Integrating Behavioral Health and Primary Care at Three Academic Safety-net Clinics

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Mental illness and substance use disorders are common and primary care providers (PCPs) often encounter them in practice.1,2,3 Many PCPs in national surveys cite lack of access to mental health and substance use services, and shortage of behavioral health providers, as barriers to providing their patients with optimal care.2, 3 Collaborative care models are designed to overcome these barriers.4,5 These models consist of interventions that use non-physician mental health providers working closely with PCPs and psychiatrists in collaborative, co-located and integrated teams.4,5 The aim of this article is to describe three examples of integrated behavioral health teams in academic primary care settings in different geographical locations and highlight their challenges and successes.

First, the Internal Medicine Associates (IMA) Practice at Mount Sinai Hospital in New York City is an academic practice with more than 170 providers treating more than 18,000 underserved patients. IMA’s Integrated Behavioral Health Primary Care Program (IBHPCP) features universal screening for depression, alcohol, and substance use; advanced training in mental health and substance use for providers; embedded mental health providers; and, close partnerships with social work care coordination. Medical assistants screen patients annually for depression and substance use during triage. For a positive screen, the patient completes a PHQ-9, AUDIT-C or DAST-10 questionnaire. As appropriate, the PCP places a consult to the behavioral health team (for mental health) or to the social work team (for substance use). Depression Care Managers (DCM-licensed masters social workers) conduct real-time warm handoffs or will call the patient within the week for triage to one of the following services. Patients with depression and a PHQ-9 score >9 are enrolled in the depression care program, in which the DCMs provide short-term psychotherapy. Patients in need of medication management for depression or anxiety are seen by PGY2 medicine residents in the IMA Mental Health Evaluation Clinic. Patients with refractory depression or other complex mental illnesses see the integrated psychiatrist for consultation and may be referred to the psychiatry social worker (PSW) for psychotherapy. Patients with substance use disorders see social work for referral to an outside treatment program. The IBHPCP team meets weekly to review workflows and caseloads, and to develop treatment plans and coordinate outside referrals.

IMA’s IBHPCP team includes two DCMs (2 FTE [0.55 FTE/5,000 patients]), one PSW (1 FTE [0.3FTE/5,000 patients]), one consulting psychiatrist (1FTE [0.3FTE/5,000 patients]), one administrative coordinator (1 FTE), one physician champion (0.2 FTE), and two medical directors (one psychiatrist and one internist 0.1 FTE each). The psychiatrist and PSW are funded by the department of psychiatry and the other team members are supported by a state-funded program through 2019. In addition, the DCMs receive a per-patient per-month rate from New York State Medicaid via a new collaborative care billing program.

Challenges for IMA include patient adherence with appointments (no show rates vary from 20-50 percent) and medications and provider confusion about the different services. Communication between the PCP and the behavioral health provider is sometimes delayed or missed because resident providers are not in clinic every week. Successes of the IBHPCP include increased PCP awareness and referrals to the programs. Patient engagement and response to treatment has improved for the DCMs by establishing a standard therapeutic protocol involving more warm-handoffs, increased frequency of patient appointments and clearly defined goals for each session. Early data show that disenrollment from the program due to no shows dropped by 50 percent and quarterly improvement rates of PHQ-9 scores went from 31 percent (2015) to 49 percent (2016).
Second, Cambridge Health Alliance (CHA), a safety-net network of primary care clinics in the Boston area serving more than 100,000 patients, has implemented a program of primary care and behavioral health integration (PC/BHI) that includes universal screening, mental health (MH) specialists embedded within primary care (PC) teams, and proactive outreach using disease-based registries. Every adult patient is screened annually for key targeted conditions using validated screening tools for depression, unhealthy alcohol drinking, and illicit drug use at the beginning of a visit by a medical assistant; when the PCP enters the room, they review the collected data and address identified issues.

New team members at the PC sites are key to the PC/BHI implementation at CHA. The new staff consists of a consult/liaison psychiatrist (0.2FTE/5,000 patients), a therapist (0.75FTE/5,000 patients), and a mental health “care partner” (0.5FTE/5,000 patients; an unlicensed bachelor’s or master’s level professional). The integrated psychiatrist and therapist see patients with mild-moderate symptoms for whom short/moderate-term treatment is warranted, while the care partner performs a variety of roles, including health behavior counseling/coaching (e.g., smoking cessation), care coordination/navigation (for patients with mental health concerns), and proactive outreach for patients with depression. The integrated therapists and care partners have time available for “warm handoffs” for patients in need. The care partner reviews challenging cases with the clinic’s integrated psychiatrist and then feeds information back to the PC team—adding to clinic-wide learning while directly helping patients.

At CHA, the most significant problems relate to screening processes and workforce. Building new routines into clinic workflow has been challenging and has required multiple rounds of training and supervision at every site. The care partners, whose efforts are central to ensuring buy-in from primary care staff and filling gaps in patient care, provide services which are unbillable; thus, significant institutional commitment and vision is essential for sustainability. CHA is optimistic that this system will improve patient care in a cost-effective manner; early results show promising effects on local collaborative system functioning and PCPs’ knowledge about local MH/SU care.

Third, UNC Internal Medicine’s Ambulatory Care Center Practice (UNC IM) is a hospital-based, safety-net academic primary care clinic in North Carolina. More than 100 providers and many staff care for more than 12,000 underserved patients per year. Since 2008, UNC IM has integrated mental health into its primary care setting via screening, treatment algorithms and a depression care program. Screening began first in people with diabetes and then extended to all new patients with annual rescreening. Licensed practical nurses (LPNs) and Medical Assistants (MAs) administer the PHQ2 and PHQ9 and clinicians initiate algorithm-based care which includes medication management and, as needed, referral to the LCSW DCM (1 FTE [0.4 FTE/5,000 patients]) and/or medication or diagnostic assistance from our onsite psychiatrist (0.1 FTE [0.04 FTE/5,000 patients]) who bill for their services. Patients with severe depression (PHQ9>15) return at 1-month intervals and with moderate depression (PHQ9>9) return at 3-month intervals to their provider until their PHQ9 scores improve through medication adjustment, counseling referral and support. Pre-health profession college graduate “care assistants,” funded by UNC’s Chronic Care Management program (CCM), extend our care by interval phone calls to severe patients to troubleshoot issues associated with medication adherence and facilitate follow up appointments. Residents, attendings, and staff receive annual case-based training on depression screening and treatment algorithms, suicide assessments and anxiety inquiry and treatment algorithms. The UNC IM clinic uses a PHQ “10” in which a follow up question about active suicidal ideation is asked if question 9 (suicide) is positive. The P4 Suicidality Screener is used to further clarify and assess suicidality risk and initiate protocols for determining the need for hospitalization. Residents have contributed via...
ity improvement projects to enhance our algorithms. In addition, the team incorporated a similar process for anxiety care using the GAD7 as a screening tool, now in its second year. Medications are offered by PCPs and patients may be referred to the LCSW for Cognitive Behavioral Therapy and Mind Body Skills training. This year UNC IM added annual screening for alcohol misuse with the AUDIT and associated algorithms for counseling, medication and referrals for substance care.

Initial challenges for UNC IM’s program were provider discomfort and lack of knowledge about providing mental health care. However, providers now feel confident after training. Other challenges include longer than optimal wait times for counseling and psychiatry, finding affordable, long-term psychotherapy for patients in need and making sure that suicide assessments are completed. Another challenge is that despite enhanced teaching, providers still struggle to transition patients from benzodiazepines to safer anti-anxiety medications. Some successes include the use of pre-health profession care assistants, which has greatly aided in entering the PHQ9s and GAD7s into the electronic health record as well as performing phone follow-up for severely depressed patients and for those with missing data. In addition, more than 50 percent of patients diagnosed with depression experience a drop of 5 or more points on the PHQ9 at minimal cost per patient. In fact, UNC Physician Associates incorporated UNC IM’s model of Depression Care and spread it throughout the health system.

As highlighted above, three unique health systems in varying regions of the United States demonstrate that integrating behavioral health services into primary care settings is a feasible and effective way to increase access to mental health and substance use care for patients. Key components for success are universal screening for mental illness and substance use disorders, co-located and collaborative mental health providers, use of care extenders for care delivery, a team approach to care, and an algorithmic, stepped approach to behavioral health treatments. Challenges include designing screening protocols, inconsistent communication between providers, variable adherence rates, long wait times and variable provider comfort with mental health treatments. Despite the challenges faced, patients in these integrated programs receive improved access to behavioral health services and very effective, efficient, and coordinated mental health care.

References