GE-NMF PCLP Community Project

<u>Mental Health Integration Program at Northeast Community Clinic</u>
A Physician Assistant student's experiences in developing policies and procedures for a Federally Qualified Health Center

Emily Wang, PAS-III, Midwestern University
Externship Site: Northeast Community Clinic, Los Angeles, CA
Site Mentor: Dr. Christopher Lau
Faculty Advisor: Dr. Kevin Lohenry
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Introduction

Mental health is an integral component to an individual's wellbeing. Relationships, work, school, and quality of life all depend on an individual's motivation and ability to solve problems. Unfortunately, many Americans struggle with mental disorders, and in low-income populations, access to mental health services continues to remain a problem.

According to Healthy People, mental health disorders are one of the most common reasons for disability in the United States. In 2004, as many as 1 in 4 adults had a mental illness in the past year, and 1 in 17 had a serious mental illness. By definition, a serious mental illness is a condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM) that has persisted for at least 12 months and causes significant impairment in the patient's life. People with mental health disorders were much more likely to engage in high risk behaviors that included drug use, alcohol use, and suicide, which is the eleventh leading cause of death in the United States for all age groups and the second leading cause of death for people aged 25-34. Additionally, multiple studies have shown a link between a patient's mental health and his physical health. Most commonly, depression was shown to be linked to the outcome of serious chronic diseases such as diabetes, hypertension, stroke, heart disease, and cancer. With these data, Healthy People 2020 established clear objectives such as improving mental health status and expanding treatment, goals aimed at improving the overall health of all Americans.

Federal and local governments have taken note of the gravity of untreated mental health disorders and have taken measures to increase access to services. In November 2004, California voters approved Proposition 63, known as the Mental Health Services Act, in an effort to improve county mental health services. In its vision statement, "the California Department of Mental Health (DMH) will dedicate its resources and energies to work with stakeholders to

create a state-of-the-art, culturally competent system that promotes recovery/wellness for adults

and older adults with severe mental illness and resiliency for children with serious emotional

disorders and their families." This move toward providing services for low-income mentally ill

patients was further potentiated in November 2010, when the Centers for Medicare and Medicaid

Services granted the state of California a 1115 Medi-Cal waiver. This waiver, entitled the

"California Bridge to Reform", could give California up to $10 billion in federal funds for the

development of programs like a Low-Income Health Program (LHIP).

 Mental health services are desperately needed in California and Los Angeles County,

especially for underserved populations. According to the National Alliance on Mental Health,

3.19% of Californian adults are living with serious mental illness. In 2006, 3,334 people

committed suicide. At the time the report was published in 2010, California's mental health

services were only meeting the needs of 34% of adults living with serious mental illnesses. Data

collected from the California Health Interview Survey is listed in Figure 1, which charts the

percentage of adults in Los Angeles County with various mental health prognosticators against

their federal poverty level. As is evident from the data, adults living in the lowest poverty level

consistently experienced the most hardships.

CHIS Data for Los Angeles County				
	Federal Poverty Level			
	0-99%	100-199%	200-299%	300+%
Likely has had serious psychological distress during past year	10.5%	8.8%	7.3%	5.3%
Severe work impairment past 12 months	10.3%*	3.2%	3.4%	4.3%
Needed help for emotional/mental health problems or use of alcohol/drug	16.6%	12.8%	15.9%	16.2%
Has taken prescription medicine for emotional/mental health issue in past year	11.9%	6.9%	9.6%	9.2%
Had difficulties/delays getting mental health care	6.8%	4.8%	6.5%	5.0%
Received emergency room care for emotional/mental issues during past year	12.0%	10.5%	7.8%	4.6%

Mental health treatment covered by insurance	61.0%	68.0%	88.7%	83.9%

*Statistically unstable.

Los Angeles County's LHIP, known as Healthy Way LA (HWLA), has enrolled 200,924

Los Angeles residents as of June 30, 2012, providing insurance and much needed medical

services to a medically underserved population. HWLA has also partnered with Los Angeles

County's Department of Mental Health (LADMH) to implement a Mental Health Integration

Program (MHIP) for previously uninsured residents. Marvin J. Southard, Director of LADMH,

outlined several reasons for integrating mental health into primary care. For one, addressing

mental health concerns can improve the health outcomes of the population, as people with

serious mental illnesses die on average 25 years earlier than the general population. Treating

mental illnesses can also decrease the per capita costs associated with healthcare; as an example,

people with depression have nearly twice the annual health costs compared to people who do not

have this diagnosis. Lastly, mental disorders are often intricately linked with other disorders, can

successful treatment of mental illnesses can improve a patient's quality of life by decreasing pain,

physical inactivity, and other co-morbidities.

Intervention

My learning site was Northeast Community Clinic (NECC), a group of eleven clinics

scattered throughout the Los Angeles area. One of their sites is a federally qualified health center,

and the other sites are considered look-alikes. Of the 152,093 patients entered in NECC's system,

4,196 of them have some sort of mental health diagnosis. Of those mental health patients, 329 of

them have been referred out for treatment. However, Medi-Cal recently changed its policies so

people now need a referral from a primary care provider to access mental health services. With

these changes, NECC has seen an influx of new mental health patients, and administration

predicts many more Medi-Cal patients will also come to community clinics to seek treatment for mental health disorders. To prepare for the influx of new patients, NECC decided to create a new onsite mental health program that would encompass regulations and policies instituted by HWLA and LADMH.

During my stay at NECC, I worked primarily with Bernard Carrillo, a physician assistant at the clinic who also doubles as the Clinic Services Administrator. Bernard was working on implementing the new mental health program at NECC, and I jumped on the opportunity to assist Bernard with implementing this new program. Mental health is one of my professional interests and I had recently completed my psychiatry rotation at South Central Health and Rehabilitation Program, also located in Los Angeles.

My project was essentially to help NECC's administrative team develop a new program for improved and expanded mental health services for the new patients they would receive under HWLA. The following section will chronicle my experiences in researching the mental services offered by HWLA, MHIP, and LADMH and how I helped the administrative team design new documents. As such, there are no data collections or "results" in the traditional sense, but more a reflection and chronicle of my experiences in designing this new program.

I split my workweek in halves. I spent half of my time at the clinic shadowing various providers, learning Spanish and community medicine. I spent the other days of the week in NECC's administration building, mostly with Bernard but also with various other administrative personnel. Bernard briefed me on the project and then gave me an outline of a presentation he would be giving to NECC's 30-40 providers. He also gave me the screening forms he had been working on that would be handed out to patients at their annual physicals or to track their

symptoms. With his outline and the first drafts of the screening forms, I compiled a packet of information that would be given to the providers at their meeting and my real work began.

The screening forms he had found were English and Spanish versions of questionnaires that incorporate diagnostic criteria from the DSM. The four forms Bernard chose reflect the four major types of mental disorders that NECC will be screening for: PHQ 9 for depression, GAD 7 for generalized anxiety, MDQ for mood disorders (namely bipolar disorder), and PCL-C for posttraumatic stress disorder (PTSD). These forms are standardized and very helpful in the primary care setting for diagnosing and even implementing treatment plans, as the scoring guidelines for each of these forms come with treatment recommendations. NECC decided to pull certain questions from each form and combine these questions to make a master form, one they called CMAP. The idea behind creating a CMAP follows as such: if a patient answers "yes" to a question on the CMAP that was originally from the PHQ, then that patient will receive the PHQ in full to complete to evaluate for depression. Likewise, if a patient answers "yes" to a question on the CMAP that was originally from the PCL-C, then that patient will receive the PCL-C in full, along with the PHQ and GAD because depression and anxiety are often seen with PTSD.

One of the lessons I learned while working in the administrative side of a federally qualified health center (FQHC) is that approving items in administration can take quite some time. Choosing the questions for the CMAP was simple enough, but formatting them (aligning checkboxes vs. choosing yes/no answers) and formatting the form itself (font sizes, headers, footers, etc.) took many drafts. But once the forms were finalized and approved by Dr. Christopher Lau, my site advisor and CEO of NECC, we moved on to even meatier tasks.

Bernard gave me a large resource binder from LADMH and told me to read through the materials and develop a workflow for the providers. The workflow was by far the most

challenging task I completed for this project. I had never used Microsoft Visio before, and the first few drafts of my flowchart were horrendous. Thankfully, the administrative personnel were kind and gave me another chance. After hours of toiling on it at work and at home, I finally came up with the semblance of something they might be able to work with. Using Microsoft software comes naturally to me, so I quickly learned how to navigate the program and came up with a better looking draft. Patiently, Bernard took me through the process of developing a usable flowchart step by step. By reading through all the materials provided by LADMH, I also became fairly well acquainted with the Mental Health Integration Program and suggested to Bernard how we could apply this new program to NECC. The flowchart is now completed and Dr. Lau has given it the final stamp of approval. It incorporates not only what happens from the moment a patient checks in, but also the treatment algorithm the medical providers and the LCSW will follow, along with eligibility criteria for the different levels of services. I cannot attach the actual flowchart because it is proprietary, but I have taken a screenshot of the completed chart (Figure 2) so readers can see how intricate and detailed the chart has become.

The flowchart was essentially a pictographic outline of the policies and procedures. The policies and procedures was much easier to create with the flowchart completed, but it still took quite a bit of time to research and compile DSM criteria, treatment plans, and medications for each of the following mental health disorders: depression, anxiety, bipolar disorder, and PTSD. Both the flowchart and the policies and procedures are documents that NECC needs for all its programs, and everyone on the staff – the front office, the back office, and the medical providers – must follow them to the letter. I went through at least twenty drafts each of the flowchart and policies and procedures, and Bernard and Dr. Lau kindly but firmly tore them all apart. Bernard expressed the importance to me of simplicity but comprehensiveness so there

would be no room for ambiguity, confusion, and mistreatment. He brought up numerous points I had never considered before in designing policies and procedures, and I realized just how important administrative work is and why it can take so long. The level of attention to detail is incredible.

Figure 2: Adult mental health flowchart
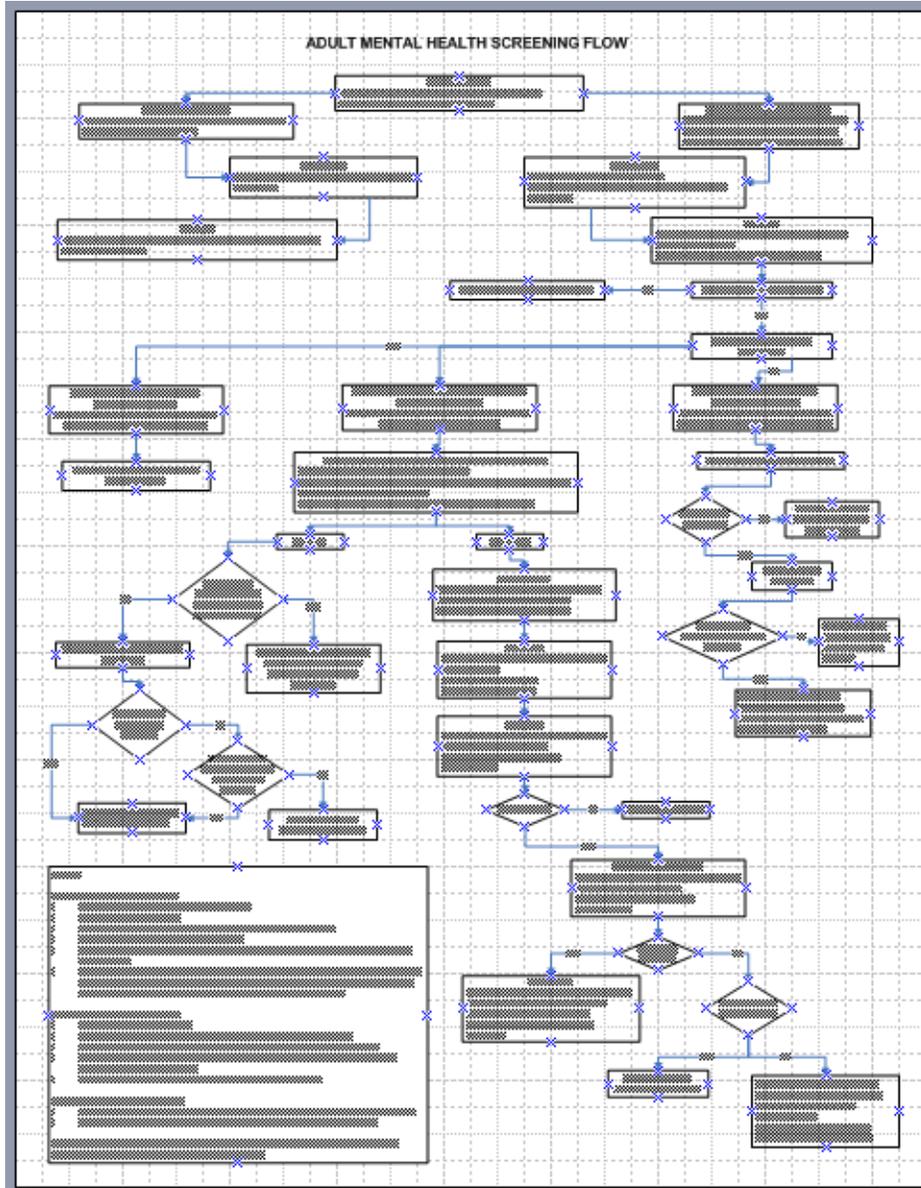
At this point, only a handful of items on the following list are completed or close to being completed. I have included an informal numbered list of items that need to be completed before the program can officially begin at NECC. The program was begun in November 2011 and was originally slated to be completed by the end of July 2012. That tentative deadline has come and gone, but I do not know when the program will be ready to be implemented. However, after seeing how lengthy the process can be due to the level of detail and precision needed, I understand why government-run programs can take longer to be implemented, especially in an organization as large as NECC.

1. ~~Meetings with DMH and HWLA committees~~

2. ~~Develop a workflow for medical providers and LCSW~~

3. ~~Develop policies and procedures with treatment protocol~~

4. Discuss plans with providers so they will conform to the program

5. Train providers at providers' meeting

6. Hire more LCSWs

7. Develop payscale for new LCSWs

8. Train new and existing LCSWs in EBT

9. Develop billing processes

10. Have patient brochures available in English and Spanish

11. Have a consent form in English and Spanish

12. ~~Have screening forms available (PHQ, GAD, etc) in English and Spanish~~

13. Develop mental health progress note

14. Decide if the mental health progress notes will be a separate chart or just a tab in the regular medical chart

15. Find space – decide if all the new mental health patients will be clustered in one facility or if they will be spread out throughout all the clinics

16. ~~Have a resource binder available to the providers with all policies and procedures for internal use and with material from the county~~

17. ~~Meetings with mental health services providers (group homes, psychiatrists, other treatment centers) for consultations and referrals~~

18. Develop a matrix of clinic and mental health agencies referrals

19. Develop a matrix for substance abuse referrals

Conclusion

My project was to help NECC design a new mental health program that would allow them to properly provide services and referrals for their new mental health patients under HWLA. In the beginning of the project, I was slightly disappointed when I realized the mental health integration program would not be ready to implement while I was physically on site so I would be unable to collect data. I was interested in seeing how many patients would actually be referred to mental health services, essentially to see if this CMAP screening tool is valuable and yields a high referral count. Nevertheless, I enjoyed myself greatly as I worked on the various documents and learned all about HWLA's MHIP program and NECC's administrative structure.

Working on this project has given me many valuable learning experiences, both practical and theoretical. Not only did I learn how to use a new software program, but I also learned about many of the intricacies of government-run community medicine from the administration's point

of view. Through my research, I learned a great deal about government health care plans and how the government is trying to provide more services to underserved populations. I learned how a large community clinic operates internally and how they design programs from the ground up. I learned how to ameliorate my direction-writing skills and how clarity is utterly indispensable. I also learned why implementing new programs takes so much time, and why absolutely everything needs to be planned down to the last letter.

If I were to restart this PCLP project, I would probably choose a topic or program that is already in existence so I can collect data and analyze trends. I have a professional interest in mental health, so I would probably still choose a topic related to mental disorders. Like I mentioned in the introduction, mental health can impact the outcome of serious chronic conditions such as diabetes, hypertension, and cancer. Therefore, if I were to redesign my project, I would be interested to see how a patient's mental health affects his disease state, management, and outcome. This kind of project would probably require far more time than 4-6 weeks, but I would still be interested to see if people with good mental health have better physical health as well. Nevertheless, I am still grateful for the opportunity I had to learn so much about administrative community medicine.

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