Healthy San Francisco-Psychosocial Medicine Team: Primary Care-Mental Health Integration in the Public Sector

Progress Report to the Joint Conference Committee
September 8, 2009

David Ofman, MD, MA
Susan Scheidt, Psy.D.
Hali Hammer, MD
The Team

- SFGH Foundation - David Ofman, MD
- FCM/FHC - Hali Hammer, MD
- DGIM/GMC - Alice Chen, MD; Claire Horton, MD
- Division of Psychosocial Medicine - Alicia Boccellari, Ph.D.; Susan Scheidt, Psy.D.

- Clinical Team - Susan Scheidt, Psy.D.; David Guldmann, LCSW; Susanna Kanther, Psy.D.; Juanita Dimas, Ph.D.; Harvey Segalove, MD
6 Chronic Care Redesign Projects

- Chronic Care Projects
  - Diabetes (Endocrinology) (2/08)
  - Adult Asthma (Pulmonary) (2009)
  - Heart Failure (Cardiology) (2009)
  - Back Pain (Orthopedics/Rehab) (4/08)
  - Primary care - mental health integration (Psychiatry) (7/08)

- Use of NPs to improve continuity in resident clinics (DGIM- General Medicine Clinic) (3/08)
The Case for Integrating Mental Health and Primary Care

- MH patients have significant chronic medical conditions that often go untreated and lead to higher morbidity and mortality
- Patients with both MH and physical conditions are common and generate higher costs; treatment of the MH conditions lowers costs
- Many PCPs feel poorly equipped to handle significant MH issues by themselves
- Health care systems which have implemented successful integration projects have tended to show improved care, significant cost savings, and improved patient & provider satisfaction
Goals of the HSF-PSM Team

1. Increase access to mental health care to improve chronic disease management and to promote mental health - primary care integration

2. Support primary care providers’ efficiency, effectiveness, and satisfaction by co-managing patients’ chronic care and mental health needs

3. Enhance reimbursement for MH services, especially FQHC
Integrated Treatment Model

- In GMC, FHC, MHHC; integrated, not just co-located
- Referrals from PCPs

Services:
- Consultations, Evaluations
- Brief, targeted, strength-oriented treatment (6 individual sessions, every 2 weeks)
- Group treatment: Coping with Pain, Toward Wellness (Depression), Healthy Heart, Healthy Spine, Breathe Better/Feel Better, Managing Diabetes, Body and Soul
- Assist with referrals to community programs
Clinical Vignette #1

- 62 y/o divorced Caucasian man with CHF and new diagnosis of diabetes
  - Previously high functioning, quit job due to perceived memory problems
  - Became depressed, suicidal
  - Overwhelmed by new diagnosis and poor understanding of diabetes
Interventions

- 6 individual sessions:
  - Psychoeducation re: depression, diabetes
  - Cognitive work re: Negative thought patterns
  - Motivational work re: lifestyle changes
  - Coordination with Diabetes Educator, group
Clinical Vignette #1: Outcome

**Outcome:**
- Mood improved from 4 to 7 on 10 pt scale
- No suicidal ideation, improved functioning
- HgA1C decreased from 14.1 (4/09), to 8.0 (7/09)
- Attending the Psychosocial Depression Group
- Neuropsych testing in progress
Clinical Vignette #2

- 50 y/o single homeless AA man with CAD, back pain
  - Hx of methamphetamine, alcohol, tobacco
  - Heart attack 3 months ago, stopped meth use, but poor med compliance
  - Intense fear of dying and concomitant suicidal ideation
  - Specific homicidal ideation toward brother; pt. believed he was dying of heart disease so he wasn’t concerned about consequences
Interventions

- 7 individual sessions:
  - Addressed impulses to harm self/others
  - Reinforced sobriety
  - Worked with cardiologist and NP re: how to communicate info re: health status
  - Prepared patient for referral to community treatment
Clinical Vignette #2: Outcome

- **Outcome:**
  - Impulses to harm self and others contained; coping skills improved
  - Maintained recent sobriety
  - Improved medication adherence, better follow-up with cardiologist
  - After much preparation and support, connected with longer-term therapy in community
Challenges: Clinical

- Transition from Psychosocial Medicine Clinic to HSF-PMT
- Creating a new program
- Change in target population
- Fewer resources
- Integrating into primary care clinics: space limitations, scheduling logistics
- Fewer community referrals for longer-term specialty mental health treatment
Challenges: Financial

- Establishing FQHC billing procedures
- Complicated FQHC and state regulations for billing for MH services in a primary care clinic
- Addressing limitations of billing (one billable service/day, 2 visits/month, interns)
Meeting Our Goals: Goal 1

- **Goal**: Increase access to mental health care to improve chronic disease management and to promote mental health - primary care integration
- **Results (7/08 - 6/09):**
  1. Hired staff, developed treatment model
  2. Successfully co-located MH providers in primary care clinics
  3. 958 unduplicated patients treated
     (3,694 units of service: visits, consultations, case management)
Healthy San Francisco-Psychosocial Medicine Team Quarterly Visits Year 1

- Jun-Aug 08: 184
- Sept-Dec 08: 353
- Jan-March 09: 413
- April-June 09: 495

Legend: Patient Encounters
Meeting Our Goals: Goal 2

- **Goal:** Support primary care providers’ efficiency, effectiveness, and satisfaction by co-managing patients’ chronic care and mental health needs
- 175 GMC and FHC providers sent survey in 4/09
- **Results:**
  - 57% responded; **85% rated services as good-excellent overall**
  - 82% rated communication w/ PCP as good-excellent
  - 80% felt tx helped pt. manage chronic med. illness
  - 90% felt tx helped pt. manage mental health issues
  - 93% felt tx helped the PCP better manage the pt.
Meeting Our Goals: Goal 3

- **Goal:** Enhance reimbursement for mental health services, especially FQHC
- **Results:**
  1. Successfully worked through complicated FQHC issues
  2. Successfully billing, increasing long-term viability
  3. Reimbursement for first (pilot) year of operations $94,652, and on the way up with stable staff, billing experience, & increasing productivity
  4. Financial success supports programmatic success (MH-PC integration, increased access, enhanced chronic care infrastructure, support for pts. & PCPs, new forms of PC-specialty care collaboration)
DPH MH-PC
Integration Efforts

1. Improved referral process
2. Education & training
3. Co-located services
   a. CMHS C-L services at CPC clinics
   b. PCP at CMHS MH clinic
4. Special projects - e.g. OBOT
5. Sister clinic relationship
6. Integrated, on-site services
   a. MH teams integrated into PC clinic
   b. Merging MH clinic and PC clinic
Primary Care-Mental Health Integration in the SFDPH:
Healthy San Francisco Access and Innovation

- 7,300+ Healthy San Francisco patients have GMC or FHC as their Medical Home
- 1,800 are brand new patients
- Over 71,000 patient encounters at the two SFGH primary care clinics during FY08-09
- Large number of patients with complicated chronic illness, psychosocial impediments to care
Conclusion

• Multi-disciplinary, team-based care is the key to sustainability and feasibility, at the level of the patient, provider, clinic, and integrated delivery system.