Integrating Behavioral Health into Primary Care

Our Journey Establishing Behavioral Health Services for Patients in Crisis

Feather River Tribal Health, Inc.

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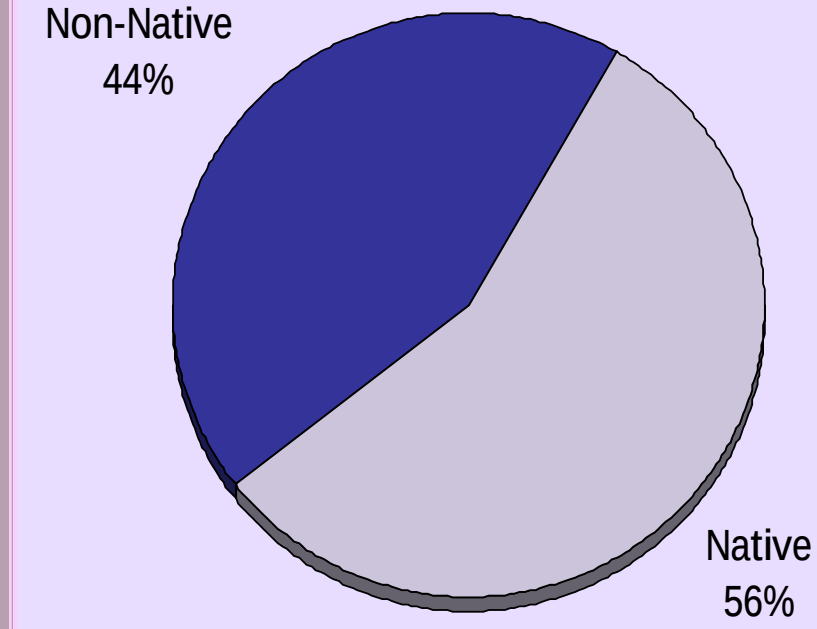
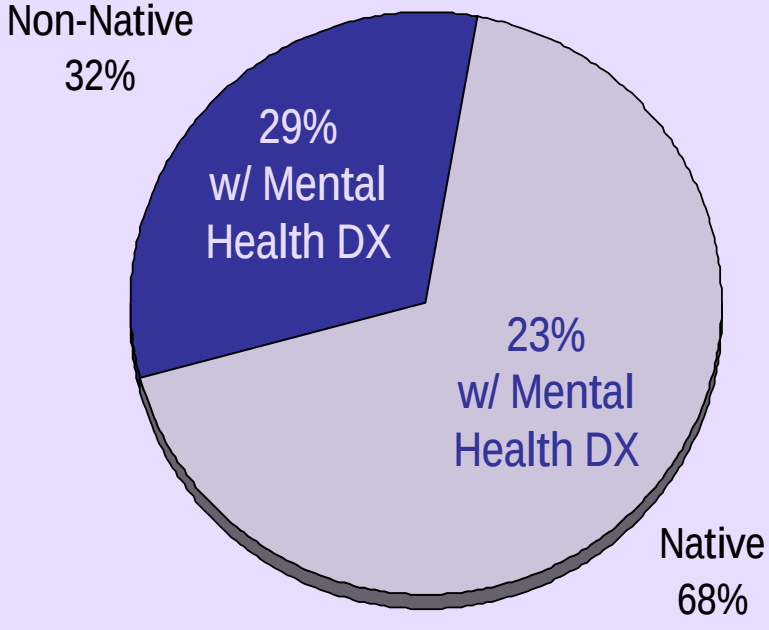
Who We Are

- Feather River Tribal Health (FRTH) is a non-profit tribal health clinic formed by the **Tyme Maidu Tribe of Berry Creek Rancheria**, the **Concow Maidu Tribe of Mooretown Rancheria**, and the **Estom Yumeki Maidu Tribe of Enterprise Rancheria**.
- We serve all Native Americans as well as the general public

Whom We Serve in Medical



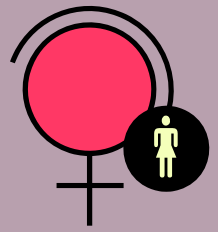
# of Pts



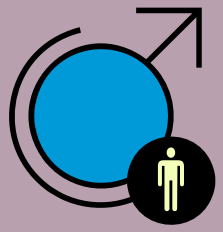
# of Visits

5,255 pts served in 2007 = 55,437 visits

Demographics



Female 55%
(3,023)



Male 45%
(2,447)

- Age Categories (male & female):
  - 18 and under = 33% (1,820)
  - 19 to 64 = 58% (3,150)
  - 65 and over = 9% (500)

How We Started

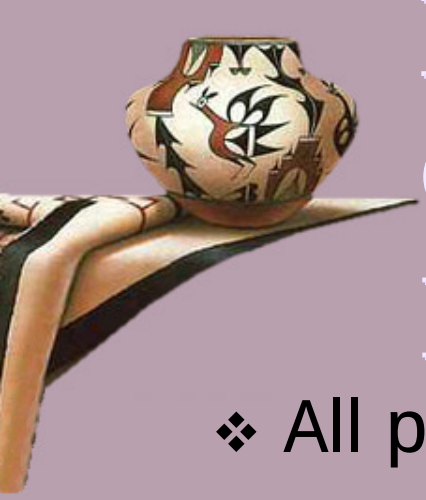
- Presentation on BHS/Medical integration at National Combined Council meeting in 2006
- Upon return, presented info to Board and staff
- Search for Medical LCSW (LCMSW) took over one year
- Found grants to pay the salary & created the job description
- Medical LCSW started 04/02/07
  - Saw 1st patient on 04/05/07

Why We Started

- BHS demand exceeds capacity
- BHS dept has long waiting list & timeframes for children & adult
- Found patients being seen in BHS were not patients in Medical (253/731)
- Disconnect between Medical & BHS

Why we started

- Medical pts were presenting in crisis with no access to services available for Native and/or Non-Native
- Medical schedule not conducive to meeting needs of pts w/non-medical crisis (15 min appts. vs. 45 min in BHS)



Integrated Emergent Care – Setting Parameters

- All pts receiving behavioral health services must be primary care pts
- All pts are initially seen by their primary care provider who refers to LCMSW same day
- All new pts are screened for depression & DV using standardized screening tool
- Pts scoring >3 on the depression screen or a positive on the DV screen are referred to LCMSW the same day

of Visits – 4/07 – 3/08

- 208 pts for 613 visits
  - Female 78% (vs 55% in Medical)
  - Male 22% (vs 45% in Medical)
  - 72% Native American (vs 56% in Medical)
  - 28% Non-Native (vs 44% in Medical)

1st 6 Months: Patient Age

- 18 and under = 22%
  (vs 33% in Medical)
- 19 to 64 = 76%
  (vs 58% in Medical)
- 65 and over = 2%
  (vs 9% in Medical)

Top Purpose of Visit

- Counseling 34%
- Depressive disorder 13%
- Posttraumatic stress 12%
- Dysthymic Disorder 10%
- Tobacco use disorder 9%
- Adjustment disorders 10%
- Anxiety disorders 9%
- Conduct disturbance 3%

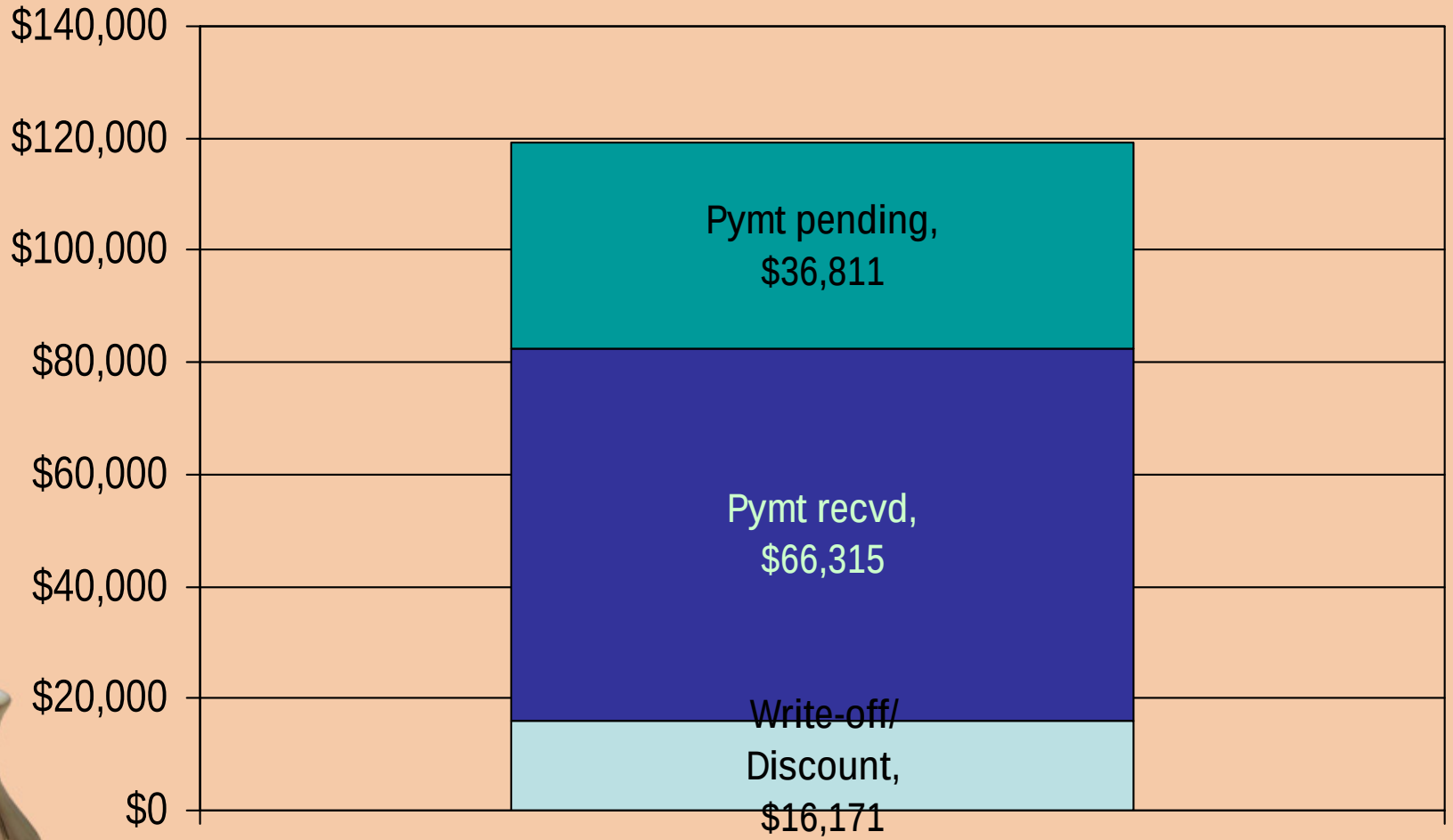
1st 6 Months:
Top 10 Group Pt Ed Topics

- Lifestyle adaptations 14%
- Stress management 13%
- Readiness to change 12%
- Quit (smoking) 12%
- Medications 11%
- Psychotherapy 9%
- Cultural/Spiritual aspects 9%
- Exercise 8%
- Disease process (i.e. pain mgt) 7%
- Follow-up 5%

LCMSW Fiscal Sustainability

- We are an FQHC facility with an MOA for Medicare/Medi-Cal
- Current patient payment sources
  - Medi-Cal
  - Private insurance
- Salary partially paid by Diabetic grant as many LCMSW patients are Diabetic
- Depending on purpose of visit, will bill as Medical or BHS visit

Billed Services – 4/07 – 3/08



Provider Reaction to Integrated Emergent Care

"Closes the invisible gap between Medical and BHS departments."

"Allows pt to access counseling services during acute times of need (i.e., pt upset, crying in exam room w/ provider)."

"LCMSW aware of other programs for assisting pt than the provider."

"Very helpful."

Lessons Learned

Patient receptivity to BHS increased:

1. Behavioral/mental health issues addressed day of primary care visit
2. Clear coordination between primary care provider and LCMSW
3. Decreased stigmatization often associated with receiving services at mental health center
4. Immediacy of the response

Lessons Learned – cont'd

- Primary Care providers appreciate the immediate availability of LCMSW for crisis intervention, psychosocial issues, & community resources
- Development & reinforcement of self-management goals through this model strengthens patient outcomes/compliance

Lessons Learned – cont'd

- Primary Care providers gain confidence dealing with the psychosocial issues of patients
- Improved case management between Medical & BHS
- Improving coordination with ALL departments

Challenges

- Still defining/refining relationships and fiscal sustainability
- Consistent use of depression/DV screening tool – some pt resistance
- Back-up for LCMSW
- Language barriers (Hmong, Spanish, etc)
- LCMSW blurred reporting accountability (Medical ⇔ BHS)

Questions?

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