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Integrating Primary Care and Behavioral Health: A Nurse Practitioner's Perspective

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Practitioners' Essay

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Abstract

Health equity for individuals with serious mental illness (SMI) requires collaborative partnerships between primary care and behavioral health organizations. This paper presents the experiences and perspectives of a nurse practitioner in a large-scale pilot program to integrate primary care and behavioral health between an FQHC and a community mental health center, both serving predominantly Asian immigrant populations. This paper discusses lessons learned through program implementation and provides insights on developing a truly integrated system involving equal and full cooperation across disciplines to provide quality and holistic care for patients with SMI. Implications for clinical practice and policy are discussed.

Introduction

Individuals with serious mental illness (SMI) (defined as any diagnosable mental, behavioral, or emotional disorder resulting in functional impairment that substantially interfered with or limited one or more major life activities within the past twelve months; Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act) die an average of twenty-five years earlier than those without SMI (Agency for Healthcare Research and Quality, 2009). Individuals with SMI experience greater morbidity from medical conditions such as cardiovascular disease (Goldstein et al., 2009) and diabetes (Mai et al., 2011). This increased morbidity and mortality can be partially attributed to behavioral risk factors, such as smoking, obesity, physical inactivity, and poor medication adherence. These problems are

further exacerbated by poor access to care, including preventive care (Bradford et al., 2008). For Asian American immigrants with SMI, disparities in health conditions and access to care are compounded by language and cultural barriers that challenge the delivery of quality and accessible care (Kim and Keefe, 2010).

To address these stark disparities in health conditions and access to care, there has been a push by the federal government, which has been further bolstered by the Affordable Care Act, toward integration of primary care and behavioral health care services for individuals with SMI (Centers for Medicare & Medicaid Services, 2010). The Substance Abuse and Mental Health Services Administration (SAMHSA) began its Primary and Behavioral Health Care Integration (PBHCI) program in 2009 to fund community-based behavioral health settings in their efforts to improve access to and availability of primary care and wellness services for their clients. To date, SAMHSA has funded ninety-nine settings (Substance Abuse and Mental Health Services Administration 2014). Each setting falls along a continuum of integration and collaboration between primary care and behavioral health; some involve coordination of services, others involve colocation of services, and still others involve closer integration and collaboration (Heath, Wise Romero, and Reynolds, 2013).

Asian Primary Care Integration Project

In September 2010, Asian Community Mental Health Services (ACMHS) in Oakland, California, received a grant from SAMHSA's PBHCI program. ACMHS is a nonprofit mental health clinic established in 1974 to provide comprehensive outpatient behavioral health and substance abuse treatment services. ACMHS provides behavioral health services to more than 1,000 adult clients annually, including over 400 with SMI. Clients are mostly low-income immigrants with limited English proficiency and represent over ten distinct Asian languages. ACMHS contracted with Asian Health Services (AHS), a federally qualified community health center (FQHC) in Alameda County that serves more than 24,000 patients in more than 114,000 patient visits a year, to provide colocated primary care services for their clients.

In this paper, we present the experiences and perspectives of a nurse practitioner (first author writing in the first person in subsequent sections) who provided primary care services through AHS for the Asian Primary Care Integration Project (PCI). We dis-

cuss challenges and opportunities that arose from this integration of services and suggestions for the development of a truly integrated system involving equal and full cooperation between primary care and mental health professionals to provide quality and holistic care to the SMI population.

The Primary Care Integration Program

As a family nurse practitioner who has some background in psychology and social welfare, being in a position to serve as a primary care provider (PCP) for the SMI patient population and in a role of project nurse manager of an integration project between AHS and ACMHS has truly been a once-in-a-lifetime opportunity. I was excited to be part of an innovative and promising solution to help reduce major health disparities for the SMI patient population in the Asian community. PCI was created as a collaborative effort to integrate care and resources using an interdisciplinary team approach between primary care (PC) and behavioral health (BH) to serve Asian immigrants with SMI. The goals of the project were to improve the patients' physical health, allow for better access to care, reduce stigma, and develop successful partnerships between primary and behavioral health providers in order to holistically care for each individual patient.

Program Structure

The overall program is structured to provide patient-centered care. We moved our PC services to a satellite clinic located in the same building as the BH facility so that BH services are on the second floor and PC services are on the first floor. The referral process starts with the BH case manager (CM) bringing the patient down for a warm handoff with the PCP, who then provides an initial physical exam. This is where the patient first meets the PCI primary care team, consisting of the front desk patient services representative (PSR), medical assistant (MA), nurse practitioner (NP), and occasionally, the consulting physician (MD). Because most PCI patients are monolingual, language-concordant CMs' participation at the medical visits is crucial in helping the patient break language barriers while bridging the gap between primary and behavioral health treatment plans. Any specialty referrals or follow-up initiated by the PCP are coordinated between the MA or the PSR and the CMs, patients, and patients' family members. In addition to engaging with

the CMs during medical visits, the PCP also meets in a case conference with the four ACMHS psychiatrists twice a month to discuss each individual patient's care plan with the assigned CM. During these case conferences, individual cases are highlighted, concerns are shared, and treatment plans are discussed.

The PCI program complements its medical health care services with wellness activities. ACMHS introduced the Wellness Program to encourage patients to be creative and active while assisting them to become more involved with their peer support, take advantage of community resources, and become motivated to live a healthier lifestyle. The Wellness Program is led by the Wellness Coordinator at ACMHS with shared participation from the various CMs and the nutritionist. Some of these wellness activities include weekly walking groups with the use of a pedometer, yoga, tai chi, Zumba, healthy eating with hands on workshops, healthy cooking with demonstrations in a community kitchen, and even weekly trips to the local farmers' market to learn how to buy produce. The program reinforces the idea that a healthy lifestyle does not have to be pricey or time consuming.

Patient Demographics

In total, 243 patients enrolled in the PCI project from June 2011 to September 2014. Fifty-four percent were female. Nearly three-quarters spoke a language other than English as their primary language (place of birth and other immigration information was not collected). Patients represented ten different Asian ethnicities, with half being Chinese. The age range of patients at enrollment was 21–80 years with the mean age being 45 years old ($SD = 12.17$). Table 1 illustrates basic demographic information for patients enrolled in the program.

Program Challenges
Language and Cultural Competency

One of the most unique aspects of integrating care for the Asian American SMI community has to do with the struggle to overcome language and cultural barriers between the care providers and each of our individual patients. Ironically, as someone who can speak four different Asian languages, I still find that one of the biggest challenges of our particular PCI program was the language and cultural barrier. As a Chinese person, born in Vietnam and hav-

Table 1. Sociodemographic Characteristics
of PCI Patients (N = 243)

Variable	% of Patients
Gender	
Female	54.3
Male	45.3
Transgender	0.4
Age Group	
18–24	3.3
25–34	21.8
35–44	21.8
45–54	27.6
55–64	22.2
65–74	2.5
75–84	0.8
Ethnicity	
Chinese	49.8
Cambodian	16.5
Vietnamese	14.8
Korean	9.5
Filipino	4.9
Mien	1.6
Japanese	1.2
Thai	0.8
Burmese	0.4
Laotian	0.4
Primary Language Spoken	
Cantonese	29.2
English	27.6
Khmer	12.8
Vietnamese	11.1
Mandarin	8.6
Korean	7.4
Tagalog	2.1
Burmese	0.4
Japanese	0.4
Mien	0.4

ing immigrated to the U.S. at the age of nine, I can speak Chiu Chow, Cantonese, Vietnamese, and even a little bit of Mandarin. I have always identified myself as Asian until I began to work for an organization that serves over ten different Asian languages, with each culture identified uniquely with their own specialized needs within the category of "Asian." Here, I find myself constantly asking if I am culturally competent enough to work with patients whose language I do not speak. In building meaningful therapeutic relationships with language discordant patients, I rely on the expertise of the language-concordant CMs to help me interpret what the patients are saying, decipher body language, and explain the patients' cultural norms. Add on the layer of mental illnesses and I find myself constantly struggling to be sensitive and nonjudgmental in reaching out to build trusting relationships with my patients.

On an operational level, language plays a major barrier to implementation of many aspects of our program. For example, when we decided to run a series of nutrition and healthy living workshops for our Wellness Program, we had to figure out how to create the same curriculum in four of the most frequently spoken Asian languages and implement the same course four different times with four different sets of language-concordant support staff and volunteers. Even with these efforts, we are still limited and unable to reach the many patients who do not speak those languages. If we wanted to publish an educational pamphlet or an activity flyer, we would have to translate it into the various Asian languages before distribution. If we also consider patients' literacy level, we must do without evaluation tools such as surveys or questionnaires as most of our patients do not read. Every component of our program must take into consideration the fact that everyone is speaking a different language and coming from a different culture. Every staff member who we hire must be bilingual at the very minimum. Compared to a clinic that serves primarily English-speaking patients, we are at a huge disadvantage in terms of resources, staffing, and time.

Staff and Organizational Buy-In

The journey towards setting up and establishing the PCI project has been challenging. One of the biggest challenges was attempting to promote staff buy-in and commitment to the SMI patients while advocating for organizational and administrative buy-in for the program. There were a few factors that might have

contributed to staff's hesitancy towards working on the PCI project, with a few major ones being stigma and fear about working with patients with SMI, lack of training, and lack of leadership support. The stigma of serving the SMI patients most likely came from the fear of working with a population that PC staff are not accustomed to working with on a daily basis. I would sometimes hear that staff members are afraid that patients with SMI are dangerous, nervous because they are not sure how to approach the patients, curious when the patient does not turn out to be what they had expected, and annoyed that it takes them so much time to care for the patient and yet the patient still does not understand or will not follow through with treatment or may not even care. When there is a miscommunication or misunderstanding, the patient's mental state is often the first to be blamed or feared.

In hindsight, I also recognize that our support staff did not receive adequate and ongoing training at the start of and throughout this program on what it means to integrate with BH and what would be expected of them in their new roles. There were no incentives to keep PC staff motivated to perform job functions that constantly challenge and require them to go above and beyond their "normal" job duties. There is no system created to foster an environment that encourages networking and socializing between the staff of PC and BH in order to build camaraderie and a trusting relationship that would allow them to work together everyday and see each other as part of the same team.

In my opinion, our pilot program struggled (especially in the initial planning stages) with the misunderstanding and miscommunication regarding the structural and operational differences between PC and BH. This led to undefined roles and unrealistic expectations of each other. For example, one of the biggest reasons why the PC team felt a disconnect with the BH team was the fact that there were only four main PCI PC staff (NP, MD, MA, and PSR) while there were over twenty case managers bringing PCI patients to the clinic with a BH staff turnover rate of at least fifty percent over the three operational years of the PCI clinic. Our staff simply did not have a close working relationship with most of the BH team because there were too many to "get to know" over such a short period of time. During the first year of our PCI clinic implementation, when I realized that there were going to be an overwhelming number of CMs working on the PCI project, I had suggested

that to build a stronger pilot program with only 150 active patients, we should have a smaller PCI core team. That is, we should have only one CM per language specifically assigned to the PCI project in order to specialize in integration and to build rapport with the PC team. This would allow for more intimate working relationships between the PC and BH staff. The idea was considered but then it was decided that given the way the current BH system is set up, rearranging caseloads is not an option. The same rigidity was also demonstrated on the PC side when it was discovered that the no-show rate for medical appointments, especially for specialty referrals, was too high (>20%). The BH team suggested that someone from PC, such as the NP, should escort the patients to imaging studies and specialty appointments. The idea was heard but rejected due to the fact that it is not common practice in PC to escort patients to such appointments. Because there was no baseline understanding of certain operational and cultural differences between PC and BH settings, it was difficult to negotiate, and thus, both parties appeared to be resistant to change. Consequently, these tug of war negotiations inevitably revealed major cultural clashes between the PC and BH team and gradually resulted in a difference in prioritization of the PCI program within each organization.

Working with the SMI population requires a lot of extra time and patience from our front line staff, but ultimately the program can only succeed with organizational buy-in from our BH and PC administrative leaders in order to provide the attention, support, and advocacy required for the program to thrive in its pilot stage and to sustain it after initial funding runs out. The first time I recognized our lack of PC leadership support for the PCI program was during our second year of the grant, when I was attending the annual SAMHSA conference in Baltimore. I was having a discussion with the director of another primary care partner of the same cohort about the idea of getting buy in. At the end of our talk, she told me that I would not be able to get staff buy-in for the project unless I have leadership buy-in first. She then pointed out that I was the only one representing AHS at this major annual conference. I told her I was not sure what she was suggesting, and she said, "What does that say about your leadership support?"

I cannot speak for ACMHS, but as a subcontractor to the grant, our focus had been to ensure that we deliver the contracted services as indicated in our Memorandum of Understanding

(MOU). As the project grew over time, the PCI program did not stand a chance against the endless competing priorities that were occurring at AHS. Time and attention was stretched far too thin to do anything beyond the basic MOU services. One of the biggest barriers that ACMHS's leadership faced was the fact that they were unable to schedule meeting times with our CEO and medical director in order to negotiate and plan for program improvement and sustainability. Even with the possibility of a no-cost-extension period after the grant ended, AHS was hesitant to discuss plans to sustain the pilot program in its entirety. At the same time, ACMHS did not provide any incentives for AHS to maintain the partnership, such as offering at least a break-even budget plan or an improvement of operational efficiency (i.e., to successfully decrease no-show rates). Staff and organizational capacity must be assessed and planned for before developing a partnership program.

Program Outcomes and Benefits

Despite the important staff and organizational challenges, one of the most impressive components of the PCI program that I have witnessed is the effect of the Wellness Program on the patients' whole health and motivation to take better care of themselves. Through the Wellness Program, patients are taking ownership of their own health in deciding how they want to be cared for. Their participation in the Wellness Program influenced their commitments to taking better care of themselves by eating better, staying active, and supporting their peers in the community. Together, patients are also publishing their own newsletter to voice their enthusiasm for wellness and concerns regarding their own individualized needs.

To illustrate the success of the wellness program I would like to present a case study:

> Mr. W is a 32-year-old male with schizoaffective and bipolar disorder. He started the PCI program in 2011 with a weight of 168 lbs., Body Mass Index (BMI) of 26.9, and a history of elevated liver function test (LFT) due to fatty liver. In mid-2012, he reached his heaviest weight at 188 lbs., putting him at very high risk of metabolic syndrome. By July 2012, he was diagnosed with diabetes (DM). At this point, he became very concerned and fearful of the future of his medical problems. He began to express interest in changing his lifestyle to "get rid of" his diabetes. We had several lengthy discussions re-

garding healthy food choices and staying active. He was also referred to the nutritionist and the diabetic nurse for counseling. He began participating in the Wellness Program at the persistent encouragement of his CM. He participated in the walking groups and was given a pedometer to set his own personal goal of 6,000 steps a day, 3–4 times a week. Additionally, he also decided that he would give up junk food. Shortly, he began losing weight and maintaining it. Three months after his DM diagnosis, he had lost 10 lbs., lowered his Hemoglobin A1C to 5.5%, began a low carbohydrate diet, and also started taking Zumba classes through the Wellness Program, while at the same time, maintaining his 6,000 steps a day. Through his participation in the Wellness Program and his commitment to take better care of himself, his current weight is his lowest, at 138lbs., about eighteen months after his diagnosis of DM. In addition to staying active, he has also learned to eat five small meals throughout the day. A year ago, his chronic medical problem list included elevated LFTs from fatty liver, hyperlipidemia, obesity, and diabetes. As of March 2014, these diagnoses have been considered resolved as his LFT's, lipid panel, BMI, and A1C have all been normalized without medications. Mr. W was very determined and persistent in his effort to become healthier, and through the encouragement of his CM and the resources provided by the PCI program, he was able to achieve a goal that most, with or without mental illness, would consider impossible.

Caring for the SMI population in this integrated effort has been one of the most eye-opening and innovative experiences I have had. The qualitative benefits of the program are apparent to both patients and the providers of PC and BH. I have heard from psychiatrists that they see their patients feeling and looking better as the program progresses. Patients who engage in wellness activities report noticing changes to their overall wellbeing and increased self-efficacy in improving their own health. As a PCP, I have witnessed increases in independence, involvement, and motivation in some patients' self-management in terms of their health and seen how the patients come together in support of each other and themselves.

Objective measures of patient progress in the program are critical to helping both PC and BH identify strengths and areas of improvement. Through data collected from SAMHSA's National Outcome Measures (NOMs) instrument, based on patient labs and self-report, we have been tracking outcomes such as blood pres-

sure, BMI, HDL and LDL cholesterol, and triglycerides in addition to social and mental health outcomes for patients every six months. Tables 2 and 3 illustrate key indicators, at-risk status, and outcome changes from baseline to second and most recent interviews. Note that the number of valid cases for each outcome varies and is significantly lower than the total number of enrollees. There are several factors that account for this, namely difficulty obtaining lab samples and patient drop-out. Ideally, we would like to use these data to inform programmatic changes, but given that our overall program covers so many components, it has been difficult for us to discern what particular aspects of the program have been most effective.

When we launch new Wellness Programs within the larger project, such as a tai chi class for patients and their family members, we monitor progress through the collection of data on health indicators (e.g., weight, blood pressure) as well as psychological and mental health indicators (e.g., self-efficacy to maintain exercise or diet). We are challenged in analyzing quantitative data due

Table 2. At-Risk Status and Improvement of Health Indicators across Baseline, Second Interview, and Most Recent Interview for PCI Patients

Indicator	Number of Valid Cases	At-Risk at Baseline	At-Risk at Second Interview	Outcome Improved	No Longer At-Risk	Outcome Remained At-Risk
Blood Pressure - Systolic	108	29.6%	18.5%	18.5%	19.4%	10.2%
Blood Pressure - Diastolic	108	17.6%	15.7%	11.1%	14.8%	2.8%
Blood Pressure - Combined	108	31.5%	26.9%	17.6%	18.5%	13.0%
BMI	110	57.3%	53.6%	44.5%	8.2%	49.1%
Waist Circumference	53	28.3%	28.3%	39.6%	1.9%	26.4%
HgbA1c	44	61.4%	68.2%	34.1%	4.5%	56.8%
HDL Cholesterol	44	18.2%	27.3%	54.5%	6.8%	11.4%
LDL Cholesterol	39	30.8%	25.6%	53.8%	15.4%	15.4%
Triglycerides	43	41.9%	46.5%	65.1%	14.0%	27.9%

Table 3. Positive Status and Improvement of Self-Report
Health and Social Indicators across Baseline, Second Interview,
and Most Recent Interview for PCI Patients

Outcome	Number of Valid Cases	Positive at Baseline	Positive at Second Interview	Outcome Improved	% Change from Baseline to Most Recent Interview
Healthy overall	146	37.0%	51.4%	23.3%	38.9%
Functioning in everyday life	150	29.3%	46.0%	60.7%	56.8%
No serious psychological distress	143	62.2%	74.8%	21.0%	20.2%
Had a stable place to live	149	57.0%	75.2%	25.5%	31.8%
Socially connected	149	43.6%	54.4%	51.0%	24.6%

to small samples (e.g., the tai chi class only has 10–15 regular attendees), but we continue to see both qualitative and quantitative performance measurement and monitoring as important aspects of the work we do. In anticipation of greater patient participation, we hope to use data to better inform what aspects of the program work and do not work in improving patient outcomes.

Discussion

In our fourth year of the PCI project, we have managed to work out some of the kinks and found ways to compromise within the rigid structure of our own PC and BH practices in order to implement a smoother workflow for integration. To address miscommunications and clarify roles, we participated in a two-part facilitated meeting with administrative leaders and clinical staff from both agencies. Here, we were able to establish vision, discuss struggles, and suggest change. In trying to bridge gaps for the patient, BH required that their CMs be present for medical visits and assist patients with PCI enrollment. To be on the same page with one another, PC staff would input PCP follow-up appointment dates and times into the BH electronic scheduling system so that CMs can have access in order to plan for future medical visits. Together, the CMs and the PC staff assist patients with scheduling specialty appointments, arrang-

ing for interpretation services as well as making reminder phone calls in an effort to reduce no-show rates. Although the program struggled with a high BH staff turnover rate, we were able to better acclimate new team members to the vision and goals of integration.

The areas of focus I would recommend for improving on this particular PCI project would be: 1) to obtain leadership buy-in early on; 2) to build a strong foundational core PCI team consisting of committed PC and BH staff who share a similar vision for integration; 3) to continually work on maintaining good team dynamics between PC and BH, such as additional trainings and team-building activities or workshops; and 4) to focus on integrating Wellness Program activities early on as well as incorporating peer support to encourage and improve patient participation and outcome.

Many of the lessons I have learned from our PCI program about primary care-behavioral health integration for our distinct Asian immigrant SMI patient population shed light on flaws in PC-BH integration as it is commonly practiced. My experiences suggest that even when providers have the best of intentions to work together to treat patients with SMI and develop innovative solutions to engage patients in addressing their physical health, true success and sustainability cannot be attained without addressing broader issues having to do with how primary care and behavioral health integration is set up from the beginning.

The PCI program's model of integration, like many other integration programs, involved "artificially [inserting]" services to make a cross-disciplinary team (Manderscheid and Kathol, 2014, 62); yet in our case, this approach led to culture clashes, different expectations and priorities, and misunderstandings. Although the PCI program's PC and BH services were co-located in the same building, even being on a different floor created a separation and perpetuation of an "us versus them" mentality, which caused coordinated care to suffer as a result. Instead, if both PC and BH were housed in the same place, we could each see how hard the other person is working to assist our mutual patient, and it would be easier to allow each other the benefit of the doubt when miscommunications do arise.

In addition, funding opportunities and current billing practices should be structured to promote better collaboration between PC and BH agencies and smoother coordination of care. Currently, there are major funding opportunities to integrate services for individuals with mild to moderate BH problems into PC and separate

funding opportunities for BH agencies to integrate PC for those with SMI. This setup can perpetuate many of the same problems we experienced, where the grantee organization and the subcontracted organization do not share similar priorities and organizational cultures. To ensure that both parties are equally invested in the ultimate goal of integration, rather than funding a primary grantee and a subcontractor, funding should be granted to a paired PC and BH partnership. The leaders of both PC and BH organizations need to take equal responsibility to promote the success of the program that they signed up for, to ensure that staff does not get burnt out while committing to a very difficult patient population, to encourage innovative thinking toward change and improvement of outcomes, and to provide adequate training and support to allow for creativity and empowerment. Manderscheid and Kathol suggest that if integrated services are for a person's whole health then payment for "all health services [should] be paid from a single budget by using common procedures" as opposed to the more commonly used billing systems, including ours, that have separate billing procedures for PC and BH services (2014, 63).

Although the Health and Human Services Plan for Asian American, Native Hawaiian, and Pacific Islander Health recognizes the importance of improving language and cultural capacity of the health care workforce to better address the diverse needs of Asian American communities, and the PCI program's SAMHSA staff have been attuned to an understanding of the linguistic and cultural challenges our program has faced in delivering care to our diverse patient population, more can be done to address these challenges. Agencies funding integration programs must take into account the additional staffing, time, and costs associated with translation services. More resources and training of peer health coaches and lay health workers may help ease some of these burdens.

Conclusion

Witnessing the slow and imperfect progression of our PCI program towards true integration has been as rewarding as it has been challenging. A few drawbacks from our integration model that are worth mentioning include a nonspecific PCI team from BH, co-locating on separate floors of the same building, and the lack of ongoing training for staff development. A few notable successes of our model included the structured PCI case conferencing as well as the

incorporation of the Wellness Program into the patients' daily life. We are nowhere close to where we had hoped to be, but as we learn to navigate culture clashes and negotiate for policy changes, I hope that the countless mistakes and painful lessons we have learned as well as our suggestions for improvement will be helpful to future integration efforts for individuals with SMI.

On a more personal note, I am grateful for the opportunity to participate in this growing and innovative movement toward physical and behavioral health care integration. As a new clinician, being able to hear patients' stories, to learn what they have been through, to figure out how to meet them where they are, and to help them find motivation to move on and do well has truly been an inspiring and humbling experience. The PCI program opened my eyes as I got to experience firsthand not just how my SMI patients became the way they are but, more importantly, that they have hopes and are determined to get better, move on, and feel great. It has changed the way I see difficult situations and taught me to be empathetic and understanding, especially to the people I find most difficult to work with. I realized that mental illnesses, on a varying spectrum, exist everywhere, on every street corner and in every neighborhood. And if they mostly present themselves as "difficult" people, it's no wonder our first instinct is to turn away. It's no wonder we prefer not to surround ourselves with their burdens. Even when we don't realize it, we are placing stigma without ever meaning to.

I applaud the people who are these patients' support network, whether it is their children, spouses, parents, caretakers, or just their case managers. It truly is admirable to see the strength they have in them to be able to support these patients on a daily basis. It takes a lot to care for the SMI population, and no one person or one specialty or one clinic can do it well alone. Therefore, new programs, such as the PCI project, carry the hope of changing the way we view mental illnesses in our community and improving the ways that we reach out and care for them, regardless of the obstacles and resistances that lie ahead. These pilot programs can inspire us to move away from the structure of our current system and towards collaborative, patient-centered care. We really can change the quality of life for these individuals when we can finally become equally participating, fully engaging, and enthusiastically invested as an integrated interdisciplinary health care team.

Acknowledgments

Note

1. The article reflects the opinions and experiences of the first author and not necessarily the organizations that have supported the PCI program. In her role as a primary care provider, the first author made substantial contributions to the intellectual content of the paper, including writing and editing. The second author served as a research consultant for the PCI program. Her contribution to this paper included writing and editing, primarily of the introduction and discussion of assessment and performance evaluation.

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