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Practitioners' Essay

Improving Access to Care for Asian American and Pacific Islander Communities by Integrating Primary Care into a Behavioral Health Setting: Lessons from the Field

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Abstract

International Community Health Services, a Federally Qualified Health Center, and Asian Counseling and Referral Service, a multi-social service agency, collaborated to develop a unique integrated model of care for Asian American and Pacific Islander patients with limited English proficiency and severe mental illness. In this practitioner's essay, we explore lessons learned from a five-year demonstration project and discuss future implications related to health care reform and applicability to similar programs. Keys to the success of the project were committing to partnership, transforming staff roles, developing systems of documentation, adjusting productivity standards, and adapting for cultural competency.

Introduction

According to the Agency for Healthcare Research and Quality's "National Healthcare Disparities Report 2012," among all measures of health care quality and access that are tracked in the reports and support trends over time, Asians or Asians and Pacific Islanders in aggregate had worse care than Whites in the most recent year for thirty-seven measures (U.S. Department of Health and Human Services, 2013). The report shows a worsening disparity reflected in the growing gap for End Stage Renal Disease due to diabetes.

Additionally, Asian Americans and Pacific Islanders (AAPIs) who live with serious mental illness (SMI) represent populations

that are adversely affected by disparities in health and face significant personal, social, economic, and environmental stressors that impact health status. People with SMI have a higher risk of premature death, dying on average twenty-five years earlier than people without SMI. People with SMI also have higher rates of hypertension, diabetes, obesity, and cardiovascular disease compared to people without SMI. The presence of diabetes is estimated to be four times that of an age- and gender-matched control population (Morden et al., 2009). High morbidity among those with SMI from these particular diseases can be attributable to modifiable behaviors, such as cigarette smoking, poor diet, and inactivity, as well as a result of the medications taken to manage SMI. Although primary care can address these modifiable risk behaviors as well as monitor medication metabolic side effects, access to quality health care is often impeded by elevated rates of poverty, unemployment, linguistic barriers, lower adult literacy rates, and lack of or inadequate health insurance (Gee et al., 2009; Gee and Ponce, 2010). Additional factors that contribute to poor health care adherence include a primary care system uncomfortable with, and too often ill-equipped to serve, the SMI population, which is compounded by a lack of coordination between mental health and primary care (Morden et al., 2009).

Many AAPIs are unfamiliar with the concept of preventive health care and patient self-management. The language and cultural barriers compound their struggles to navigate U.S. health and social service systems, and they are often unable to find support in the larger community. In particular, AAPIs with SMI face significant isolation, often ostracized from their own families and communities due to the severe stigma around mental illness.

To address these identified barriers and disparities, two community-based organizations serving the AAPI communities in Seattle, King County, WA, partnered to create a new, integrated primary care access point within an existing mental health organization. For over forty years, a primary care partner, International Community Health Services (ICHS), which is a Federally Qualified Health Center (FQHC) located in Seattle, WA, has been serving predominantly AAPI refugees and immigrants as well as the broader community by providing quality, affordable health care. ICHS provides primary medical and dental care with an array of enhanced services, including behavioral health, health education, and community advocacy

to address health literacy issues and chronic disease education and management services. ACRS is a multi-social service agency, providing a variety of human services programs, including mental health outpatient services, to the AAPI populations in Seattle. Its Behavioral Health Program provides comprehensive case management and serves approximately 1,500 individuals from diverse AAPI groups, including Cambodian, Hmong, Lao, Mien, Thai, Vietnamese, Burmese, Bhutanese, Japanese, Korean, Samoan, South Asian, Tongan, and Chinese (including Taiwanese and Hong Kong). Based on ACRS' agency statistics, these populations experience significant challenges to health care access and mental health: (1) Over eighty-three percent speak a language other than English and need an interpreter; (2) ninety-one percent were not born in the U.S.; (3) ninety-five percent of patients served are either "low-income" or "very low income;" (4) many have experienced major trauma in their lives, including war, refugee camps, sexual assault, loss, and reeducation camps; and (5) over fifty percent are over the age of sixty-five. The most common mental health diagnoses include major depression, posttraumatic stress disorder, schizophrenia, bipolar disorder, and dementia.

An Integrated Model of Care: Wellness for Asian Pacific Americans (WAPA)

Funding for this collaborative partnership to implement the Wellness for Asian Pacific Americans (WAPA) Project was provided by SAMHSA through Primary and Behavioral Health Care Integration (PBHCI) funding, which awarded ACRS two million dollars for the project period from October 2010 to September 2014. Initially, funds supported capital investments and primary care clinic renovation within ACRS. Following the renovation of the primary care clinic, funds were used to support personnel and operational costs. The WAPA project capitalized on the existing strengths of each organization. Both organizations recognized that the disparities are due in part to conventional interventions, including public health education and primary care models that do not successfully address unique and multiple-community barriers, especially for people living with SMI. The partners recognized the need for culturally competent interventions focused on intensive support and coaching; person-centered planning; and a holistic, integrated, and community-based approach that addresses both

physical and mental health together. Also, each organization recognized the critical importance of creating and ensuring family engagement and support networks that could continue to promote positive healthy choices outside of the service setting. The goals of the project were to (1) increase access to primary health care services by providing primary care service at ACRS' outpatient mental health setting; (2) to promote healthy living and community building through an array of culturally competent wellness-education and support services, such as yoga, tai chi, line dancing, acupuncture, and social support groups; and (3) develop a unique model of care utilizing the ACRS behavioral health case manager as a member of the health care team, providing medical interpretation, self-management support, referral follow up, and care management.

Bringing Primary Care into the Community Mental Health Setting

Through a formal collaboration between partner organizations, the project brought primary care services delivered by an ICHS team to the ACRS outpatient mental health site, immediately removing access barriers. The model not only meant sharing of physical space but also sharing of expertise and knowledge, including cross-training and team consultation with the ICHS primary care team, ACRS psychiatric team, and ACRS case managers. ICHS' medical team regularly attended ACRS' medical staff meetings to coordinate care for shared patients. Plans were developed for shared access to patient records to enable coordination and monitoring for effective integration. ACRS' bilingual, bicultural mental health case managers received training in primary health care and health promotion from ICHS medical providers and health educators. Training covered the most common health issues, such as diabetes (including prevention and treatment management), hypertension, cholesterol, women's health, and the importance of self-management support.

Designing and Developing a Person-Centered Care Management Team

WAPA used a team approach in developing a comprehensive integrated mental health and primary health care service plan or wellness plan, which was developed by the care management team, including all stakeholders in the process of the patient's recovery and physical health improvement. The care management

team brought together the primary care provider, a wellness educator, the psychiatric service provider, an ethnic-specific mental health case manager, as well as the patient and their identified family members. The plans integrated not only primary and mental health but also culture and community as well as traditional health practices, such as acupuncture and acupressure, and ensured self-management plans were coordinated with the use of traditional medicines.

As a result of the project, a major organizational culture shift occurred in the changed role of ACRS' mental health case manager, which evolved to a whole health care manager, placing the bilingual and bicultural mental health care managers at the core of the model. They served as health educator, lifestyle coach, interpreter, cultural broker, and advocate. They are the patients' liaison and navigator, instilling hope and motivation for change. The care managers understood patients' mental health conditions, triggers for mental and physical decompensation, learning styles, and effects of psychotropic medications. The care managers recognized and effectively integrated patient strengths and resources such as motivation, natural support network, and connectedness to ACRS. Though the root of the work is mental health service, a patient knows that he/she is seen as a whole person with challenges and interests well beyond his/her illness. This is further supported because staff spoke the same language, understood the culture and its values, shared common experiences in migration and acculturation to the United States, and had experience with other unique social and community issues.

Building Community Through Wellness and Health Promotion Activities

Lastly, because achieving wellness extends beyond clinical care, the project also focused on developing culturally competent wellness and health promotion activities. The project sought to increase knowledge and skills on self-care and to develop family and community networks that could support and promote healthier lifestyles. This was especially important for AAPIs living with mental illness who often faced isolation from their own traditional support networks due to stigma. Wellness and health promotion activities were provided in their language and in a manner easily understandable to people with SMI. Patients were engaged in an array of cultur-

ally appropriate wellness support services that addressed nutrition, exercise, smoking cessation, self-help, healing, and stress management. Physical and wellness activities promote movement that is culturally familiar, such as tai chi, qigong, traditional dance and music, gardening, and meditation. These activities were provided at ACRS, a familiar place, which has become a second “home” for many community members. The group activities focused on building community and strengthening supportive relationships for positive behavior change. There are now over twenty wellness groups, mostly ethnic specific, with a focus on wellness, health, celebration of their culture, and the building of social support.

Lessons Learned

Patient Recruitment Never Ends

Since the implementation of the WAPA project in September of 2010, 584 ACRS’ behavioral health patients enrolled and have been participating in project activities. Of these, there are 273 who now receive primary care through ICHS’ health care team and have an established primary care provider (PCP) and care management through the ICHS integrated clinic at ACRS. All others participate in wellness activities and benefit from the support of case management. To enroll, patients consented to have several key health indicators monitored throughout their tenure. Those without a PCP often required education on the benefits of establishing a relationship with a PCP.

WAPA Works

The project monitored health indicators through a required tool provided by SAMHSA project staff, and projects throughout the country showed variable outcomes (Scharf et al., 2014). Health indicator data presented in Table 1 includes all patients who had at least two reporting periods, each six months apart, at any time within the four-year project. The total patient number varies by each indicator as there was often data missing, or patients may have only recently enrolled in the project and there had not been a sufficient amount of time to collect two data points that were at least six months apart. Still, the results are significantly positive. The health indicators show improvements of 24.6% in blood pressure, 49.0% in BMI, 54.7% in waist circumference, 44.0% in fasting plasma glucose, 42.1% in HgbA1c, 39.5% in HDL, 46.2% in LDL,

Table 1 – Health Indicators

Health Indicators	Number of Patients	At-risk* at Baseline	At-risk at Second Interview	Outcome Improved	No Longer At-risk	Outcome Remained At-risk
Blood Pressure- Systolic	464	47.4%	41.8%	21.8%	18.5%	28.9%
Blood Pressure- Diastolic	464	33.8%	21.3%	15.5%	23.3%	10.6%
Blood Pressure- Combined	464	54.7%	45.7%	24.6%	21.6%	33.2%
BMI	447	60.2%	59.5%	49.0%	7.2%	53.0%
Waist Circumference	382	52.6%	46.9%	54.7%	10.7%	41.9%
Plasma Glucose (fasting)	134	53.0%	56.0%	44.0%	11.9%	41.0%
HgbA1c	38	81.6%	78.9%	42.1%	2.6%	78.9%
HDL Cholesterol	167	26.3%	32.9%	39.5%	4.8%	21.6%
LDL Cholesterol	158	24.7%	24.7%	46.2%	10.1%	37.7%
Triglycerides	162	53.1%	51.9%	49.4%	15.4%	37.7%

Source: "Services Outcome Measures (PBHC) only." Transformation Accountability System (TRAC). <https://www.cmhs-gpra.samhsa.gov/TracPRD/default.aspx> (accessed October 17, 2014) Note: Data is only available to SAMHSA and their grantees. * At-risk was defined as:

Blood pressure: systolic greater than 130 OR diastolic greater than 85

BMI: greater than or equal to 25

Waist circumference: male, greater than 102 cm; female, greater than 88 cm

Fasting Plasma Glucose: greater than 100

HgbA1C: greater than or equal to 5.7

Cholesterol: HDL, less than 40; LDL, greater than or equal to 130; Triglycerides, greater than or equal to 150.

It is important to note, that several of these "at-risk" definitions are more stringent than many standard Healthcare Effectiveness Data and Information Set (HEDIS) and Uniform Data System (UDS) measures generally reported by FQHCs.

and 49.4% in triglycerides level. Because there is no way to determine which patients had both integrated primary care and wellness activity participation, or the frequency of their participation, it is impossible to determine if it was certain aspects of WAPA, which aspects might have been the most effective, or whether it was the project in its entirety that contributed to these outcomes. A more detailed analysis and evaluation of the WAPA project is beyond the scope of this article.

Commit to Partnership and Innovation

Full commitment from both the FQHC and mental health organization was necessary for an integration project to work. This included organizational leadership having a shared vision with buy-in from all staff involved, including mental health case managers, psychiatric staff, primary care providers, support staff, and administrative team members.

Two different cultures, care systems, payment models, workflows, electronic health record systems, and approaches to treatment and care delivery, all challenged both partners to work together and think outside of the box. It required all involved staff (e.g., administrative team, primary health care team, mental health team) to be flexible, resourceful, and to encourage continuous development of system design utilizing quality improvement change strategies. One difference that impacted program design, and which required training for both partners, was the different payment structures of each organization. The mental health agency was subsidized through a tiered methodology, receiving a certain amount of funds to provide services to a specific number of people regardless of the services provided. The primary care agency was reimbursed through multiple methodologies, including fee for service model, managed care model, and/or a sliding fee scale based on income and insurance status.

Transform the Culture and Staff

The paradigm shift and transformation from a mental health program and a primary health care program to a whole health wellness program needed to be reflected in staffing, management, infrastructure, policies and procedures, job expectations, and documentation. ACRS made the transformation throughout the mental health program: (1) day activities program became the Well-

ness Program; (2) physical movement is now a part of all group activities; (3) primary care needs are followed from intake to exit; (4) in addition to the primary care visit, vitals such as blood pressure, BMI, and waist circumference are taken and monitored at every visit by psychiatrists and/or psychiatric nurses; (5) self-administering blood pressure machines are available at visible public places to encourage self-monitoring of health conditions; and (6) the agency visibly promotes our commitment to wellness by becoming a Tobacco Free Campus and hosting an annual Health Fair to the wider community.

Transforming the staff required training on health education strategies, common health issues in primary care and those experienced by people living with SMI (e.g., diabetes mellitus, hypertension, women's health, and cancer screenings), lifestyle coaching, and care management. ACRS staff now suggest that these topics should be a required education for all mental health workers. Additionally, ACRS staff required training in FQHC standards, such as sliding fee scales and the need to collect income and insurance status.

Through the integrated model, we learned that for patients living with SMI the role of care manager may be more effectively performed by a bilingual, bicultural mental health case manager and served in a community mental health setting. Once he/she is equipped with health education skills like motivational interviewing and lifestyle coaching skills, the trusted mental health case manager can be an effective whole health care manager producing positive physical and mental health outcomes. The whole health care managers brought an understanding of mental health conditions, community strengths and resources, as well as language and culture. They acted as a liaison and patient navigator.

Develop Systems to Document and Communicate

We learned that providing onsite support by ICHS eligibility worker for primary care registration, eligibility, and sliding fee scale enrollment was necessary to ensure that all patients were properly supported through this process. ACRS' care managers participated in this process with the patients, serving as interpreter and often assisting the patient to acquire the necessary income verification documentation for a sliding fee discount.

As a demonstration project, partners collaborated on developing workflows to collect and report on health indicators and

other quality of life measures. Currently, vital signs are collected at least every six months and metabolic lab tests every year. A quality of life outcome survey was administered every six months. Both individual patient-based data and aggregated data was extremely important in measuring outcomes, motivating patients to continue their wellness work, celebrating successes, and analyzing problem areas to direct future programming. Additionally, we learned that providing patient-level data to the whole health care manager improved outcomes. While it is difficult to collect information about the cost of health care for an individual and the service population, it is a critical piece of information in system designs.

Sharing health records was critical in integrated care but also challenging with two separate electronic health record systems. And while HIPAA allowed for provider-to-provider communication, we thought it was necessary to ensure that all patients agreed to “releases of information” between the two organizations’ staff. This allowed primary care staff to print and share treatment care plans and visit summaries for the patient and the care manager. While this solution was not ideal, it accommodates the health care team’s communication needs. Additionally, a Business Associate Agreement was signed, and in order to enhance psychiatric consultations, a separate contract for the provision of these services was signed between the two agencies, which allowed for the psychiatrist to have limited and appropriate access to the primary care organization’s electronic health record, thereby allowing for tasking and consultation to be streamlined and become a part of the final medical record. Meeting regularly among clinical and administrative staff has improved services and understanding of each organization’s culture and priorities.

Adjust Productivity Standards

A major barrier in implementing this project was ensuring adequate staff capacity and supporting the expanded role of the whole health care managers within the context of integrated care. High caseloads needed adjustment to balance expanded roles. Additionally, on the primary care side, addressing the health care needs of patients living with SMI may take additional time and relationship building. For example, initially, accommodations for longer visits were necessary to build trust and create a safe environment for patients, despite impacts to reduced productivity and

reimbursements. As the patient–provider relationship evolved, increased productivity was realized. A full evaluation of health care cost savings is beyond the scope of this article.

Adapt Wellness to Address Cultural Competency

We have seen that people who participate in wellness groups experience more positive outcomes, compared to those that do not participate. Wellness groups share the following common characteristics: emphasis on health and wellness rather than mental health; wellness activities built upon culturally relevant practices (such as Laotian, Cambodian, and Samoan dancing and singing; gardening; karaoke; shared spiritual or religious beliefs; and cooking and sharing healthy ethnic foods); promotion of social supports and connectedness by inviting family members to join and encouraging people to help each other; health and wellness education offered in their own language and in a manner they can easily understand and relate to; and permission for care managers to be creative in developing their own culturally relevant wellness groups and acting as a facilitator, role model, and a part of the community. A detailed evaluation of each wellness activity was beyond the scope of this project and paper.

Future Implications

The primary and behavioral health care integration project designed and delivered by two community-based organizations has produced positive health outcomes. While we believe this has likely impacted health care cost savings, more robust analyses and research is needed to confirm this.

Still, we believe that in order to address health disparities and the economic costs of fragmented health care for AAPI immigrants and refugees with a SMI and with LEP, it will take a fundamental paradigm shift in service system approach and payment design to treat the whole person in a coordinated and more effective manner. We believe this model of care can be successful, replicated, and sustainable when the care is designed and delivered in a culturally competent manner that is focused on the whole person. Future research should identify and confirm which cultural adaptations result in improved outcomes and positive patient experiences.

In addition, the model of care requires a payment system based on achieving health outcomes instead of office visit volume.

It must be a system with whole person approach services, including disease prevention, wellness, care management, and medical services that should be covered by all health insurances, including Medicaid and Medicare. While there are efforts to evolve health care reimbursement reform with a focus on quality instead of quantity, this change has not yet been fully realized. Furthermore, outcome based reimbursements should consider and account for populations that experience significant health disparities. Improvement should be rewarded, whether or not the improvement has resulted in meeting industry-standard quality goals. In other words, while achieving optimal health and meeting clinical guideline standards is the goal, reimbursement could be modified if improvement occurred and health disparities are reduced. Health care reimbursement systems need to acknowledge that more resources may be needed when serving populations with SMI and LEP.

While we should continue to engage in advocacy for fundamental system changes to support an integrated care model, fiscal sustainability may be supported for primary care services through increased numbers of patients with health insurance as a result of the Affordable Care Act (ACA). While it is too soon to predict the impact of the ACA, more patients with insurance potentially means more revenue for primary care providers and less reliance on sliding fee scales. Still, there will be a number of patients in the AAPI community who are ineligible for health care coverage and/or who decide to forego having insurance, opting instead to pay the penalty.

We were successful at creating a model of care that addressed chronic disease management and psychiatric consultation with an integrated team approach that utilized strengths from each organization's staff. However, there were challenges with provider turn over. And, there were some issues that we were not successful at resolving. The volume of lab and phlebotomy demand was low, so it was necessary to train medical assistants (MA) to perform phlebotomy. While this is in the scope of a MA, there was not enough demand to develop sufficient expertise, which significantly impacted patient and clinic work flow. Thus, we often encouraged patients to go to one of the existing main clinic sites for these services. Additionally, some services were simply not offered at the satellite clinic site due to risk management concerns (e.g., IUD insertions, wart removal, and acute management of chest pain).

In the future, we anticipate that there will be increased awareness for wellness activities' positive contributions to health care outcomes, and individual payers may find ways to reward patients who do participate. For now, WAPA will sustain these activities through a partially capitated payment system, which allows mental health providers more flexibility in providing holistic care. Within this partially capitated payment system, we are able to maintain our transformed model of services and treatment that allows ACRS/WAPA to embed whole health and wellness in its core services.

While there have been significant gains with health care reform, there remains a very real political challenge with inconsistent implementation throughout the country. And finally, there is a possibility that health care reform could fail, which would negatively impact the sustainability of these integrated models serving complex patients.

Our patients have experienced improvements in health care access and health outcomes. They deserve nothing less than a continued commitment to these comprehensive, integrated services. Health care reform policy advocates must champion the unique needs of limited English proficient AAPI refugees and immigrants with SMI to ensure health equity.

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