Integrating Behavioral Health at Bread for the City Primary Care Clinic:

A one year snapshot of the "warm hand-off" model and its impact on patient care

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Why Integrate Behavioral Health in Primary Care?

In September 2013, Bread for the City launched an integrated behavioral health program to address the estimated 14% of patients in need of behavioral health treatment.[1] In addition, the medical clinic wanted to introduce more focused behavioral health interventions to patients with chronic, unmanaged diseases such as Diabetes. By imbedding a full-time behavioral health specialist who was available to meet with patients immediately following their primary care visit, Bread for the City hoped to:

- Reduce barriers to accessing mental health care by confering the rapport established with the provider and meeting patients when they are most motivated to seek support;
- Reduce stigma associated with mental health care;
- Address the barriers of transportation, long waiting lists, and lack of appropriate behavioral health services within the community;
- Improve overall quality of care and health outcomes among patients; and
- Increase the efficiency of primary care providers.

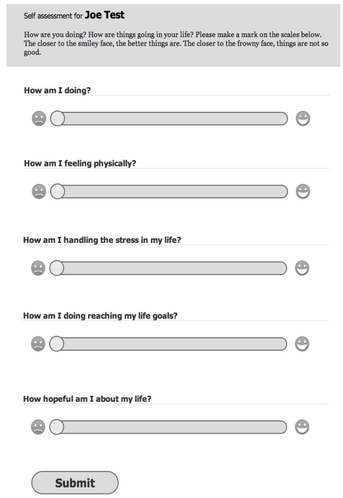
Warm Hand-Off[1] Integration Model

- One full-time behavioral health specialist to four full-time medical providers and 18 volunteers.
- Referred patients through "warm hand-off" from provider and meet immediately after primary care appointment.
- Collaborate with providers to recognize, manage, and treat patients' chronic behavioral health conditions.
- Use short (20-40 minute), solution-focused interventions that include clinical assessment, non-stigmatizing psycho-education, CBT, MI, and Mindfulness-based coping strategies.
- When appropriate, link patients to specialty mental health care, substance abuse treatment, social services case managment, etc.
- **Cost 3% of total medical clinic budget in FY14.**

1 In the "warm hand-off" model the primary care provider directly introduces the client to the behavioral health provider at the time of the client's medical visit. Many clinicians report that this face-to-face introduction helps ensure that the next appointment will be kept. Many models can be found at SAMHSA: http://pcwp.integration.samhsa.gov/integrated_care_models/behavioral_health_in_primary_care

1 Estimate is based on a 2012 qualitative needs assessment conducted among Bread for the City primary care providers.

Patient-Centered Outcome Assessment Tool



On their second visit with the behavioral health specialist, patients were asked to answer five Likert scale questions on a touch screen computer.

Bread for the City chose to use this ORS-based measurement tool[1] because tested measurements like the PHQ-9, DUKE or GAD-7 presented challenges among patients with low literacy skills, and failed to capture smaller, incremental measurements of symptom change over time.

The assessment tool was offered in English and in Spanish.

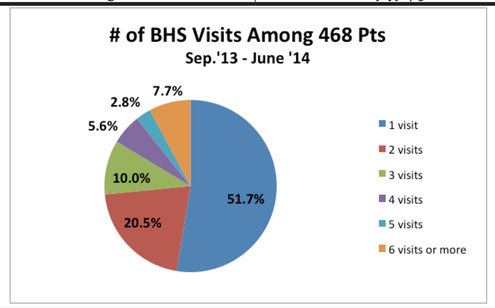
1 Tool is based on Scott. Miller's Outcome Rating Scale (ORS), a simple, four-item visual analog scale designed to assess areas of lifefunctioning known to change as a result of therapeutic intervention. http://scottdmiller.com/wp-content/uploads/documents/OutcomeRatingScale-JBT-v2n2.pdf

Integration Results

From September 2013 to June 2014, the behavioral health specialist treated **464 unique patients through 1,073 total patient visits.** During the same time, the clinic provided care to 2,886 unique patients through 13,260 patient visits.

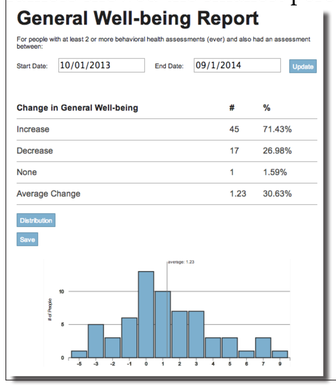
Nearly one in five (17.6%) of all patients seen in the clinic had a visit with the behavioral health specialist. During the same time, the medical director was able to increase quantity of unique Pt. visits by 8.8%, possibly as a result of increased clinic efficiency.

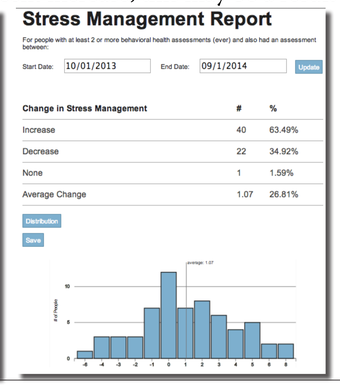
# of BH Visits	Percentage (of 464 Pts)
1	51.7%
2	20.5%
3	10.0%
4	5.6%
5	2.8%
6	7.7%

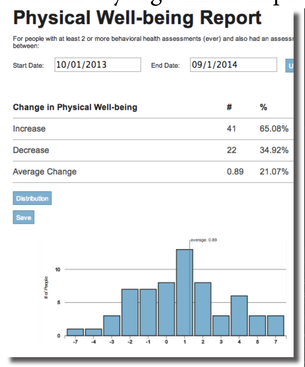


Patient Self Assessment Outcomes

Among the 27.8% of patients seen three or more times (130 patients), we captured 63 patient self assessments. Of those 63 patients, a majority reported improvements in each of the five areas tested. Notably, patient self-assessment of hopefulness showed the smallest percent increase; this may be a result of relatively high initial hope self assessment scores.







Assessment	% Increase
Overall Wellbeing	30.63%
Physical Wellbeing	21.07%
Stress Management	26.81%
Reach Life Goals	23.12%
Hopefulness	5.82%

Assessment	% Pts. Improved	% Pts. Worse
Overall	71.43%	26.98%
Physical	65.08%	34.92%
Stress	63.49%	34.92%
Life Goals	66.67%	31.75%
Hopefulness	57.14%	39.68%

Note: the 39.68% of patients who reported a decrease in hopefulness, reported an average 22.7% decrease after three or more BH visits. It is possible that as patients build trust with the behavioral health specialist, they provide a more honest assessment of their hope levels—explaining the decrease in scores among some patients.

Patient Presenting Concerns Sep. '13 to Jun. '14

Based on a collaborative assessment by the provider and the behavioral health specialist, patients presented with a broad range of behavioral health issues. Nearly one in five patients (19%) presented with a complex mental health diagnoses, such as personality disorder, complex trauma, Bipolar Disorder, Schizophrenia and TBI.) Nearly one in five (18.2%) of patients presented with Depression, 12.5% of patients presented with Anxiety; and 7.4% of patients presented with primarily a need for social services case management. A smaller, but significant percentage of patients presented with concerns about weight management, substance abuse, insomnia, smoking cessation, Diabetes & chronic pain.

Presenting Concern	# of Pts	%
Complex Mental Health Dx (complex trauma, personality disorder, Bipolar, Schizophrenia, TBI, etc.)	90	19%
Depression	86	18.2%
Anxiety	59	12.5%
Social Services Case Management, along with mental health Dx	42	8.9%
Social Services Case Management Only	35	7.4%
Weight Management	27	5.7%
Stress/Coping (Adjustment Disorder)	22	4.7%
Susbtance Abuse	17	3.6%
Insomnia	16	3.4%
Smoking Cessation	16	3.4%
Diabetes II	15	3.2%
PTSD (recent trauma)	15	3.2%
Chronic Pain	13	2.7%
Domestic Violence / Family Conflict	9	1.9%
Alcoholism	8	1.7%
Life Goals	3	0.6%

Conclusion and Next Steps for FY15

One year after launching the behavioral health integration program, Bread for the City surpassed its goal of helping the estimated 14% of patients in need of behavioral health treatment, and reached nearly one in five (17.6%) of all patients seen in the clinic. Based on the initial data gathered, we will prioritize the following program improvement areas in FY15:

1. **Address the 19% of patients who present with complex mental health diagnoses.** including personality disorders, complex trauma, Bipolar Disorder, Schizophrenia and TBI. Among these patients, we will track attempts made to connect them to specialty mental health care, the rates of patients in this category that refuse to connect or are unsuccessful at connecting, and the types of interventions attempted and their outcomes.
2. **Improve delivery of the assessment measurement tool.** The fact that the assessment tool was given to just 48.46% of eligible patients suggests that tweaks must be made to improve speed and ease of delivery. At the same time, we acknowledge that this finding points to the challenge of administering the assessment tool within the fast-paced primary care setting. While we continue to utilize the tool, we remain cautious about its ability to assess overall benefits of behavioral health services and will intrododuce additional assessment measurements, including the PHQ-9.
3. **Track specific behavioral health interventions and outcomes.** We will track specific interventions (including CBT, DBT, MI and Mindfulness-based strategies) used on patients with various presenting concerns and assess symptom improvement.