The Affordable Care Act and integrated behavioral health programs in community health centers to promote utilization of mental health services among Asian Americans

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Abstract

The Affordable Care Act has greatly expanded health care coverage and recognizes mental health as a major priority. However, individuals suffering from mental health disorders still face layered barriers to receiving health care, especially Asian Americans. Integration of behavioral health services within primary care is a viable way of addressing underutilization of mental health services. This paper provides insight into a comprehensive care approach integrating behavioral health services into primary care to address underutilization of mental health services in the Asian American population. True integration of behavioral health services into primary care will require financial support and payment reform to address multi-disciplinary care needs and optimize care coordination, as well as training and workforce development early in medical and mental health training programs to develop the skills that aid prevention, early identification, and intervention. Funding research on evidence-based practice oriented to the Asian American population needs to continue.

Keywords

Integrated behavioral health, Primary care

INTRODUCTION

The passage and implementation of the Patient Protection and Affordable Care Act (ACA) expanded health care coverage by historic proportions in the USA. By the end of March 2015, over 11.4 million people have been enrolled in the health insurance marketplace, and over 10.8 million additional individuals are covered under Medicaid and the Children's Health Insurance Program (CHIP) [1, 2]. Importantly, this landmark policy included key provisions requiring coverage of mental health services at parity with general medical benefits, thus recognizing and promoting mental health as a major health priority in this country.

Individuals who suffer from mental health disorders often face multiple barriers to care and are often of low-income status, in part because the disorders frequently impact the individuals' work and functional capacities [3]. They may be uninsured or have incomplete coverage for mental health and substance use

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treatments, and depending on their work status pre-ACA, they may have even been denied coverage due to "pre-existing conditions" [4]. When left untreated, these disorders can worsen and create a greater burden on the health care system.

The ACA offers a turning point for mental health by enhancing affected patients' ability to obtain and maintain coverage. Specifically, it includes prevention, early intervention, and treatment of mental and/or substance disorders as "essential health benefits" of health plans in the health insurance marketplace [5]. The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 and the ACA policies help break down some barriers to care access, but there are still major gaps in mental health care utilization and care coordination. For disadvantaged populations, access to an already complex health system is often further hindered by socio-cultural and linguistic barriers, which need to be addressed in order to effectively engage individuals with mental health conditions [6].

This paper describes an effective community-oriented, behavioral health care model that promotes care access and utilization among Asian Americans (AA) with mental health conditions. With expanded support for behavioral health services, the ACA has encouraged the development of such care models and helped health care providers better address prevalent mental health needs in AA populations.

AAs are the fastest growing racial/ethnic group in the USA [7]. Approximately two thirds of Asian Americans are foreign-born [8] immigrants, many of whom face cultural and linguistic barriers. Counter to the misleading "model minority" narrative [9], AAs face similar mental health issues as other racial groups and may even carry a greater burden of some disorders. A study from the California Health Interview Surveys (CHIS) reported that among adults 55 years and older, Vietnamese are more likely than non-Hispanic whites to report needing help for mental

health problems but less likely to have their providers discuss these problems with them [10]. In other studies, AAs have been found to have a high prevalence of domestic violence, alcohol abuse, and psychological distress [11, 12]. Furthermore, AAs consistently underutilize mental health services when compared to the general population [11, 13–15].

While social stigma around mental health pervades across cultures, AAs may feel even greater stigma [16] because of cultural values stressing the avoidance of shame [17]. Cultural values around the family name and “saving face” may impede utilization of mental health services for fear of being poorly viewed by their communities [16, 18]. Other underlying causes for low access and utilization rates include the following: (1) discrimination associated with mental health services, (2) pressure from individuals and families to seek assistance from only the most trusted and familiar authorities within their respective communities, (3) the most trusted community sources tend to be community leaders and providers of non-mental health programs, often not trained to identify, assess, and manage mental health issues, and (4) existing mental health programs historically have not served AA communities, thus often lacking the skills to address needs in a culturally and linguistically competent manner [19].

ROLE OF PRIMARY CARE

Because they often serve as the first point of contact for patients and families, primary care medical homes are instrumental to the health care system and play an increasingly important role in the management of mental health disorders. The World Health Organization identifies the integration of behavioral health services within primary care as the most viable way of addressing underutilization and subsequent undertreatment of mental illnesses [20].

Community health centers (CHCs) provide primary health care to more than 20.2 million people nationwide and have become the mainstay of this nation’s safety net for medically underserved populations [21]. Importantly, CHCs provide comprehensive services which address not only specific health needs but also the varied social determinants of health affecting their patients, including poverty, lack of health insurance, low health literacy, and language barriers [21]. CHCs with predominantly minority populations serve patients in great need of culturally sensitive and

linguistically competent services. According to the 2012 Uniform Data System Report on federally qualified CHCs, 62 % of CHC patients are racial/ethnic minorities, 23 % have limited English proficiency (LEP), 93 % live at or below 200 % federal poverty level (FPL), and 36 % are uninsured [22].

Asian Health Services (AHS) is a CHC in Alameda County, California, that provides comprehensive, culturally and linguistically competent health care to low-income patients, including AAs. AHS provides primary care and select subspecialty services in English and 12 Asian languages to more than 24,000 patients, of which 59.8 % are female, 96.4 % are Asian, and over 95 % live at or below 200 % of the federal poverty level. As shown in Table 1, among patients 12 years and older recently seen in AHS’ clinics, the most prevalent behavioral health conditions were depression (12.4 %) and anxiety (4.1 %). These high rates among AHS patients and in the AA community are what motivated AHS to implement an integrated primary care-behavioral health program in 2012. The passage of the ACA furthermore provided timely and critical support to our program development efforts.

IMPLEMENTATION OF AN INTEGRATED BEHAVIORAL HEALTH PROGRAM

An integrated health program is “the systematic coordination of general (primary medical) and behavioral healthcare” in order to effectively care for people with multiple healthcare needs [23, 24]. Asian Health Services’ integrated program combined the essential elements of medical care home, care teams, and evidence-based step care protocols targeted to serve patients with mild to moderate behavioral health conditions. AHS further refined the model to include cultural and linguistic components and concepts important to serving its AA populations: (1) universal screening as part of routine care, (2) culturally and linguistically concordant services, (3) understanding the family system perspective, and (4) concrete services and case management support.

Figure 1 shows AHS’ integrated model and the multi-disciplinary care team, the core of which consists of a primary care provider (PCP), behavioral health clinician, medical assistant, case manager, and practice nurse. These care team members are co-located spatially and functionally within the medical care homes at

Table 1 | Top behavioral health conditions that were ever diagnosed among active patients age 12 years and older at Asian Health Services during the period of August 1, 2013 through July 31, 2014

Behavioral health condition	Unique diagnoses	Prevalence (%)
Depression	2357	12.4
Anxiety	777	4.1
Dementia	644	3.4
Schizophrenia	252	1.3
Post-traumatic stress disorder (PTSD)	328	1.7

Fig. 1 | Integrated primary care-behavioral health care system at Asian Health Services

AHS. Besides licensed clinical social workers (LCSWs) as counseling clinicians, behavioral health professionals within AHS' integrated program also include Master's level social workers (MSWs) who support panel management and patient engagement, as well as case managers who provide concrete services and linkages to community resources. In addition, a consulting psychiatrist is available on-site on a rotating basis to support the care team either through chart reviews, case conferences, or direct patient evaluations.

AHS proactively and universally screens patients annually for depression and anxiety with the PHQ5 as they engage in routine medical care, when enrolling as new members, and as needed (see Table 2). Similar to other validated PHQ4 screening scales [25], AHS' PHQ5 combines the PHQ2 depression screen with two questions from the Generalized Anxiety Disorder scale (GAD). Additionally, it includes a validated question on functional status [26]. For AHS' AA patients who often lack the specific language or cultural constructs to describe their experiences, screening for functional impact along with a mix of anxiety and depression symptomology was found to be important for detection and initial assessment.

In AHS' medical clinic, the screening instrument is administered by the medical assistant so as to incorporate it as part of the wellness or routine follow-up medical visit, or it may be applied as needed by the PCP when a patient experiences a self-reported or observed change in behavioral health status. The medical provider then evaluates the PHQ results and discusses with the patient the appropriateness of referral to a behavioral health clinician. The medical provider introduces the consenting patient to the behavioral health staff via a warm handoff which fosters continuity and an opportunity for an initial intake assessment.

In collaboration with the PCP and in the same medical home where the patient has always received services, the behavioral health clinician on the team may utilize other assessment tools (e.g., PHQ9, GAD7 [27–31]) to further identify care needs and provide treatment. All this is optimally provided by language-concordant care team staff and clinicians or with on-site translators as part of the care team. AHS' delivery model strives to destigmatize and promote utilization of its behavioral health services through integration and co-location of primary care and behavioral health professionals.

Table 2 describes in greater detail the stages of care in AHS' integrated system. AHS' integrated care model targets patients with mild to moderate mental health conditions, e.g., minimal-mild depression defined with a PHQ9 score of 1–9 to moderate depression with a PHQ9 score of 10–14 [32], who respond to brief therapeutic interventions.

The following real case description below gives an example of the complexity of behavioral and medical health issues among AHS' patients and the elements paramount to AHS' best practice in providing integrated care to its AA populations:

A 54-year-old Chinese-speaking woman has been under the care of her PCP for a cancer diagnosis. As the disease progressed, the patient decided to discontinue treatment. She voiced concern for her daughters, especially since her husband was unemployed, had a developmental disability, and suffered from chronic alcohol abuse. The patient struggled with serious emotional, physical, and end-of-life issues. Her 17-year-old daughter was also showing symptoms of mood disorder and education issues, while her 18-year-old daughter was the parentified child holding the family together. All were patients of AHS, allowing for an

Table 2 | Stages of care of Asian Health Services' integrated primary care-behavioral health model

Stages of care	Integrated Behavioral Health (IBH) at AHS
Access	<ul style="list-style-type: none"> • Proactive universal screening—with language concordant tools. Screening tool embedded in EHR • In integrated primary care (PC)-behavioral health (BH) clinic—by clinic staff [medical assistant (MA)/health coach (HC)] • At membership services department—BH staff co-located & proactively screen for psychosocial needs on initial eligibility and enrollment • Patient's initiation in primary care clinic
Engagement	<ul style="list-style-type: none"> • Triage nurse/primary care provider (PCP) calls for immediate warm handoff as needed or as screening results warrant • Immediate brief “huddle” between BH clinician and PCP to discuss engagement goals, further assessment • BH clinician meets patient in same exam room—with language concordant staff • Same-day in-depth BH assessment or arrange for return appointment
Assessment	<ul style="list-style-type: none"> • BH and PC staff with access to patient's medical and mental health records via common EHR • BH clinician provides culturally and linguistically concordant assessment • Patient familiar with interpreters as they have interpreted for medical appointments
Intervention	<ul style="list-style-type: none"> • Evidence based brief BH therapy • Joint intervention with case management and PCP to address holistic needs • Regular huddles based on acuity and needs to determine course/plan of treatment/intervention • Psychiatrist consultant available on-site for support and collaboration. Huddles with care team to deliberate treatment strategies
Monitoring/evaluation	<ul style="list-style-type: none"> • BH Clinician uses evidence-based tools and protocols to monitor progress of patients, tracks progress and data in EHR. • Program coordinator assists with population-based panel management. Coordinates with BH Clinician and PCP regarding “high Priority” list to be reviewed during huddles • BH clinician/PCP assist patients with “step up” or “step down” treatments depending on progress and common care plan
Transition/termination	<ul style="list-style-type: none"> • BH clinician discusses BH care termination with PCP prior to discharge • Review and formulate culturally appropriate Relapse Prevention tool with patient. Plan documented and communicated to PCP • PCP monitors for patient-specific warning signs and re-discusses/case confer with BH clinician as needed.

interdisciplinary meeting among the medical providers and behavioral health staff to develop comprehensive strategies to address both the patient's and the family's needs.

The co-location of AHS' primary care providers and behavioral health clinicians facilitated routine cross-interactions and fostered "curb side" consultations which set an integrated approach in motion. The patient's primary care provider presented her with an offer of behavioral health services to help her better manage her stressors and concerns, emphasizing that the behavioral health clinician was Chinese-speaking and able to provide culturally sensitive services. During one behavioral health session, the patient disclosed that she was aware her husband had been seeing another social worker in the clinic to address alcohol issues. Both she and her husband gave consent for the care team to address their family issues together. Although the daughters were not ready to accept counseling services, the family was aided by the case manager, who coordinated referrals to the daughter's school services, alcohol treatment for the father, and financial assistance programs for the family as the patient became more incapacitated and unable to work. While the patient continued under the medical care of her PCP, continuing a course of treatment appropriate to her cancer, a consulting psychiatrist provided recommendations on the behavioral health medications prescribed and gave the care team anticipatory guidance on alternative intervention strategies.

AHS' model of care delivers services with cultural sensitivity, acknowledging the importance of family as part of the behavioral health treatment plan. Patients and often their families, with the patient's consent, collaboratively develop and discuss treatment and support options with primary care and behavioral health clinicians during usual care contacts as well as in formal family conferences. Linguistically concordant staff allow the patients and families to fully engage and participate in the dialogue on assessment results and treatment plans. Engaging patients within their trusted primary care homes allows for flexibility and more customized approaches to care. The patients' long-standing relationships with their PCPs give rise to a sense of security and decrease the stigma of addressing mental health and disability issues. Inclusion of case management and concrete services linkage and navigation support are also important keys to engagement with Asian American patients and families. Concrete support services that address social determinants of health promote the acceptance of social workers, other behavioral health professionals, and adjunct staff as essential members of the care team. The trust built with the case managers often lead to patient's willingness to accept more in-depth behavioral health therapeutic services. This case illustrates how an integrated primary care-behavioral health model, culturally appropriate and linguistically concordant, effectively addresses some of the complex needs of Asian immigrant patients.

DISCUSSION

In the few years since AHS established its integrated primary care-behavioral health program, important lessons have been learned. First, the majority of AHS' primary care patients with behavioral health issues have mental health conditions in the mild to moderate spectrum of illness. These cases often go undiagnosed and undertreated, especially when compounded with language barriers, social stigma, and family influences. Proactive universal screening helps identify cases that risk-based testing would have otherwise missed.

Effective screening requires tools that can properly assess patients. However, with the relative paucity of mental health research on AAs, there is a scarcity of culturally and linguistically appropriate tools. Because of this "evidence gap", AHS has had to pilot and then adapt validated screening tools such as the PHQ2 beyond just language translations. AHS formulated a more AA population-appropriate PHQ5, expanding the PHQ2 to include PHQ questions targeting depression and anxiety as well as a functional impact question based on those symptoms. Furthermore, an effective and efficient universal screening protocol within a busy clinic requires great planning and continual process improvement to ensure its fit within the complex workflow.

The effective integration of behavioral health specialists on the care team is also critical. The availability of trained specialists familiar with cultural and linguistic nuances specific to the diverse AA population is limited. Thus, AHS dedicates a great amount of resources to train staff in the primary care-behavioral health integration model and continually engages in process improvements. Literature has shown that one cannot simply transplant traditional specialty mental health services into a primary care setting [33]. AHS' behavioral health specialists wear many functional hats: mental health diagnostician, therapist, medical social worker, gerontologist, child development expert, and care coordinator. All care team members need to know how to function as part of a multidisciplinary team and within the rhythms and pace of a busy primary care clinic environment. Intentional on-boarding, in-depth orientation to the primary care-behavioral health integration model, and continued support are crucial to sustaining staff for meaningful and effective service delivery.

The realization that many AAs may present with mild to moderate mental illnesses has important implications for the ACA. These less-symptomatic cases, if not identified in earlier stages through universal screening, may become medical emergencies detrimental to patients and their families as well as costly to the health care system. Investment of resources to understand how best to translate evidence to practice, application of validated materials in multiple languages with appropriate cultural and linguistic nuances, and intentional development of a sensitive and competent workforce are paramount to an effective program serving underrepresented and underserved

communities. Most of the ACA language places emphasis on severe mental illness, which while important, misses the opportunity to adequately address the importance of prevention and early intervention. As essential principles of a primary care-behavioral health integrated care system, proactive screening, prevention, and early intervention provide the most powerful means toward achieving the triple aims of improving the patient experience and overall health while reducing the costs of care. In addition, while significant evidence has demonstrated the effectiveness of an integrated primary care-behavioral health care practice [34, 35], payment and reimbursement models continue to lag in support of an integrated paradigm. Current payment models preclude reimbursements for same-day visits or warm handoffs between primary care and behavioral health providers in the same setting. Also, many funding streams support psychotherapy only by a licensed clinician or reimburse solely for the most severe mental health conditions rather than for early identification and management of mild to moderate symptoms. Reimbursement re-engineering and payment reform will be paramount to sustaining integrated care delivery models.

RECOMMENDATIONS

AA populations are reaping the benefits of the ACA by gaining increased access to coverage and primary care services. However, underserved and ethnic communities continue to face a myriad of challenges that limit their access to mental health care. Moving forward, true integration of care will require financial support and payment reform to sustain primary care-behavioral health integration in order to effectively address multi-disciplinary care needs and optimize care coordination. Training and workforce development also need to begin early in medical and mental health training programs to effectively equip clinicians and staff with the skills and mindsets needed for an integrated medical-behavioral health approach to early identification and intervention. Furthermore, funding for research to support evidence-based practices with AA populations needs to continue.

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