Integrating Behavioral Health and Primary Health Care: Development, Maintenance, and Sustainability

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Why Integrate?

1. ***Provides holistic care.*** Integration increases the ability to meet the mental health needs of people with physical disorders, as well as the physical health needs of people with mental disorders.
2. ***Enhance access.*** When mental health is integrated into primary care, people can access mental health services closer to their homes and thus save money on transportation costs as well as time away from regular activities.
3. ***Facilitates community outreach and mental health promotion***.
4. ***Decreases the gap between the number of people needing mental health treatment and the number who are able to receive treatment.***
5. ***Reduces stigma and discrimination.***
6. ***Cost-effective.***
7. ***Increases the likelihood of a good outcome.***

Components of a Healthcare or Medical Home

1. Everyone has a health home practitioner & team
2. Team has a person-centered, whole person orientation…
3. …And a focus on population health outcomes
4. Care is tailored to the needs of each patient
5. Team engages in care coordination/management
6. The team also coordinates with other healthcare providers/organization in the community
7. Patients are active participants
8. There is continuous learning and practice improvement…
9. …supported by a sustainable business model & appropriately aligned incentives
10. The health home is accountable for achieving improved clinical, financial, and patient experience outcomes

From SAMHSA-HRSA Center for Integrated Health Solutions. 2011. The Makings of a Health Home

Barriers to Integration

1. ***Separate silos.*** Primary care people have less knowledge of BH providers than other specialists and have not developed a working relationship with them.
2. ***Different confidentiality laws.*** Substance abuse (federal and state) and mental health (state) are generally more restrictive than those pertaining to physical health.
3. ***Payment parity issues are prevalent.*** Payment for medical services is generally greater than for behavioral health services.
4. ***Different record-keeping regulations.***

Models of Integration

1. ***Minimal collaboration***. Mental health providers and primary care providers work in separate facilities, have separate systems, and communicate sporadically.
2. ***Basic collaboration at a distance***. Primary care and behavioral health providers have separate systems at separate sites, but now engage in periodic communication about shared patients. Communication occurs typically by telephone or letter. Improved coordination is a step forward compared to completely disconnected systems.
3. ***Basic collaboration on-site***. Mental health and primary care professionals have separate systems but share the same facility. Proximity allows for more communication, but each provider remains in his or her own professional culture.
4. ***Close collaboration in a partly integrated system***. Mental health professionals and primary care providers share the same facility and have some systems in common, such as scheduling appointments or medical records. Physical proximity allows for regular face-to-face communication among behavioral health and physical health providers. There is a sense of being part of a larger team in which each professional appreciates his or her role in working together to treat a shared patient.
5. ***Close collaboration in a fully integrated system***. The mental health provider and primary care provider are part of the same team. The patient experiences the mental health treatment as part of his or her regular primary care.

Models of increasing integration

1. ***Improving collaboration between separate providers***—providers practice separately and have separate administrative structures and financing/ reimbursement systems.
2. ***Medical provided behavioral health care***—medical providers are directly involved in service delivery, either by offering strategies to decrease symptoms of BH disorders, monitoring medication prescribed by a psychiatrist, or by prescribing medication for BH diagnoses. Psychiatrist acts as a consultant to primary care provider. Diagnoses are made in primary care practice by the use of screening tools, e.g. PHQ-9 ,and SBI.
3. ***Co-location***—The co-location model uses specialty mental health clinicians who provide services at the same site as primary care. This approach shares space but is run as a separate service.
4. ***Disease Management***—Psychological stress and disability accompany many chronic illnesses. The disease management (or chronic care) model is an integrated system of interventions to optimize functioning of patients and to impact the overall cost of the disease burden. A care manager provides follow-up care by monitoring the patient's response and adherence to treatment. The care manager is either a medical professional or BH professional. The care manager provides education and brief psychotherapy.

Models of increasing integration (cont.)

1. ***Reverse co-location***—The reverse co-location model seeks to improve health care for persons with severe and persistent mental illness. a primary care provider (physician, physician's assistant, nurse practitioner, or nurse) may be out-stationed part- or fulltime in a psychiatric specialty setting to monitor the physical health of patients.
2. ***Unified primary care and behavioral health***—Another approach that targets persons with serious mental illness is the unified primary care and behavioral health model, in which psychiatric services are part of a larger primary care practice. The hallmark of the model is the integration of clinical services combined with the integration of administration and financing. Integration is an organization-wide effort. At the clinical level, primary care and behavioral health staff interact regularly and typically have an integrated medical record and single treatment plan.
3. ***Primary care behavioral health***—Behavioral health is a routine part of the medical care. A patient is just as likely to see a behavioral health clinician as a nurse during a routine office visit in this model. The behavioral health clinician is part of the primary care team, not part of specialty mental health. The primary care behavioral health model uses a "widenet" approach aimed at serving the entire primary care population with emphasis on brief, focused interventions.
4. ***Collaborative system of care***—The collaborative system of care model has particular promise for serving those patients with high mental health needs and those who require more specialized mental health services than primary care can realistically offer. In order to sustain this type of model, it will be important to engage additional partners, such as housing, education, employment, justice, and welfare organizations.

Integration at SCHC

* Collaborative team
* Consultation
* Referral to traditional outpatient therapy services
* Co-facilitated groups
* Shared medical records
* Billing

Collaborative Team

* Weekly provider meetings with all medical providers, nurses, behavioral health provider, dental provider
* When feasible, BH provider participates in "morning huddle" to discuss mutual patients with appointments during the day.
* BH provider works with patient advocate and care coordinator to enhance patient services
* "Skills and pills"--strategies for change given by BH provider and medications prescribed by medical provider
* BH provider provides in-depth diagnostic assessment to enhance choice of medications
* BH provider monitors use and efficacy of medications and gives feedback to medical provider

Consultation

* ***BH provider in a medical appointment***. If BH provider is on-site and in a scheduled session, medical provider can interrupt and request a consultation with a patient at end of the scheduled session. Consultations range from "meet and greet" to more in-depth discussion of a presenting problem and may include anxiety reduction techniques to calm a distraught patient.
* ***Medical provider in a BH session***. BH provider can request a medical provider in the session to discuss medication concerns.
* ***Request for services within a BH session***. BH provider requests services from nurse or medical assistant to check on medical status or to provide "warm hand-off" for a medical service such as nutritional counseling.
* ***Case Consultation***. BH and medical providers discuss case to provide feedback to enhance treatment and develop mutual treatment plans.

Referral to outpatient BH treatment

* Most of the BH provider's time is scheduled in the traditional 50 minute hour with either an individual or family
* Medical providers can suggest that a patient schedule a visit with BH provider for either an assessment or ongoing services. Scheduling can be done as the patient leaves the clinic or can call in to schedule.
* Patients can call in and schedule directly with the BH provider without receiving a specific referral from a SCHC medical provider. Referrals are received from other patients, an inpatient setting, BH agencies that have clients who would be better served locally, and from the court system.

Co-facilitated groups

* OBOT (Outpatient Based Opiate Treatment) program—combines the use of Suboxone with a program of addiction recovery that includes groups and individual treatment
  - Administration management is done by BH provider
  - All treatment decisions are made jointly by MD and BH provider
  - Most groups are co-facilitated by MD and BH provider
  - The patient is charged for one medical visit for a group. All individual sessions are charged either as a BH visit or medical visit depending on the service provided
* Other possible groups include those for patients with pain management issues or certain medical diagnoses. BH Provider could co-facilitate with medical provider or nurse.

Shared Medical Records

* Each patient has one integrated medical record.
* Behavioral Health notes are confidential and can be seen and accessed only by the BH provider and medical. providers. Medical notes can be accessed by BH provider.
* BH notes use a standard SOAP format.
* Family and social/environmental information is combined with medical information in the same forms. Various assessments forms are co-located in the record.
* When there is co-facilitation each provider writes a note for the session, based on her services and observations.

Billing

* All billing is done by one billing department.
* Providers use a variety of CPT codes to bill services—BH provider uses standard MH/SA billing codes.
* When MD is present in group, a medical code is used. BH provider uses an in-house code to designate no charge for the group.
* If BH facilitates group alone, a BH group code is used.
* If there is co-facilitation by BH and a nurse, a BH code would be used.
* Payment for services performed by a medical provider usually is higher than services performed by a BH provider.
* BH provider is a salaried employee. Because SCHC is a federally qualified community health center, there are federal grant funds to provide low cost services to those without health insurance to people in need.
* Each BH service provided is charged separately.

References

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