Anonymous meetings, reducing alcohol consumption, increasing exercise and having the patient make her bed each morning so she would not to return to it, as had been her practice. The second session focused on supporting her healthy choices and identifying and reducing potential barriers to continued improvement.

OUTCOME: Six weeks later, the patient had lost 21 pounds and stated that she felt much better. She had reduced alcohol use to a glass of wine once or twice a week and increased her exercise. She found an app for her phone to track calories and this helped her to stop obsessing about what she eats, but she had not yet attended Overeaters Anonymous. In this case, the team approach addressed a potentially life-threatening condition and minimal interventions were sufficient for the patient to find her own solutions.

Lessons Learned

Continued success depends on careful investigation of what's worked and why, as well as areas for improvement and ongoing development. Below is a compilation of lessons learned in the first six years of IBH services.

Operational Lessons

Plan and train

Universally, staff felt having a year to plan and train was a significant factor in this program's ongoing success. Medical providers need ongoing training in all of the ways that even one consultation with a BMS can benefit their patients. The behavioral medicine specialists need ongoing training in this model and in various therapeutic techniques that can benefit their patients. All staff members need ongoing training on process and communication issues, including how to recognize those who can benefit, and how to best use the interdisciplinary team to reduce behavioral health symptoms.

Reimbursement restrictions must be overcome

Limits on reimbursement that prohibit payment for more than one visit on the same day prevent reimbursement for the warm handoff, which is central to integration. If billing for two services in the same day becomes allowable in California, as it is in many other states, an IBH program could theoretically be self-sustaining. At the moment, however, it continues to rely on philanthropic or grant support.

Be flexible

A fully experienced BMS might see 15-18 patients a day – with a good deal of unpredictability. The BMS must be flexible and accommodate interruptions for warm hand-offs, as well as varied appointment times and visit lengths. Because warm handoffs alone won't fill the BMS schedule, but jam packed appointments won't allow time for warm handoffs, each site has its own balance among the number of providers, the proximity of the BMS to the providers, the number of exam rooms and the no-show rate. "It's a complex equation to optimize visits," says Nancy Facher, LCSW, MPH and Manager of La Clínica's IBH services.

The medical assistant plays a critical role

When a clinic has a dedicated medical assistant (MA) for behavioral health, the BMS can use his/her time more efficiently, because the MA:

- prepares the charts
- ensures the patients receive the Behavioral Health Screens
- calls the primary care providers' attention to positive screening responses
- handles all paperwork
- moves patients quickly in and out of exam rooms
- makes follow-up appointments

Be patient and stay committed

It takes time to reach the level of integration where all providers in a fast-paced primary care setting are referring for all possible mental health and chronic disease issues. Developing an effective screening tool took time and the process requires ongoing monitoring and adjustment as patient needs and provider training changes – and as evaluations find gaps in what the screens pick up. Technology challenges are another concern, especially as La Clínica tries to transfer the screening process to its EHR (Electronic Health Record) implementation.



Consider the whole system

True integration depends on the integration of all departments, including Information Technology (IT) and Management Information Systems (MIS). Both departments have been essential to operations and evaluation. Computer alerts signal that a patient is due for an annual screen. Codes entered into the computer register that the screen has been administered, and allow us to report quarterly on our screening rates. Therefore, all front desk clerks, medical assistants, and both medical and behavioral health providers interact in some way with IT and MIS processes.

Be prepared for the data collection challenge

Originally, gathering and merging data from the patient screens, behavioral health clinician notes and demographic data proved to be a difficult challenge. This compromised the ability to confidently track patient progress. Providers at La Clínica hope the new electronic health record system will provide a better way, but the system will have its own challenges, even as the demands from an efficiency and regulatory standpoint continue to increase.

Clinical Lessons

Continually refine the collaborative relationship with medical providers

Because it is important to standardize care and reduce practice variation, behavioral health providers must work with medical leadership to define and prioritize cases that demand an interdisciplinary approach and create a structure that facilitates such an approach. Among the things to consider:



- Adapting the EHR to accommodate an integrated behavioral health visit
- Clarifying the role of screens in leading to a diagnosis
- Crafting a process for crisis intervention
- Helping medical providers build skills for motivating patients who are reticent about improving their mental and/or physical health
- Teaching the BMS to better understand medical concerns around conditions such as chronic disease and chronic pain
- Helping medical providers discern when a behavioral health intervention can be effective, and when it may be appropriate to begin with behavioral changes rather than medication

None of this is easy. At La Clínica, medical providers have tightly packed, 15-minute appointment schedules throughout the day and confront the system-wide pressures that most health care settings face. This has, at times, complicated the ability to make the best use of IBH. In addition, despite some formal orientation, maintaining awareness of IBH among the medical providers can be as much a function of circumstance as of training.

For example, Lessenger originally had a desk among the medical providers. “This helped us remember to refer; it really helped the idea of a warm handoff,” says

Akera. But when La Clínica Monument hired more medical providers, Akera made the difficult decision to shift Lessenger to another space in the facility.

“When she’s not as visible, warm hand-offs drop,” says Akera, though she notes that other things can counteract that drop, such as when Lessenger switched to a more regular schedule or trying to step out of her office to connect with providers to maintain visibility.

Another issue was the patients’ connection to their primary care provider. “Warm hand-offs are not always simple, because sometimes patients are hesitant to see someone else,” says Akera.

In addition, rather than using the screen as a flag for referral, busy providers typically only refer when they see a patient in obvious distress. Continued training could remind them to also refer for behavioral health interventions that can improve management of diabetes, hypertension, obesity, and chronic pain.

Patients are responsive

Despite some concern that Latino patients would not feel comfortable disclosing behavioral issues, most patients have responded well. This may indicate the level of trust engendered by the medical providers and Spanish-speaking behavioral medicine specialists, as well as the value of this integrated model, especially warm handoffs.

Adapt the model

There is always a difference between theory and practice. Be prepared to adapt the original model to meet realities on the ground as well as changing patient needs and clinic circumstances.

Extension of the model affords more flexibility

For patients who need and want brief counseling rather than consultation, the BMS collaborates with social workers to determine which patients are ready to engage in brief therapy and where that therapy would be most appropriate: individual, group or family therapy with the on-site social worker or through an external referral to specialty care.

Establish brief therapy groups

Groups with a psycho-educational focus build skills and support effective coping, thus enabling La Clínica to serve a much larger segment of its population. Equally important, the groups have been effective at reducing symptoms for a range of conditions.

Make psychiatric consultation available

Primary care is now expected to provide basic psychotropic medication for behavioral health conditions, but this can get complicated. A patient might not respond to medication as expected or a new patient might have a history of multiple behavioral health medications; patients experience side effects or have multiple medical and behavioral health conditions. In these circumstances, primary care providers may need access to a psychiatric consultation to guide their prescribing.

Newly hired behavioral medicine specialists need additional training on the integrated model

In order to enable even highly trained clinicians to work in the fast-paced primary care setting – and to help them handle the vast range of clinical content while managing challenging and often unpredictable schedules and visit lengths – additional clinical training is usually necessary.





Future Directions

In the era of health care reform, clinical coordination is emerging as an important priority; concepts like patient-centered medical homes and accountable care organizations demand close links between all elements of care that patients receive.

La Clínica's IBH approach is a good example of how the linking of services can improve overall care quality and efficiency. It also fits neatly with another central reform component: an emphasis on preventive care including new mandates about screening patients for behavioral health issues. Moreover, La Clínica has the advantage of five years of experience and an evaluation process that has concentrated the organization's attention on areas for future improvement.

With this in mind, La Clínica will continue to examine ways to expand its screening to improve access for all patients. One idea is to employ the screens in La Clínica's dental clinics, but this will depend to some degree on La Clínica's ability to successfully incorporate an integrated behavioral health visit into its new EHR system.

La Clínica will also look to ensure its clinical approach continues to meet patient needs by constantly striving to strike the proper balance between brief interventions, more concentrated in-house interventions and referrals to external providers. Facher (Manager of IBH Services) believes one clear area of expansion is providing trauma informed care, as trauma affects many of the other diagnoses, and is an area for further development of primary care based interventions.

Coordination and standardizing practice with medical providers also will be part of an ongoing improvement effort. For example, La Clínica will seek to standardize interdisciplinary protocols for identified conditions, including standardizing prescription practices for conditions that require medication. But beyond medication, standardizing what it means to be an integrated behavioral health clinician will be important: can the organization articulate valid protocols for managing all of the different presentations, in the context of the various types of behavioral health visits, which could range from 10 – 30 minutes or more?

In addition, La Clínica is striving to find the balance between population health approaches versus more intensive services for those with complex presentations or those who are high users of primary care and who are not being served in specialty mental health and substance use programs.

La Clínica is also transitioning to "team-based care" that brings together medical and behavioral health providers, health educators, medical assistants and panel managers to efficiently manage the health of the entire patient population. Given limited resources and great patient need, La Clínica has to calculate staffing ratios by answering the challenging question: how many behavioral health professionals are needed to provide high quality primary care at the lowest cost?

This evaluation highlights the rich rewards of the integrated model – and the expansion to teams – but it also points out the need for ongoing interdisciplinary training and program development. Ultimately, IBH is most effective when it is truly an interdisciplinary approach to managing diverse needs and complex patients. The more medical providers and behavioral health clinicians work together, the more successful the IBH approach is likely to be at optimizing the health and wellbeing of La Clínica's patients. ■

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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