



After Katrina: Integrating Behavioral and Primary Health Care in the New Orleans Metro Area

A quality improvement learning collaborative paves the way for health care integration

SUMMARY

In August 2005, Hurricane Katrina and the subsequent breach of the levee system caused catastrophic damage to the health care infrastructure and workforce in the New Orleans metropolitan area. This loss of infrastructure converged with elevated rates of mental illness to seriously challenge the delivery of both primary care and behavioral health care services.

In response to these challenges, from 2008 to 2011, the [Louisiana Public Health Institute](#)—a New Orleans-based nonprofit that works to improve population-level health outcomes—organized and supported a quality improvement learning collaborative aimed at integrating behavioral and primary health care. An evaluation of the initiative, conducted by the Louisiana Public Health Institute, measured outcomes, examined challenges and identified lessons.

The initiative built on a \$100 million grant from the U.S. Department of Health & Human Services—called the Primary Care Access and Stabilization Grant (PCASG)—to assist in the restoration and expansion of medical, mental health and other support services in the metro New Orleans area.

Key Results

The Louisiana Public Health Institute reported the following results to RWJF in its evaluation report:

- The number of primary care sites with behavioral health staff increased from 13 to 20 sites.
- The Commonwealth Fund 2009 Survey of Clinic Patients in New Orleans found that about 78 percent of patients surveyed who needed to see a behavioral health professional were able to see a provider at their PCASG primary care clinic.

- The PCASG project team helped the Louisiana Department of Health & Hospitals secure a Medicaid Demonstration Waiver for the greater New Orleans area that includes reimbursement for behavioral health services provided through primary care and thus preserve the accomplishments achieved under this initiative.

Funding

The Robert Wood Johnson Foundation (RWJF) supported this project through a grant of \$821,940.

CONTEXT

Eleven months after Hurricane Katrina destroyed much of New Orleans, a survey in July 2006 found that only 42 of the 208 licensed psychiatrists in the region had returned to practice there. In addition, the number of psychiatric hospital beds in southeast Louisiana shrank from 462 to 190.¹

This loss of infrastructure converged with elevated rates of mental illness to seriously challenge the delivery of both primary care and behavioral health care services. Another post-Katrina survey found that 31 percent of those who lived in the hurricane-affected areas had a mental illness, and 11 percent had a severe mental illness. These were twice the levels recorded before the hurricane.²

A Rebuilding Grant

In 2007, the federal Department of Health and Human Services awarded the state of Louisiana a \$100 million Primary Care Access and Stabilization Grant (PCASG) to help restore and expand medical, mental health, and other support services for the low-income population in the affected region. The state contracted with the Louisiana Public Health Institute to oversee the grant. Some 25 health care organizations received funding under the federal grant.

The influx of federal funds provided an opportunity not only to address a dire local need for behavioral health care, but also to apply lessons from RWJF's *Depression in Primary Care* national program, which was completed in 2007. Directed by Harold Pincus, MD, the national program was designed to spur health care organizations to recognize and treat depression in primary care settings. For more information on the program see the [Program Results Report](#).

¹ Walsh B and Moller J. "Few Doctors, Facilities Open after Hurricane." *The Times-Picayune*, 2006. Available [online](#).

² Kessler RC, Galea S, Jones RT and Parker HA. "Mental Illness and Suicidality After Hurricane Katrina." *Bulletin of the World Health Organization*, 2006. Available [online](#).

RWJF's Interest in This Area

RWJF has provided a variety of support to the New Orleans metro area as it recovers from Hurricane Katrina. See a special report, *In the Eye of the Storm*, about RWJF's immediate response.

See also a [Program Results Report](#) on RWJF's support of the Rapid Evaluation and Action for Community Health in New Orleans, Louisiana (REACH NOLA), which from 2007–2010 tackled the city's mental health crisis through its Health and Resilience Project, which brought together community members, service providers, faith-based organizations and academic institutions to develop culturally relevant services for stress, depression, anxiety and trauma-related mental illness among low-income, uninsured residents.

Outside of the region, RWJF has funded *Prescription for Health* and *Depression in Primary Care*, two programs focused on integrating behavioral health into primary care practices.

The Project

In 2008, the Louisiana Public Health Institute launched a quality improvement learning collaborative to help health care providers in metropolitan New Orleans integrate behavioral and primary health care. Some 23 of the 25 health care organizations funded under the \$100 million federal Primary Care Access and Stabilization Grant (PCASG) participated to some degree in the learning collaborative funded by RWJF—amounting to 81 total service delivery sites (with 370 providers), including federally qualified health centers, community health centers, and mental health centers.

Specific goals of the initiative, called the Collaborative to Improve Behavioral Healthcare Access (CIBHA), were to:

- Increase identification and treatment of depression in primary care.
- Promote the use of the [chronic care model](#) and evidence-based practices to treat and manage depression and other common behavioral health conditions. As applied in RWJF's *Depression in Primary Care* national program, the chronic care model entailed the use of practice elements such as screening for depression, creating chronic illness registries to track patients' progress, and including a behavioral care consultant in the care team. The model was developed by Edward Wagner, MD, MPH, under RWJF's program, *Improving Chronic Illness Care*. (For more information on the program, read the [Program Results Report](#).)
- Implement clinical and financial strategies that could sustain the integration of behavioral and primary health care

The project team provided support to the health care sites through several means:

- Three conferences with all the participating sites. Two of the conferences provided training on integrating behavioral and primary health care; the third provided an opportunity for participating organizations to share experiences and also learn how the 2010 federal health reform legislation—the Patient Protection and Affordable Care Act (ACA)—will affect the integration of behavioral and primary health care.
- Five didactic and interactive workshops providing participants an opportunity to develop their skills in integrating behavioral and primary health care. Some of the workshops offered continuing education credits.
- Five roundtables providing participants with an opportunity to network with each other regarding their efforts in the project
- One-on-one technical assistance with national experts via conference calls and in-person visits

External Consultants and Partners

The Louisiana Public Health Institute contracted with two consultants for assistance in overall project design, implementation and evaluation:

- Co-Project Director Harold Pincus, MD, of the Research Foundation for Mental Hygiene and Columbia University, and formerly the director of RWJF's *Depression in Primary Care* program
- Jeanie Knox Houtsinger of the University of Pittsburgh Department of Psychiatry and the RAND Corporation, formerly deputy director of *Depression in Primary Care*

The institute also contracted with two companies to provide training and technical assistance:

- **Comprehensive Motivational Interventions** trained providers in techniques to engage and motivate patients with common behavioral and chronic diseases to practice self-care management. They also developed and conducted a train-the-trainer program to instruct providers in how to train their colleagues in the use of these techniques.
- **Mountainview Consulting Group** provided training, along with onsite and telephone technical assistance and consultation.

In addition, three schools planned and certified some of the training activities for continuing professional education credits for physicians, nurses, and social workers:

- Louisiana State University Health Sciences Center
- Tulane University School of Social Work
- University of Massachusetts Medical School

Evaluation

The Louisiana Public Health Institute conducted an evaluation of the initiative to determine:

- The degree to which the sites were able to implement and sustain specific elements of the clinical model for behavioral health management in primary care settings
- The implementation barriers that were encountered and how the sites overcame them
- The overall lessons learned from the program and the implications for policy and other programs

The evaluators collected qualitative data from clinic personnel and project staff, chiefly through questionnaires and interviews. For quantitative data, they relied on findings from the Primary Care Access and Stabilization Grant program, as well as, some additional findings from the Commonwealth Fund 2009 Survey of Clinic Patients in New Orleans³.

RESULTS

The Louisiana Public Health Institute reported the following results to RWJF in its evaluation report:

- **The number of primary care sites with behavioral health staff increased from 13 to 20.**
- **Among all patients seen in years two and three of the Primary Care Access and Stabilization Grant (PCASG) program, about 30 percent received a behavioral health diagnosis.**
- **The Commonwealth Fund 2009 Survey of Clinic Patients in New Orleans found that 78 percent of patients surveyed who needed to see a behavioral health professional were able to see a provider at their PCASG primary care clinic.⁴**
- **By the second year of the project, the two components of the chronic care model most firmly in place were decision support and leadership:**
 - Decision support includes the implementation of evidence-based guidelines and systematic screening procedures.
 - Leadership includes the presence of a care team (composed of primary care, mental health, and senior administrative personnel) responsible for reviewing treatment and quality improvement guidelines, and for setting goals.

³Doty MM, Abrams MK, Mika S, Rustgi SD and Lawlor G. *Coming Out of Crisis: Patient Experiences in Primary Care in New Orleans, Four Years Post-Katrina—Findings From The Commonwealth Fund 2009 Survey of Clinic Patients in New Orleans*. New York: The Commonwealth Fund, January 2010. Available [online](#).

⁴ *ibid.*

- **The PCASG project team helped Louisiana secure a Medicaid Demonstration Waiver that includes reimbursement for behavioral health services provided through primary care, thus preserving the accomplishments achieved under this initiative.** The waiver, awarded in 2010, is in effect until the end of 2013, when the state’s Medicaid expansion and insurance exchanges begin under the ACA—the federal health reform legislation.

Barriers to Success

The evaluation report also noted several challenges the project team faced during implementation:

- **The role of the behavioral health clinician within the care team was not always clearly defined.** This led to situations in which, for example, behavioral health care providers reported seeing themselves not as behavior change consultants contributing to the care team, but rather as traditional psychotherapists who were simply sharing clinic space.
- **The typical challenges related to the turnover of leadership and staff was complicated by the need to train new personnel in the intricacies of integrating behavioral and primary health care.** Practices reported frustration that each time a new person was hired, their efforts at integration almost had to start over again.
- **Memorandums of understanding and other contractual agreements were often poorly structured or absent.** The most common weaknesses of these agreements related to:
 - Defining the role of the behavioral consultant
 - Information sharing between the behavioral health providers and primary care entities, particularly when it involved matters of patient privacy
- **Most practices interviewed cited some challenges to workflow.** For example, some had difficulty incorporating behavioral health screening tools into the clinic workflow, while others had scheduling conflicts that prevented patients from seeing a behavioral health consultant the same day as their primary care visit. An additional barrier is the Louisiana Medicaid prohibition to paying for two different Medicaid services in the same day.

LESSONS LEARNED

1. **Starting small and working up to organization-wide changes is an effective, workable approach to practice redesign.** For example, one practice learned that universal screening of every patient was not feasible given the capacity of its behavioral health staff. As a result, they focused their screening efforts on patients with chronic illnesses. (Formative Evaluation Report)

2. **Encourage buy-in through regular feedback to providers.** Performance feedback that allows providers to see that their patients are improving as a result of seeing a behavioral health consultant can help encourage further commitment to integrating behavioral and primary health care. (Formative Evaluation Report)
3. **Identify and groom leaders at the front-line level who can execute a clear vision of integrating behavioral and primary health care.** An effective leader can generate buy-in from staff and hold them accountable for achieving goals and outcomes for the integration efforts. (Formative Evaluation Report)
4. **Carefully craft memorandums of understanding and other contractual agreements.** These documents should clearly explain the roles, responsibilities and expectations for behavioral health staff, and how information should be shared between the behavioral health providers and primary care entities. (Formative Evaluation Report)
5. **Strive to integrate behavioral and primary health care within the context of the chronic care model.** Some clinics found it easy to slip into old patterns of care. For example, though the chronic care model calls for holistic care of the whole person, some clinics continued to treat co-occurring diseases (such as diabetes and depression, which occur simultaneously in individual patients at a high rate) as separate conditions. (Formative Evaluation Report)
6. **Provide technical assistance proactively, and adjust to changing needs when necessary.** The project team identified its “on-the-ground” technical assistance, provided by nationally recognized experts, as key. Further, when the team determined that attendance was low during their technical assistance conference calls, they switched to site visits and one-on-one coaching. (Formative Evaluation Report)

AFTERWARD

The Collaborative to Improve Behavioral Healthcare Access (CIBHA) project team reported the following post-grant activities to RWJF:

- The quality improvement trainings and technical assistance conducted during the RWJF grant continued until the end of September, 2011, through a quality improvement component established through the Primary Care Access and Stabilization Grant (PCASG).
- The Louisiana Public Health Institute has convened a collaboration of several major hospitals, public health agencies and community-based primary care providers in the Crescent City Beacon Community (CCBC) initiative focused on reducing the burden of chronic disease, mainly diabetes and cardiovascular diseases by accomplishing the following goals: Improving chronic care management (CCM) through patient-centered medical homes, enabled by health information technology (HIT); reducing health care costs by improving transitions of care (TOC) between hospitals and

primary care practices; and testing innovative technologies and strategies to engage patients and the public in the health care process. The project will incorporate technical assistance and training similar to that offered under the RWJF grant. It is funded through the [Beacon Community Program](#) of the Office of the National Coordinator for Health Information Technology at the U.S. Department of Health and Human Services.

Prepared by: Robert Crum

Reviewed by: Robert Narus and Molly McKaughan

Program Officer: Andrew D. Hyman

Grant ID # 063540

Program area: Vulnerable Populations

BIBLIOGRAPHY

(Current as of date of the report; as provided by the grantee organization; not verified by RWJF; items not available from RWJF.)

Reports

Evaluation Report

CIBHA Evaluation Team. *Formative Evaluation Report*. New Orleans: Louisiana Public Health Institute, 2011. Available [online](#).

Education or Toolkits

Toolkits, Toolboxes or Primers

Draft Referral MOU Template (Memorandum of Understanding Between Behavioral Health Organization and Primary Care Organization). New Orleans: Louisiana Public Health Institute, 2009.

Patient Self-Management Toolkit. Available [online](#).

Quality Improvement Toolkit. Available [online](#).

Communication or Promotion

Grantee Website

www.lphi.org. The website of the Collaborative to Improve Behavioral Healthcare Access contains project descriptions, toolkits, conference slides, and a listserv for participants. New Orleans: Louisiana Public Health Institute. It includes the following toolkits:

- *Adult Depression Toolkit*. Available [online](#).
- *Adolescent Depression Toolkit*. Available [online](#).
- *Care Management and Disease Registry Toolkit*. Available [online](#).