A Journey Toward Full Integration: The Abbottsford Falls Community Health Center

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1992: A Commitment to Behavioral Health from the Start. The Family Practice and Counseling Network's (FPCN) Abbottsford Falls community health center, a public housing-based federally qualified health center (FQHC), opened for business in July 1992. It was nestled in the center of the Abbottsford public housing development, where it occupied an area formerly known as "Piper's Row" for its infestation of drugs and drug dealers. Among the health center's 11 staff was a psychologist, a South African woman, who manifested behaviors that exemplified her belief in the need for strong community connections. She was the first person to be hired, evidence of the director's commitment to behavioral health (BH) care. The director believed that people did not have the resources to tend to their personal medical needs or to their families if they were depressed, substance abusers or afflicted with a mental illness. Furthermore, the rates of trauma, substance abuse and mental illness were disproportionately high among residents of public housing communities. A strong and

supportive relationship was built between the center's psychologist and the community. A drug and alcohol support group met weekly. By the second year, the center held two licenses from the state Office of Mental Health and Drugs and Alcohol. Care provided by a part-time psychiatrist augmented the department.

1994–2000. The Growth of Outpatient Behavioral Health Services. As FPCN's health centers grew to serve more people, so did the size and complexity of the outpatient behavioral health department, which currently serves over 700 patients. The relentless waiting list compelled FPCN to continue to hire more clinical staff. Today, there are 20 licensed therapists in the three Philadelphia sites. Long waiting lists meant long waiting periods for patients as they treaded water or deteriorated before they could receive attention for their behavioral health needs. Long wait lists also frustrated the primary care providers (PCPs), who longed to see their patients served. The frustration grew to a point of tension between PCPs and their mental health clinical counterparts. They questioned the relevance of a behavioral health system that was not available when needed. Constant comparisons to primary care were made by the PCPs, who saw themselves as very accessible and who treated everyone with an urgent need within 48 hours, in contrast to their BH counterparts. "Outpatient behavioral health is a great service," noted one PCP, "for the few people who are lucky enough to gain entry." When the behavioral health director touted the

superiority of the service—"none of our patients have committed suicide"—primary care had a response. They painted a picture of those suffering in the community from a lack of care and wondered how many patients on the long waiting list had committed suicide or violent acts or had deteriorated while waiting for service. As behavioral health grew, the two departments, treating physical health and mental health, grew more distant from each other; they were two services under one roof, co-located but with little or no integration. The regulations from both the local Medicaid payer and the state department responsible for mental health licensing only furthered the isolation and the tendency to treat smaller numbers of people but taking longer periods of time. The policies and procedures were rigid, and they took up large amounts of staff time with paperwork and rules about opening and closing cases. Opening a case involved the completion of up to 30 forms, making it impractical to treat more patients in shorter periods of time.

2000–2009: The Depression Collaborative. In 2000, the health center's funder, the Health Resources Service Administration, offered FPCN the opportunity to join the Depression Collaborative. The purpose of the collaborative was to improve assessment, diagnosis, treatment and outcomes for patients with major depressive disorder (MDD) by changing internal processes. Staff wondered whether this would prove instrumental in moving toward the integration of mind and

body. While working with a team of experts to guide and advise on process change, the center's primary care staff worked closely with behavioral health to create a clinical practice guideline to lead the way. Soon there were colorful posters peppering the health center that asked red flag questions: 1. Do you or does someone you know feel down, depressed or hopeless 2. Have you or someone you know lost interest in or stopped taking pleasure in things you usually enjoy? The PRIME-MD (Primary Care Evaluation of Mental Disorders), a depression assessment tool, was integrated into the electronic health record. PCPs screened all new patients for depression and were provided with the psychopharmacology tools to treat MDD. The level of awareness grew to such a degree at the center that staff (many of whom were from the community) began to come forward and ask for help for their own depressive symptoms. This brought mental health into primary care, a big step forward even though the payers continued to separate the mind and the body. A primary care diagnosis of depression or any mental health disorder became a rejected claim by the center's Medicaid payers. The system simply did not and still does not support the integration of mind and body when it comes to paying for mental health treatment in primary care. The center got around this by using a code for fatigue or insomnia in lieu of coding for depression. The internal changes instituted during the depression collaborative are still in effect today, and they provide a great leap toward integration. But the

big problem still lingered and in fact worsened. With more patients diagnosed by primary care with MDD, more were referred to behavioral health, and the lengthy waiting list persisted and even grew.

2010: The Behavioral Health Consultant Model. William was a new patient at the health center. He was 48 years old and living in a halfway house where he was also employed as a handyman. He had spent 26 months in federal prison for a felony, and he reported that he had PTSD from that experience, that he felt hopeless and had suicidal thoughts. He was a smoker and was experiencing chest pain. He had no health insurance. The nurse practitioner (all of the FPCN PCPs were nurse practitioners [NPs]) did a full assessment and engaged the behavioral health consultant (BHC), a licensed clinical social worker, in caring for William. A more complete behavioral health history revealed that he had a history of bipolar disorder now compounded by PTSD. After it was determined that the patient was not a risk to himself or others, he was treated by the nurse practitioner with mood-stabilizing medication and was given a plan to return to see the therapist in one week and the NP in two weeks. He was about 40 percent improved in two weeks, and he was able to engage in several weeks of cognitive behavioral therapy with the BHC because his medications were closely monitored by the NP. Also, because he had seen the outreach and enrollment staff on his first visit, he now had health insurance.

All FPCN health centers now have imbedded mental health therapists known as behavioral health consultants in primary care. With this model, the patient is seen almost immediately, without the need to wait on a list, return for another appointment and endure a lengthy intake process. Care is provided in the exam room and is perceived as a part of the primary care experience, and the shame and stigma of behavioral health care are avoided. The BHC is seen as part of the primary care team, shares the same physical space as the primary care provider and records progress notes in the electronic health record. With integrated documentation, the primary care provider can reinforce the BHC's care plan. Because the PCP is supported by a BHC, she is more likely to screen for depression, anxiety, substance abuse and domestic violence. Before, a PCP might have been hesitant to ask probing questions such as, "What stresses you out?" because if the patient responded with examples or dissolved in tears, for example, the PCP would then be facing a patient in need of a more lengthy intervention; and seeing one patient every 20 minutes in primary care does not allow for this. The BHC, when called in to see a patient, utilizes depression and anxiety screening tools and other instructional aides like "behavioral" prescription pads. She relies heavily on cognitive behavioral theory, which is problem-focused; there is no engagement in any form of extended specialty mental health care or psychotherapy. The goal is simply improved life skills and functioning and a decrease in disabling emotions and

dysfunction.

Eighteen-year-old Tyrone was the victim of a random shooting at his high school graduation. Although he was not seriously wounded, he experienced persistent chest pain and shortness of breath. Before learning about the health center, he made several trips to the emergency room, where he was treated with an anti-anxiety medication called alprazolam (brand name Xanax). Ultimately he made his way to the center, where an NP promptly called in the BHC. She was able to ascertain that Tyrone was suffering from PTSD. She helped him understand the body-mind connection and the physiology of his symptoms, which were triggered by his difficult emotions. She worked with him and his family throughout the summer. With the tools she offered, he came to be able to control his anxiety without its culminating in frightening physical symptoms. He left for college in the fall with the plan that he could phone her should symptoms recur and that he would follow up during college break.

Integrated models of primary care and behavioral health have been shown to produce better outcomes, including lower total health costs and more satisfied patients. Because the BHC helps the PCP stay on schedule, the PCP is freed to see more patients. This model provides for better coordination of care and improved clinical outcomes while increasing patient and staff satisfaction. The PCP is operating as part of a team: there is decreased

provider isolation and a decreased sense of helplessness. PC and BH providers learn from one another and form a thorough appreciation of the sublime interdependence of the body and the mind. Fewer patients overall are referred to outpatient BH, leaving available appointments for those who truly need traditional long-term therapy.

A 68-year-old female diabetic patient had stopped taking her medications because she was overwhelmed and depressed from caring for her spouse, who had Alzheimer's. She was grieving his loss, and meanwhile her diabetes was badly out of control. The BHC was called in to assist. The patient was provided with support and referred to an Alzheimer's caretaker support group. Because her depression score indicated that she was suffering from major depressive disorder, her NP started her on an antidepressant medication. She was followed closely by the BHC and had medication check-ins with the NP. Within four weeks, her diabetes was under control; she was also less depressed and was engaged with the support group.

Sustainability: This service can pay for itself if it is adequately reimbursed by a third-party payer. In Philadelphia, the Medicaid BH payer reimburses $75 a visit. This amount is higher for FQHCs with cost-based reimbursement, in which case the reimbursement may be approximately $130 per visit. However, 30–40 percent of visits are likely to be for uninsured patients, and an FQHC is required to see all patients regardless of ability to pay.

For an uninsured patient, FPCN does not charge for a BHC visit because it is integrated into the primary care experience. Uninsured patients tend to be overrepresented in the BHC's service rolls. Even with 30–40 percent uninsured visits, a fully productive BHC should be able to cover his or her costs with income. A full-time BHC salary with benefits pays approximately $72,000 annually. A provider would need 960 reimbursable visits per year, about 22 per week, to pay for her compensation. A fully mature BHC is expected to see about 32 visits per week.

Conclusion: As noted above, the BHC model has clear advantages for patients and for providers and should be endorsed as a viable model now and for the future. It is not feasible for everyone in need of behavioral health services to have access to long-term traditional therapy when a third-party insurer is covering the cost. Neither the financial resources nor the availability of mental health providers exists under the Medicaid third-party payer system. This may be different in a fee-for-service model, under which the patient has the resources to pay the full fee for a private therapist. The BHC model, however, does not meet all needs for all people and does not eliminate the need for traditional outpatient services, and it would be incorrect to assume that this is the case. For example, low-income and underserved communities have disproportionate numbers of people who have experienced significant trauma, as noted in the Adverse

Childhood Experience Study. For many of these patients, significant investments by the patient and the provider are necessary for healing from trauma. Additionally, for families with significant dysfunction, the benefits of family therapy cannot be overestimated. At FPCN, both BHC and outpatient services exist under the same roof. This has provided for appropriate triage by BHCs to the service(s) that is(are) right for the patient and family. It is incumbent upon BHC providers to accurately assess each patient and family and to determine, in consultation with the PCP, the appropriate service for the patient—in this way, the maximum opportunity for patient healing and improved function can be fulfilled.