Primary and Behavioral Health Care Integration: Practical Approaches to Implementation
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Learning Objectives
- Provide an overview of integrated behavioral health and primary care
- Increase knowledge of the implementation process and ensuing sustainability
- Describe lessons learned

What is Integrated Care?
- Integrated care is a service that combines medical and behavioral health services to more fully address the spectrum of problems that individuals have
- It meets patients “where they are” in their experience of problems or pain
- Patients are not required to share the provider’s understanding or language about etiology and treatment
- Integrated care is the structural realization of the biopsychosocial model
- Reunification in practice of mind and body

Reasons for Integration
- The burden of behavioral disorders is great.
- Behavioral and physical health problems are interwoven.
- The treatment gap for behavioral disorders is enormous.
- Primary care settings for behavioral disorders enhance access.
- Delivering behavioral health services in integrated care settings reduces stigma and discrimination.

Collaborative Care
- Courtesy report of involvement
- Referral call for information exchange
- Development of special referral relationship
- Meeting to discuss cases
- Meeting of providers with patient
- Working together regularly in delivering services

“Mental health care cannot be divorced from primary care, and all attempts to do so are doomed to failure.”
(Frank Degruy)
Reasons for Integration

- Treating common behavioral disorders in integrated care settings is cost-effective.
- The majority of people with behavioral disorders treated in collaborative settings have good outcomes, particularly when linked to a network of services at a specialty care level and in the community.
- Individuals with serious mental illness die on average 25 years sooner than the general population.

Factors Increasing Health Risk

- Less likely to be screened
- Poverty
- Poor Access to Primary Care
- Self-Care Capacity/Resource
- Cognitive, Affective, and Behavioral Symptoms
- System Navigation Barriers
- Medications
- Tobacco and Substance Abuse
- Weight Gain
- Under Diagnosis & Under Treatment

Barriers to Integration

- Behavioral and physical health providers have long operated in separate silos.
- Sharing of information rarely occurs.
- Confidentiality laws pertaining to substance abuse (federal and state) and mental health (state) are generally more restrictive than those pertaining to physical health. While HIPAA is often cited as a barrier to sharing information between primary care and mental health practitioners, this is not accurate: sharing information for the purposes of care coordination is a permitted activity under HIPAA, not requiring formal consents.
- Payment and parity issues are prevalent.

Four Quadrant Model

<table>
<thead>
<tr>
<th>QUADRANT I</th>
<th>QUADRANT II</th>
<th>QUADRANT III</th>
<th>QUADRANT IV</th>
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</thead>
<tbody>
<tr>
<td>Patients with low behavioral health and high physical health needs.</td>
<td>Patients with high behavioral health and low physical health needs.</td>
<td>Patients with low behavioral health and high physical health needs.</td>
<td>Patients with high behavioral health and high physical health needs.</td>
</tr>
</tbody>
</table>

Types of Care

<table>
<thead>
<tr>
<th>COLLABORATIVE CARE STRATEGIES AT A CLINIC</th>
<th>COLLATERALized</th>
<th>INTEGRATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical evaluation and behavioral health care.</td>
<td>Medical management.</td>
<td>Medical management.</td>
</tr>
<tr>
<td>Risk of adverse outcomes.</td>
<td>Medical management.</td>
<td>Medical management.</td>
</tr>
<tr>
<td>Need for greater care setting.</td>
<td>Medical evaluation.</td>
<td>Medical evaluation.</td>
</tr>
<tr>
<td>Risk of adverse outcomes.</td>
<td>Medical evaluation.</td>
<td>Medical evaluation.</td>
</tr>
</tbody>
</table>

Note: Adapted from Miami, FL.
Levels of Integration

- **Minimal collaboration**: Behavioral health providers and primary care providers work in separate facilities, have separate systems, and communicate sporadically.
- **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.
- **Basic collaboration on-site**: Behavioral 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.

Levels of Integration (continued)

- **Close collaboration in a partly integrated system**: Behavioral 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.
- **Close collaboration in a fully integrated system**: The behavioral health provider and primary care provider are part of the same team. The patient experiences the behavioral health treatment as part of his or her regular primary care.

Model 1: Improving Collaboration Between Providers

- Behavioral health providers and primary care providers work in separate facilities; minimal interaction
- Separate administrative structures and financing/reimbursement systems
- Typical services include consultation, case management and referral
- Least amount of change to traditional practice
- Basic information is shared
- Usually the first step in integration
- Level of integration: Minimal collaboration

Model 2: Medical Provided Behavioral Health Care

- Only the medical provider is directly involved in the service delivery
- Consultation-liaison is used
- Behavioral health does not co-manage the patient
- Primary care provider uses evidence based behavioral health screening tools (PHQ-9, SBIRT)
- Not an effective model for screening and treating substance abuse
- Individuals with complex behavioral health conditions are referred to specialty care
- Level of integration: Basic at a distance

Model 3: Co-Location

- Increased collaboration as both providers are co-located
- Specialty behavioral health clinicians who provide services at the same site as primary care
- Shared space but have separate systems
- Referrals are made for services
- Earlier identification, greater acceptance of referral and improved communication and care coordination
- Shared plans of care result in higher quality of care and less duplication of services
- Level of integration: Basic On-Site
**Model 4: Disease Management**
- Integrated system of interventions to optimize functioning of patients and impact the overall cost of the disease burden.
- Model emphasizes the early identification in primary care of populations that are at risk for costly chronic disease and the provision of educational orientation and evidence-based algorithms.
- Care Managers provide follow up care to patients.
- Care Managers provide brief psychotherapy if needed.
- Clinical interventions are typically modified for the primary care setting.
- Level of integration: Close Partly Integrated.

**Model 5: Reverse Co-Location**
- Model seeks to improve health care for persons with several and persistent mental illness.
- Primary care provider may be out-stationed in a behavioral health setting.
- Often psychiatrist receives additional medical training to monitor and treat common physical problem.
- Primary care providers and behavioral health professionals develop strong collaborative relationship.
- Higher compliance to treatment from patients.
- Various levels of integration.
- Level of integration: Close Partly Integrated.

**Model 6: Unified Primary and Behavioral Health Care**
- Behavioral health services are part of a larger primary care practice.
- Full-service primary and behavioral care in one place.
- Outside referrals occur only for intensive specialty care.
- Administration and financing are integrated.
- Integration is an organization-wide effort.
- Primary care and behavioral health staff interact regularly.
- Integrated medical record and single treatment plan.
- Serve a broader population of patients with behavioral health needs.
- Level of integration: Close Fully Integrated.

**Model 7: Primary Care Behavioral Health**
- Behavioral health is a routine part of the medical care.
- Behavioral health clinician is part of the primary care team.
- Primary care physician is the principal provider.
- Behavioral health clinician co-manages with the physician.
- Emphasis on brief focused interventions.
- Educate and identify self management strategies.
- Warm handoffs and curbside consultations.
- Patient education, case management, monitoring and skill coaching.
- Level of intervention: Close Fully Integrated.

**Model 8: Collaborative System of Care**
- Hybrid model.
- Partly or fully integrated dependent upon degree of collaboration.
- Integrated model with collaborative wrap around services-system of care.
- Individualized plans of care for high risk patients across multiple service agencies.
- Range of agencies providing services is extensive.
- Services are seamlessly woven together with primary care services.

**Understand The Differences**
Culture Differences

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<thead>
<tr>
<th>PRIMARY CARE</th>
<th>BEHAVIORAL HEALTH</th>
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<tbody>
<tr>
<td>PACE</td>
<td>15 minute appointment</td>
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<tr>
<td>SETTING</td>
<td>Office setting</td>
</tr>
<tr>
<td>LANGUAGE</td>
<td>Diagnosis, medical</td>
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<td></td>
<td>terminology, complaints</td>
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<tr>
<td>HIERARCHY</td>
<td>Clear – Doctor in charge</td>
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<tr>
<td>FLOW</td>
<td>Flexible patient flow</td>
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Integration Considerations

- Space
- Policies & Procedures
- Documentation
- Registration and Scheduling
- Primary Acute Care Services – Outpatient and Inpatient Services
- Partnerships
- Labs, blood work and x-rays
- Workforce Development

The Wellness Integration Network (W.I.N.) Clinic

The W.I.N. Clinic Model

Components
- Integrated services
- Screen/registry tracking and outcomes
- Primary care staff located in behavioral health setting/no FQHC
- Embedded Nurse Care Managers
- Wellness/prevention programming

Evidence Based Models
- SBIRT
- IMPACT (Improving Mood-Promoting Access to Collaborative Treatment) Model
- Motivational Enhancement Techniques (MET)
- Eli Lilly Wellness Program

W.I.N. Clinic Philosophy

W.I.N. Clinic-Our Program

- Integration Model: Co-locate primary care physicians in behavioral health facilities to provide routine primary care services and serve as a consultant to the psychiatric care team; all staff are employed by LifeStream. There is no FQHC involvement.
- Service delivery: Includes providing wellness programming and incorporating integrated services; psychiatric and primary care are offered during the same visit. The clinic serves as a “Medical Home”. Specialty care is provided through agreements with community partners.
- Enrollment Target: 1,000 during the four year grant period.
- Populations Served: Adults with serious mental illness living in Lake County who do not have access to primary care services or a medical home.
**W.I.N. Clinic-Our Program**

**SERVICES PROVIDED:**
- Integrated Primary and Behavioral Health Care; both services provided during the same appointment (when applicable), along with appropriate follow up. Emphasis is on preventive care.
- Home visits by LPN Care Managers to coordinate and monitor care and assess goals.
- Referrals to specialists and enhanced care coordination. The clinic has had great success with coordinating free and/or reduced rates with the specialists in our community for our clients.
- Transportation to appointments when needed.

- Wellness Activities and workshops on topics such as exercise, diet and nutrition, weight management, and tobacco cessation.
- Wellness activities include: wellness testing (fitness and medical tests), health risk appraisals, hypertension screening and education, disease management seminars, in home education with care managers, stress management activities, and time management workshops.
- Access to LifeStream’s full continuum of care, including behavioral health and substance abuse services.

**W.I.N. Clinic Work Flow**

- Client identified as not having PCP and referred to the program
- Initial Visit with Care Manager: Client is screened for medical and behavioral health issues by Care Manager. Client is seen by medical staff for history and physical.
- SBIRT used to identify co-occurring issues
- Consultation with appropriate parties, including the client
- Treatment Plan

- Assess Treatment Response through Weekly Contact
- Complete Follow-Up

- Inadequate Response
- Contacted again

**W.I.N. Clinic-Staff**

- **Medical Provider**
  - Performs examinations, wound care, assigns care managers, prescribes medications, and completes histories, physicals and psychiatric evaluations.

- **Lead LPN Care Manager**
  - Assists the medical provider, monitors all care managers, prepares education packets for clients, recruits new clients and is responsible for marketing.

- **Care Managers**
  - Responsible for home visits, charting, monitoring progress, wellness activities, treatment plans, education and teaching of consumers.

- **Follow-up Specialist**
  - Responsible for contacting clients at 6, 12, and 18 months; monitoring progress towards treatment plan goals; assisting clients with affordable prescriptions and referrals for patient assistance and transporting.

- **Administrative Support**
  - Responsible for completing the "NOMS", scheduling appointments, contacting referrals, and data entry.

**The W.I.N. Clinic-Successful Strategies**

- Care Managers educate clients on nutrition and the importance of eating the right foods.
- A personalized diet plan with weekly menus is provided.
- Weekly trips to the grocery store teach clients how to shop for nutritious foods.
- Cooking lessons are provided on how to prepare healthy meals and show clients that healthy food does not have to be unappetizing or expensive.
- As a result, average weight loss is 15 pounds. Over 48% of the consumers report weight loss.
- Care Managers utilize MET with consumers with regard to exercise regimen, often starting out with basic exercise such as walking. Care Managers often participate in activities to encourage consumer participation.

**Lessons Learned**

- Hurdles, challenges and obstacles, oh my!!
  - Personnel issues
  - Cultural change/paradigm shift
  - Lab work, medications, specialty care
  - Workforce development
- What may seem simple often is not.
  - Referrals
  - EHR Considerations
  - Wellness Activities
Lessons Learned (continued)

✈ It takes a village to raise a child
  - Partnerships are important
  - Teamwork
✈ Just when things are working smoothly...
  - Systems Issues/Client flow
  - Program fidelity
  - Funding Issues/Sustainability

Recommendations for Implementing Integrated Care

✈ Think big, start small
✈ Improve physical proximity
✈ Keep a joint medical record
✈ Focus on primary care providers as important customers for mental health providers
✈ Explore new practice styles
✈ Senior management buy-in is critical
✈ Learn and understand billing codes and funding sources

Recommendations for Implementing Integrated Care

✈ Include mental health consultation earlier in the course of a patient’s evaluation in order to minimize unnecessary expenses
✈ View patients as people the organization is committed to working with over time, rather than people presenting a series of isolated treatment episodes
✈ It’s not all about your organization but the people we serve
✈ Teamwork, partnerships and thinking outside of the box are very critical for success.

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