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Poster Abstract

When the Shrink moves in with your Family Doctor – Benefits and Challenges

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Abstract

Introduction: The integration of primary care and behavioral health consists of unique multifactorial challenges and successes, which will be discussed using the example of the Integrated Behavioral Health (IBH) Clinic at Asian Americans for Community Involvement (AACI) in San Jose, California. AACI is a community-based organization that focuses on the health and wellness of predominantly Asian American and non-Asian ethnic populations. Historically, stigma towards psychological services, along with other factors, prevented Asian Americans from seeking help. Despite cultural challenges, integrated care for patients at AACI enabled patients to receive patient-centered and holistic treatment.

Practice change implementation and timeline: The IBH program was launched in June 2012. Changes included the use of shared electronic health records across health professionals, and implementation of integrated care (2012-present) includes four phases: preparation, pre-implementation, implementation post-implementation/optimization.

The PHQ-2 was implemented during medical visits and administered on an annual basis to screen and detect depression in patients. When mood symptoms are suspected, patients are referred to the IBH team, where they receive services including treatment from the evidenced-based, culturally adapted IMPACT model and other effective interventions.

The PHQ-9 and GAD-7 measures are administered weekly during psychotherapy appointments to track their depression and anxiety respectively. The referral/"warm handoff" process from physicians to psychologists facilitates the treatment and helps to reduce stigma for patients. Interdisciplinary staff discusses pertinent clinic updates through daily morning huddles as well as regular provider meetings. The IBH team consults with the physicians and consulting psychiatrist on a frequent basis, along with conducting patient maintenance calls, home visits, and community outreach.

Highlights: The integrated program has shown effectiveness in behavioral health treatment and patient engagement. Over 83% of our patients who completed short-term therapy reduced their depressive symptoms by at least half (average 70% reduction). Over 71% of patients achieved 50% or more reduction in anxiety symptoms (average 62% reduction). Patients reported

improvements in at least two areas of functioning after treatment. These results are significantly better than that of a similar treatment offered at a non-integrated mental health setting at AACI. Also, 80% of the referred patients from primary care accepted treatment compared to 50% acceptance rate in a similar IBH program in the community serving a primarily Latino population. The no show rate is also less than 15% compared to an average of 30% no show rate among community mental health centers.

In addition, our joint medical-behavioral health group visits reflected a higher degree of clinical collaboration. Group topics included self-management of patients' chronic health conditions. Groups are co-led by Psychologists and a Physician, and guest speakers (e.g. dietician, patient navigator). The integration of patient navigators at AACI has been a positive asset to help patients navigate the complicated U.S. healthcare system.

Conclusions: True integration and collaboration often comes with challenges that take a few years to overcome. AACI has shown significant progression in advocating for and implementing integrated healthcare services. In summary, besides clear methodologies of implementation, a smooth integration requires organizational support at all levels and consideration of cultural factors, since "culture eats strategy for breakfast".

Discussion: The purpose and effectiveness of integrated care has been increasingly researched and documented to support the triple aim of America's healthcare reform – improving population health, enhancing the consumer experience of care, and reducing the per capita cost of care. Well-established models of integration such as IMPACT make it transferable and adaptable to clinics in different settings. AACI has adapted the IMPACT model to better fit the primarily Asian American population and achieved satisfactory results. Financial sustainability may be challenging due to enabling services provided in integrated care that is not billable until the new payment model is established in 2016.

Lessons Learned and Future Directions:
Human side of change
Primary care physicians and mental health providers come from different work subcultures and therefore integration requires training and adaptation for both parties.

Data: In order to get buy-in from both the medical and mental health side, ability to show the mind-body connection through collection of both biomarkers and mental health outcomes will be helpful.

Systems: Electronic health records need to include more user-friendly behavioral health measures for easier reporting of relevant outcomes; and billing practices need to re-examined to catch up with clinical practices, such as allowing reimbursement for "same day visits" for medical and behavioral health services.

Integrated care can be extended to include substance abuse screening and early intervention It is AACI's plan to advance to being a truly integrated health provider—an effective "one-stop shop", patient-centered Health Home.

Keywords

integrated behavioral health; primary care behavioral health integration; integrated care; primary care psychology

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PowerPoint presentation

http://integratedcarefoundation.org/resource/icic15-presentations