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Training community-based primary care physicians in the screening and management of mental health disorders among Latino primary care patients

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ABSTRACT

Objective: To evaluate a quality improvement intervention to improve the screening and management (e.g., referral to psychiatric care) of common mental disorders in small independent Latino primary care practices serving patient populations of predominantly low-income Latino immigrants.
Methods: In seven practices, academic detailing and consultation/liaison psychiatry were first implemented (Stage 1) and then supplemented with appointment scheduling and reminders to primary care physicians (PCPs) by clinic staff (Stage 2). Acceptability and feasibility were assessed with independent patient samples during each stage.
Results: Participating PCP found the interventions acceptable and noted that referrals to language-matched specialty care and case-by-case consultation on medication management were particularly beneficial. The academic detailing and consultation/liaison intervention (Stage 1) did not significantly affect PCP screening, management or patient satisfaction with care. When support for appointment scheduling and reminders (Stage 2) was added, however, PCP referral to psychiatric services increased ($P = .04$), and referred patients were significantly more likely to follow through and have more visits to mental health professionals ($P = .04$).
Conclusion: Improving the quality of mental health care in low-resourced primary care settings may require academic detailing and consultation/liaison psychiatric intervention supplemented with staff outreach to achieve meaningful improvement in the processes of care.

1. Introduction

Improving the quality of care in general medical settings for common mental conditions, particularly depressive and anxiety disorders, has become a priority. Interventions for improving mental healthcare in primary care settings include training primary care staff, consultation/liaison, collaborative care models with ancillary personnel assisting in care management and information technology [1]. Collaborative care models have been reported to increase the delivery of guideline-based pharmacotherapy, care management and psychotherapy, thereby improving short- and long-term mental health (MH) outcomes [2–6]. Specific implementations of collaborative care models differ in emphasis, but nearly all deliver basic specialty care in general medical services and therefore require substantial infrastructure support [7].

Collaborative care is more effective and cost effective than usual care across diverse practice settings and patient populations including in low-income, predominantly minority communities [1–7,10]. Among Latinos — the largest ethnic minority group in the US [8], characterized by underutilization and premature discontinuation of MH care [9–12] — collaborative care has successfully reduced MH disparities relative to non-Latino Whites [13–17]. However, these encouraging results derive from large, highly resourced care systems with the infrastructure to support ancillary staff or information technology enhancements. Moreover, Latinos are less likely than Whites to have a usual source of care [18] and, when they do, are likely to rely on small, low-resourced healthcare settings, such as community clinics [19–21]. Small low-resourced health care settings that follow traditional fee-for-service strategies generally do not have the opportunity to implement

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resource-intense quality improvement (QI) interventions such as collaborative care.

We are aware of only one study conducted in low-resourced private healthcare settings serving a low-income minority community. In this study from Chile, a 3-month multicomponent stepped care intervention led by nonmedical health workers (e.g., social workers, nurses, midwives) available in primary care demonstrated significant improvement in MH delivery and outcomes compared to usual care [16]. Modest interventions including structured protocols and role enhancements of available staff were the focus of achieving integrated care.

Although integration of MH services within general medical care is a priority of the 2010 Affordable Care Act (ACA) in the US, many small community-based primary care clinics still do not have available staff, resources for role enhancements or incentives to change routine clinical practice. Pressure is likely to increase on low-resourced settings to meet the needs of the newly insured minority groups especially in Medicaid expansion states [22] (e.g., 4.2 million low-income Latino adults gained insurance coverage nationwide after the major provision took effect in 2010 [22]. However, very little guidance is available on feasible and acceptable primary care interventions for the clinics that most commonly serve these populations. QI interventions of this kind merit development and testing.

We engaged small clinics run by independent Latino primary care physicians (PCPs) serving a low-income area of New York City predominantly inhabited by Latino immigrants. We developed and tested a QI intervention to enhance PCP screening and management of common mental disorders that was tailored to their characteristics and resources. This intervention trained PCPs to identify and treat mental disorders by combining academic detailing and consultation/liaison psychiatry, as well as supported outreach by primary care clinic staff to engage patients with MH needs. We assessed questions that are basic to the implementation of QI interventions in low-resourced settings serving populations with healthcare disparities: (a) Did PCP's find the intervention acceptable and feasible? (b) Did the intervention impact PCP behavior, mental healthcare delivery processes and patient satisfaction? and (c) Did efforts to support administrative staff outreach have any additional effect?

2. Material and methods

2.1. Engagement of community PCPs

Our goal was to engage an opportunity sample of independent practitioner-based primary care clinics serving the predominantly Latino community of a defined neighborhood in Upper Manhattan; the clinics had to lack supports for screening and managing MH disorders. Multiple engagement approaches over 2 years were used to cultivate physician buy-in. The length of the process was due to local suspicion of the medical center to which the researchers were affiliated, which served the same patient community and was suspected of longstanding efforts to eradicate its "competition" among local private PCPs. An iterative process of working through the local ethnically organized medical society, partnering with two PCPs who first agreed to participate, and identifying as many local PCPs as possible through existing lists and walking tours of the neighborhood achieved only limited success, despite the fact that the lead researcher was a first-generation Latino physician (RLF). The turning point came when senior staff at the large medical center recommended enlisting the assistance of local Latino psychiatrists in private practice. The rationale was that if these practitioners endorsed the study as beneficial for the Latino community and not damaging to their own practice, the PCPs would be more willing to participate. The help of two senior private Latino psychiatrists in the area proved decisive, in addition to conversations with local medical leaders. With their endorsement, we were able to recruit our sample goal of seven Latino PCPs. Prior to initiation of the program at each clinic, the senior researcher (RLF) and research personnel met with the clinic PCP and administrative/nursing staff to orient them to the project.

2.2. Primary care practices

This study was carried out in seven independent practitioner-based primary care clinics located in a predominantly Latino community in New York City. The clinics typically included the PCP, a nurse, and an administrative/billing assistant. There was no other ancillary staff. The seven participating PCP clinics serve nearly 12,500 patients per year. Most patients were women (66%) of middle age (mean=52 years) with low income and limited formal education.

All PCPs were first-generation immigrants from Latin America who moved to the US after medical school, on average 20.7 (S.D.= 3.7) years prior to study entry. Physicians had a mean of 13.1 (S.D.= 5.3) years of experience. Most PCPs had basic knowledge of psychotropic medications; however, patients with MH problems they were uncomfortable treating were referred to Latino psychiatrists in private practice or to local emergency departments. The need for sensitive engagement of PCPs in the community precluded our ability to conduct a baseline assessment of PCP knowledge and capacity as we risked rupturing the initially fragile collaboration.

2.3. Intervention procedures

Intervention components were chosen based on their feasibility and sustainability and the literature on collaborative care interventions. During the process of engagement, we observed a strong sense of professional autonomy and guild-like solidarity among the physicians, which influenced our decision to choose an academic detailing and consultation/liaison-based training intervention. The goal of the intervention was to train the PCPs to identify and treat MH disorders so that, once the study ended, this practice change could be sustained independently of clinically trained ancillary staff, a key component of collaborative care unavailable in low-resourced settings. The intervention was implemented in two stages. Stage 1 included academic detailing and consultation/liaison psychiatry.

2.3.1. Academic detailing

This approach was used to train PCPs in detection and management of depression and anxiety disorders. Academic detailing aims to change physician behavior through brief but focused visits to practicing physicians by health educators [23]. Educational materials were provided to PCPs in the form of condensed American Psychiatric Association practice guidelines for treatment of the four disorders listed below [24] and clinical summaries about antidepressants and other relevant medications. PCPs were also trained to screen for psychiatric diagnoses and given a six-item Mental Health Screening Form developed for this study. On average, training lasted ~1 h for each PCP. Current major depressive disorder (MDD), panic disorder (PD) and generalized anxiety disorder (GAD) screening used one item each, two questions screened for current posttraumatic stress disorder (PTSD) and one question assessed for "nerves," a Latino idiom of distress associated with depressive and anxiety disorders [25].

2.3.2. Consultation/Liaison psychiatry

Research psychiatrists were available in clinic once a week for up to 2–3 h per day, 1 day per week for each PCP to (a) evaluate patients referred by the PCP; (b) see each patient at least once in a combined session with the PCP; (c) discuss each case with the PCP; and (d) develop a psychiatric treatment plan to be implemented by the PCP (e.g., prescription). Visits were scheduled based on patient flow and PCP availability. Three psychiatrists worked with one PCP each, and one psychiatrist worked with four PCPs.