Innovative Health Improvement Programs for Underserved & Vulnerable Populations

“The People We Serve... The People We Are”

Strategy Transfer Guide

Primary Care and Mental Health “Bridge” Program
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Dear Colleague:

As a winner in the 2000 Models That Work competition, it is my pleasure to share with you information about Chinatown Health Clinic’s (CHC) Primary Care and Mental Health “Bridge” Program, its purpose, accomplishments, and successful strategies. I welcome you to review this guide, ask questions, and even visit us, if possible.

The purpose of the Bridge Program is to 1) integrate mental health services with primary care, 2) train primary care providers on early detection and treatment of common mental disorders, and 3) educate the community about mental health issues. The Bridge Program targets Chinese-Americans in the New York metropolitan area. Training is provided for primary care providers on mood and anxiety disorders, with a focus on screening, counseling skills, psychopharmacology, and appropriate referrals. Community education and outreach on mental health issues is ongoing through bilingual radio broadcasts, news articles, development of brochures, and workshop presentations for teens, parents, older adults, and service professionals.

Since the program began in November 1997, the number of patients diagnosed with psychiatric disorders and the number of mental health encounters at CHC have more than tripled. In the calendar year 2000, the Bridge Program saw more than 300 patients, totaling over 1,800 encounters. The majority of these patients were diagnosed with mood or anxiety disorders.

The most gratifying aspects of our program are that patients in psychiatric distress are receiving an earlier diagnosis and treatment. Asian Americans with mental disorders often do not receive appropriate treatment until they are chronically ill or in crisis. In addition, our education campaign is bringing mental illness out in the open, raising community awareness, making it an acceptable topic for discussion, and informing the public that mental disorders are not shameful, but instead, treatable.

The clinical component of our model is being replicated and adapted this year at South Cove Community Health Center in Boston, a community health center also serving predominantly Asian Americans. If you would like more information, please contact Fanny Chin, Bridge Program Coordinator, at 212-966-0228 or at fchin3@hotmail.com.

Sincerely,

Alan Tso, M.D.
Medical Director
Name of Program: Primary Care and Mental Health “Bridge” Program
Lead Organization: Chinatown Health Clinic
Kind of Model: Integration of mental health with primary care
Location: New York City

Partner Organizations
Gouverneur Diagnostic and Treatment Center, Elmhurst Hospital, NYU Downtown Hospital, Hamilton-Madison House, private physicians, community mental health professionals, academic faculty at medical and nursing schools, schools and community-based organizations, funding partners.

Health Related Outcomes
- Increased number of mental health encounters by more than 300%
- Most Bridge patients are diagnosed earlier with serious disorders: 54% with depression, 17% with anxiety disorders, and 23% with psychosis. At the nearby Gouverneur Diagnostic and Treatment Center’s mental health clinic, 67% of Asian American patients present with psychotic disorders, 19% with depression, and 12% with anxiety disorders.
- Of the Bridge patients who were referred to local mental health agencies for long-term treatment, six months later 66% of these patients were still in treatment.
- 96% of Bridge patients surveyed rate the mental health treatment received as “excellent” or “good.”
- Trained over 100 primary care clinicians since inception of program.

For Additional Information:
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Population Served/Community Need

The Bridge Program was created in response to the significant barriers to delivering mental health care to the Asian American community. Compared to other racial and ethnic groups, Asian Americans have the lowest utilization of mental health services and the greatest delay in receiving appropriate care when these problems do occur. This has resulted in poor treatment outcomes since they are often in crisis or chronically ill when they do seek treatment. The reluctance to seek help can be attributed to the severe stigma of seeking services for mental illness as well as the dearth of bilingual and bicultural treatment capacity. Although national epidemiological data is scarce, evidence of poor outcomes include: 1) Asian women between the ages of 15-24 have the second highest suicide rate in the U.S., and 2) Asian women, 65 years and older, have the highest suicide rate in the U.S.

The Bridge Program serves predominantly the Chinese American population in the greater New York area, by integrating mental health services with primary care at Chinatown Health Clinic (a federally funded health center) and at its satellite site, Flushing Primary Care Center (FPCC). Chinatown Health Clinic has a 30-year history of providing bilingual/bicultural outpatient primary care services to predominantly Chinese-speaking populations in the metropolitan New York area. To meet the health needs of a growing Asian American population in Queens, CHC opened the Flushing Center in 1997. Both centers provide primary care health services, such as internal medicine, pediatrics, prenatal care, various medical specialties, as well as educational and preventative outreach programs. Although CHC is located in lower Manhattan and FPCC is in Flushing, Queens, two neighborhoods with large Chinese and Asian populations, CHC/FPCC patients seeking bilingual health services come from all five boroughs, and even from as far as New Jersey, Connecticut, and Long Island.

CHC's nationally-recognized health education department and its social work department contribute to the Bridge Program by conducting educational outreach activities in the community about mental health or substance abuse, and providing concrete services to patients who may need financial assistance or social services.

Program Goals

Since Asian Americans tend to seek primary care physicians for most of their medical needs, one major focus of the program was to increase patient access to mental health services by integrating primary care and mental health services on-site. A second major focus was to upgrade the skills of primary care providers in the community and at the integrated sites. This is an important component of the program because early identification and treatment of patients with psychiatric disorders will result in improved outcomes. The third major focus of the Bridge Program was to raise community awareness of mental health issues through on-going community education and outreach activities.

All three goals are closely linked together. Raising community awareness about mental health reduces the stigma associated with seeking mental health treatment. As individuals become more knowledgeable about the effects of untreated mental disorders, such as depression, they can adversely effect one's physical health and well-being, and their families will be more receptive to seeking treatment. Offering mental health services in a primary care setting increases the chances that an individual will pursue the necessary
treatment because the stigma of seeking help at a designated mental health facility is removed. Providing the proper training in the identification of patients with mental disorders is crucial because primary care providers tend to be the first, and sometimes, the only practitioners these patients are willing to see for their symptoms. In the general medical setting, as many as 20% of patients may have a psychiatric disorder.

Integration of Primary Care & Mental Health Services

Two-thirds of patients who are users of medical care have a psychiatric disturbance: 23% have depression, 22% have anxiety, and 20% have somatization. Patients suffering from depression sometimes present numerous somatic complaints, such as headaches, indigestion, difficulty sleeping, recurring aches and pains which can be easily misdiagnosed. Depression can also exacerbate other diseases, such as hypertension, diabetes, and heart disease. These patients may see a number of doctors before they are identified as having depression. However, even if diagnosed correctly, only 1 in 4 patients referred to specialty mental health/substance abuse services ever follow-up on the recommended referral. In addition, the success rate of referring patients from primary care to mental health services is low because of the barriers that may be related to culture, language, lack of insurance, etc.

Clearly, the primary care setting is an ideal place for early detection and treatment of commonly seen behavioral disorders, and for many patients, it will be the only place.

At CHC and FPCC, the full commitment of the Board, senior administrators, and medical staff allowed for the natural integration of mental health with primary care on-site. Patients in the Bridge Program must be registered patients at either CHC or FPCC. They are referred by their Primary Care Provider (PCP) to see a mental health clinician who is located at the same site as the PCP. Therefore, patients are not sent to a separate location for mental health services, they mingle and sit in the same waiting areas as primary care patients. As a result, seeing a mental health clinician at CHC is no different from seeing a cardiologist or allergist on-site. CHC offers several specialties on-site, e.g. dentistry, cardiology, ophthalmology, etc. Patients who need to see mental health clinicians make appointments with the same front desk receptionists as other patients.

Like the primary care providers, all mental health clinicians wear white coats when seeing patients. In terms of physical layout, mental health clinicians see patients in the same patient area as the pediatricians, internists, cardiologists, or ophthalmologist. Charting and filing is the same, i.e., clinicians complete their chart documentation on the same medical chart as primary care providers. Although occasional reminder calls and letters to patients are made by some of the Bridge Program staff, the bulk of follow-up calls or letters/postcards are sent by the same staff who routinely handle follow-up reminders for primary care patients. If a patient does not show up for initial mental health assessment, the clinician notifies the PCP so that the PCP can re-engage the patient, reassess whether a mental health referral is still needed and try to persuade the patient to pursue treatment.

All mental health clinicians in the Bridge Program have experience working with Chinese patients in mental health and are bilingual in Chinese; speaking Mandarin, Cantonese or both dialects, thus ensuring the delivery of culturally and linguistically appropriate services. As much
as possible, receptionists schedule patients to see clinicians who speak the same dialect, as a result, patients rarely need an interpreter. A Certified Social Worker (CSW), experienced in psychiatry, assesses each patient and decides whether a patient needs short or long-term treatment and whether family involvement is necessary. Occasionally, if the CSW is overbooked, initial assessments are also scheduled for the staff psychiatrist to complete. In general, patients needing more than 10-15 visits are candidates for long-term treatment.

The CSWs facilitate referrals for chronically ill patients who need more intensive mental health treatment at Gouverneur Diagnostic and Treatment Center, Elmhurst Hospital, or other bilingual/bicultural mental health services such as at the Hamilton-Madison House or Henry Street Settlement. The CSWs are crucial players in the success of the Bridge Program; by playing dual roles in both primary care and mental health settings, they are the human “bridge” between primary care and mental health. However, CSWs and psychiatrists who are accustomed to the traditional mental health model must adapt to the Bridge Program primary care model. In contrast, Bridge Program clinicians must learn to work in a faster paced medical setting, use briefer sessions, and document on the same charts as PCPs, using medically-oriented notes instead of process-oriented notes.

Training For Primary Care Providers

A shortage of bilingual/bicultural mental health professionals in the community calls for greater utilization of the relatively larger number of bilingual/bicultural primary care professionals now serving the community. However, PCPs are not trained to deal with issues related to mental disorders and mental health. Yet, they face patients with these disorders in their office on a daily basis. Research also shows that there is a considerable number of misdiagnosis, and sub-optimal treatments of mental disorders in primary care settings. With support from mental health professionals, primary care settings can be a place for early detection and treatment of mental disorders. The Bridge Program provides periodic training for PCPs (staff PCPs and community PCPs) in the detection and management of patients with mental disorders.

A four-part behavioral health lecture series is presented once a year to community PCPs and nurses. The lecture topics are: 1) Screening Methods, 2) Basic Principles of Psychopharmacology, 3) Counseling Skills, and 4) Advanced Psychopharmacology. Each lecture includes a question & answer period which, lasts an hour and a half. The Bridge team’s psychiatrist, with some help from the CSW, organizes and presents the lecture topics, using overheads or slide presentations as visual aids. Related reading materials and useful screening tools from various sources are distributed to participants at the end of each lecture for further review. For the convenience of community PCPs, lecture times are scheduled in the evenings. As an incentive, a simple buffet dinner is provided during the lectures and continuing medical/nursing education credits are arranged for all participants.

Clinical support staff and PCPs also receive periodic in-service training on mental disorders commonly seen in the primary care setting. These workshops are scheduled on days and hours when most of the staff are present, e.g. general staff meetings, nursing meetings, or provider meetings. Because of time constraints, staff workshops are generally shorter in length, 45-60 minutes. Occasionally, outside professionals such as child psychiatrists from local hospitals are invited to present mental health topics to staff.
during nursing and provider meetings. Health education, social work, and mental health staff are also invited to attend these behavioral health presentations. Since receptionists have constant patient contact, in person and through the telephone, they also participate in mental health training workshops. It is a longstanding organization policy to provide in-service training during work hours on a wide variety of health related topics, as a result, implementing behavioral health training was not unusual and widely accepted by staff and providers.

One of the goals of the Bridge Program is to produce a clinical handbook that would be a quick reference guide for primary care providers in the early detection and treatment of mental disorders commonly seen in Asian patients in a primary care setting. More than a dozen primary care and mental health professionals have joined the Bridge Program’s Editorial Advisory Board and are collaborating in writing this handbook. Many of the Editorial Advisory Board are senior faculty of major medical institutions in the NYC area or long-time mental health professionals serving Asian Americans in the community.

Community Education on Mental Health

Lack of knowledge about mental disorders and how to access mental health services prevent many patients from entering the existing mental health system. The stigma associated with mental illness is a huge barrier. Raising the awareness of the community to mental health issues, such as depression, suicide, and anxiety disorders through Chinese-language media and outreach activities is an important component of the Bridge Program. Some of these outreach activities include: periodic radio broadcasts; call-in hotline programs; newspaper articles; production and dissemination of bilingual pamphlets; workshops with teens, parents and service professionals; and presentations on Asian mental health in a variety of community forums.

In the past, patients would never bring up the subject of mental disorders during a medical encounter, yet, recently a few PCPs reported that some of their patients are actually asking the doctors to tell them if they have depression or anxiety disorders. Several community-based private PCPs in the local area also refer patients to CHC for mental health consultation and management. This increased awareness may be attributed to the broad-based community outreach education campaign waged in the last two years. Health educators recently arranged with a reporter from the World Journal Weekly Supplement, a bilingual weekly newspaper circulated nationally, to interview a patient and her daughter at CHC. The patient described her experience with depression, which began shortly after immigrating to the U.S. The daughter discussed how the family coped with her mother’s illness for many years. With emotional support from the family, her mother finally agreed to seek mental health treatment. They talked about how antidepressant treatment significantly improved her moods, how the patient’s many somatic complaints eventually disappeared, and how she can now enjoy life. Publication of the patient’s story resulted in numerous phone calls from places as far as Indiana and California. Callers said they or a family member have similar symptoms and asked how they could get help. In the near future, excerpts from the interview will be broadcast over Sinocast, a bilingual radio station aired in six major metropolitan areas in North America. Getting the message out as much as possible, especially via personal testimony, and in an ongoing consistent manner, does raise community awareness over time, and has potential for powerful changes.

Community Partnerships

From the start, collaboration was begun with hospital partners that established bilingual mental health programs in the area, primarily because of their Asian bilingual expertise and reputation for quality services. In addition, hospital affiliation offers inpatient back-up. Hence, CHC has contractual agreements with the Departments of Psychiatry at both Gouverneur Diagnostic and Treatment Center (in Manhattan) and Elmhurst Hospital (in Queens) to share bilingual CSWs. The CSWs have experience working with Asian populations in behavioral health. They work part-time at their hospital and part-time in the Bridge Program to provide initial assessment and psychotherapy for Bridge patients at CHC and FPCC.
Partnering with the local medical associations, the Chinese American Medical Society (CAMS) and the Chinese American Independent Practice Association (CAIPA) helped in the effort to train community PCPs on mental health issues. In the summer of 1998, about 75 of these community physicians participated in the Clinic's survey on mental health management skills of Asian American primary care providers. Survey results were presented at a CAMS Annual Scientific Meeting in November 1998, as well as discussion about the program model and community mental health issues. Both CAMS and CAIPA shared their mailing lists with the Clinic so that hundreds of community PCPs could be informed of the Bridge Program’s annual lecture series on behavioral health skills for community PCPs.

CHC is also an active member of the New York Coalition for Asian American Mental Health, a network of 200 mental health professionals in greater New York which advocates for improved mental health and substance abuse services for Asian American Pacific Islander communities, and meets on a monthly basis. Although a few of these professionals have private practices, most are mental health professionals who provide direct patient services at psychiatric programs in hospitals, community-based organizations or government-funded agencies. Members of the Coalition welcome referrals from Bridge Program clinicians. In 1999, CHC and the Coalition collaborated in developing and disseminating an “Asian American Behavioral Health Service Directory for Metropolitan New York” which lists over 35 mental health referral sources for the benefit of community residents, primary care providers, and service professionals. Due to the demand for the directory, a second printing was completed in 2000.

Program Outcomes

Health Resources and Services Administration’s (HRSA) Regional Office provided technical and evaluation assistance of $20,000 during the first year (1998-1999). This allowed CHC to hire a data manager to improve retrieval of diagnostic and evaluation information. Various data on patient utilization, mental health diagnoses and payor source for mental health encounters was collected from the inception of the program and incorporated as part of the Clinic patient database. The chart below reflects patient utilization of the Bridge Program services at both CHC and FPCC, from July 1997 to December 2000. The number of patients diagnosed with psychiatric disorders and the number of mental health encounters have more than tripled since November 1997 (see chart below).

The pie chart below indicates that in calendar year 2000, the majority of Bridge patients (71%) were diagnosed with mood and anxiety disorders. In contrast, at nearby Gouverneur Diagnostic and Treatment Center’s Asian mental health clinic, 67% of the patient diagnoses were psychotic disorders while 31% were mood and anxiety disorders. This shows that through the Bridge Program, primary care providers may have increased opportunities to detect...
mental disorders at earlier stages and refer patients appropriately to the mental health Bridge team for treatment.

Patient satisfaction data of the Bridge Program's mental health services is collected on an on-going basis at CHC and was last updated in May 2000. Patient surveys indicate that, thus far, patients perceive that when they return for mental health visits, they are treated as equally as other primary care patients. This may be an indicator that, for patients seeking help, an integrated model of providing mental health services helps erase the stigma associated with seeking mental health treatment. In addition, the patients surveyed feel that the mental health treatment they receive at CHC is helpful and non-stigmatizing (see charts below).

The chart below shows that in the last two years, CHC and FPCC primary care providers are diagnosing more patients with mental disorders, which is probably due to increased provider training in the early detection of behavioral disorders via the Bridge Program. Also, rather than managing these patients on their own, most CHC and FPCC providers prefer co-managing and referring patients diagnosed with mental disorders to the on-site mental health clinicians.
Implementation of Model Program/System

- Patient viewing x-ray
- Close-up of stethoscope
- Close-up of capsules
The clinical component of the program has already been adapted at South Cove Community Health Center, a center serving predominantly Asian Americans in Boston. The Bureau of Primary Health Care will support expansion of the Bridge Program in year 2001, as well as fund health expansion services at three Asian American Pacific Islander health centers in the U.S. The following is a description of steps that may be taken to replicate the Bridge Program model in other communities.

1. Define the mental health needs of your community and identify any gaps in services currently provided.

2. Reach out to community mental health agencies and the local coalition that advocates for mental health services. Collaborating with these agencies is crucial because they will be referral sources for chronically ill patients who need long term mental health treatment. Let them know that your program focuses on identifying individuals in primary care who are in psychiatric distress. Additionally, tell them that your program may bring them more patients or increase opportunities for co-management if the community service is overwhelmed. The Bridge Program is ideal for primary care patients who are not currently receiving any mental health care, who do not suffer from chronic mental disorders, and who can benefit from short-term therapy, medication management, and social services.

3. If feasible, share staff with other mental health agencies. The Bridge Program’s psychiatric social workers were originally full-time mental health clinicians at other community mental health programs that also serve Asian Americans. CHC has contractual agreements with two community mental health programs so that experienced, bilingual psychiatric social workers provide mental health services part-time in the Bridge Program (one on each site). The psychiatric social workers’ expertise in community mental health and their connections within their agency and with other mental health programs facilitate patient referrals tremendously.

CSWs or counseling staff must be trained in the model, have a short-term orientation, work at a faster pace, and be flexible in the primary care setting. They should be seen as partners in the primary care model.

4. Involve the local medical society as a partner in the project. Their support and contacts can be very important, especially if the training of primary care providers is an added component in your program.

5. Train primary care providers at your center and in your community on recognition and management of patients with commonly seen psychiatric disorders, i.e. depression, anxiety disorders. Include clinical support staff in these training sessions.

6. Educate the community about mental health issues through a variety of on-going outreach activities, e.g. radio broadcasts, news articles, workshops, presentations, educational brochures, etc.

7. Establish data collection methods to evaluate outcomes, e.g., number of mental health patients and visits (seen by primary care providers and mental health clinicians), types of mental diagnoses, patient satisfaction data, etc. Data collection improves opportunities for sustainability through grant funding and managed care contracting.
**Funding/Resource Development**

**The Robert Wood Johnson Foundation’s Local Initiative Funding Partners Program.** The major funder of the Bridge Program through its matching grant.

**The Van Ameringen Foundation.** Provides major funding for the Bridge Program’s initiatives on children and maternal primary care and mental health.

**The New York Community Trust.** Provides funding for the Bridge Program’s initiatives on adolescent mental health.

**The Pfizer Foundation.** Supports the Bridge Program’s clinical component and training initiative for primary care providers.

**The Sergei S. Zlinkoff Fund for Medical Education.** Supports the Bridge Program’s clinical and training initiatives.

**The Substance Abuse and Mental Health Services Administration (SAMHSA).** Provides funding for an elderly mental health outcome study.
Models That Work Campaign Information

Physician assisting child on crutches  Close-up of a child's face  Close-up of a woman's face
This Strategy Transfer Guide is made possible through the “Models That Work” Campaign, administered by the Health Resources and Services Administration’s (HRSA) Bureau of Primary Health Care. We would like to acknowledge and thank our cosponsors listed below:

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- Association of Asian Pacific Community Health Organizations
- Association of Maternal and Child Health Programs
- Association of Schools of Public Health
- Association of State and Territorial Health Officials
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- National Association of County and City Health Officials
- National Association of Rural Health Clinics
- National Medical Association
- National Center for Farmworker Health
- National Conference of State Legislatures
- National Health Care for Homeless Council
- National Minority AIDS Council
- National Organization of AHEC Program Directors
- National Rural Health Association
- Pharmacia and Upjohn, Inc.
- Quality Education for Minorities Network
- University of Arizona, Rural Health Office
- Virginia Primary Care Association, Inc.
- W.K. Kellogg Foundation
The Health Resources and Services Administration Bureau of Primary Health Care has published the 2000 Models That Work Compendium. This publication describes unique features of more than 80 community-based primary health care programs that participated in the 2000 competition. To obtain a copy of the compendium, video, or other materials, call (800) 859-2386.

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