**SJFC Wegmans School of Nursing**

**Integrated Behavioral Health in Primary Care, Pediatric and FQHC settings**

Information for students, faculty, and providers in primary care, pediatric, or FQHC settings

**What is integrated care?**

“The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system.” WHO (2008)

“…the systematic coordination of general and behavioral healthcare. Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.” SAMHS/HRSA Center for Integrated Health Solutions (2017)

**Advantages of integrated care (*taken from* Advancing Care Together, 2018, and AHA, 2012)**

* Increased access to behavioral health expertise.
	+ Two-thirds of primary care physicians (N=6,660) reported not being able to access outpatient behavioral health for their patients. Shortages of mental health care providers, health plan barriers, and lack of coverage or inadequate coverage were all cited by PCPs as important barriers to mental healthcare access.
* Increased efficiency (by reducing frequency of office visits by PCP for behavioral health issues through immediate access to expertise in the form of consultation or direct care, and by elimination of time spent in making specialty referrals).
	+ 84% of the time, the 14 most common physical complaints have no identifiable organic etiology
	+ 80% of people with a behavioral health disorder will visit primary care at least one time in a calendar year
	+ 50% of all behavioral health disorders are treated in primary care
	+ 48% of the appointments for all psychotropic agents are with a non-psychiatric primary care provider
	+ 67% of people with a behavioral health disorder do not get behavioral health treatment.
	+ 30-50% of referrals from primary care to an outpatient behavioral health clinic do not make the first appointment
* Cost savings (through reduction of repeat ER and inpatient admissions and disability payments).
	+ Annual medical expenses — chronic medical and behavioral health conditions combined — cost 46% more than those with only a chronic medical condition.
	+ Medical use decreased 15.7% for those receiving behavioral health treatment, while medical health use increased 12.3% for controls who did not get behavioral health
	+ According to the Finger Lakes Health Agency, both 30 day and 60 day readmission rates to ERs and inpatient care were *significantly increased* in the presence of either a co-occurring mental health or addiction diagnosis
	+ Depression treatment in primary care for those with diabetes had $896 lower total healthcare cost over 24 months
	+ Depression treatment in primary care had $3,300 lower total healthcare cost over 48 months
	+ Behavioral Health disorders account for half as many disability days as all physical conditions
	+ Of the top five conditions driving overall health cost (work related productivity + medical + pharmacy cost), depression is number one
* Increased practitioner reimbursement in the form of value-based payments for cost savings and improved patient outcomes.

**SAMHSA 5 levels of collaboration leading to integrated care**

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Level 1 Minimal (completely separate systems)

Entirely separate systems and sites, little communication or appreciation of other’s cultures

Level 2 Basic, from a distance (some coordination of care)

Focused communication, usually written; little understanding of other’s culture

**Level 3 Basic onsite (co-location with coordination of care)**

Separate systems, one site; regular communication, some face-to-face; some appreciation of other’s role

**Level 4 Close, partially integrated (co-location with enhanced coordination of care)**

Some shared systems, same facilities; face-to-face consultation, coordinated treatment plans; basic appreciation of other’s roles and culture; collaborative routines difficult d/t time, operational barriers

***Level 5 Fully integrated* (seamless care with embedded expertise)**

Shared systems/facilities; consumers/providers have same expectations; one treatment plan; in-depth appreciation of roles/culture; collaborative routines are regular, smooth, based on situation/ expertise

**Model for SJFC Wegmans School of Nursing Integrated Care HRSA grant:**

Behavioral Health Professional (Mental Health Counselor and/or Psychiatric Mental Health Nurse Practitioner) located onsite, coordinating with or partially/fully integrated into primary care, pediatric, or FQHC setting

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**Student Roles in Integrated Care**

*Traditional Behavioral Health Intervention*

* In level 3 and some level 4 integration, the student provides a variety of traditional, specialty behavioral health interventions, usually on-site, that are within his/her discipline’s scope of practice, and appropriate to the age of the client. This includes individual, group and family modalities, some appreciation for one others’ roles, and regular written or verbal communication between practitioners. Other interventions by age group may include, but are not necessarily limited, to the following types of therapeutic interventions.

*For Children:*

* + Play therapy for children aged 3-8, who are in stressful families circumstances (divorce, separation, illness, death, relocation or other significant loss), survivors of trauma, and/or who are aggressive, withdrawn, are trauma survivors, or are demonstrating other problematic behaviors
	+ Behavioral therapies for common childhood problems, such as bedwetting, temper tantrums, hyperactivity, inattention, and obesity
	+ Parenting skills training with groups or individuals using an evidence-based model
	+ Grief therapy in groups or individual settings for children and/or parents
	+ Medical Family Therapy- helping children and parents cope with chronic illness, *Medical Family Therapy and Integrated Care, 2nd ed* by McDaniel, Doherty, and Hepworth (2014)
	+ Crisis intervention/suicide assessment and prevention
	+ Initiating/monitoring medication therapy for depression, ADHD (PMHNP only)

*For Adolescents:*

* + Behavioral strategies to promote health life style (weight loss, smoking cessation, medication/dietary or other medical regimen adherence, biofeedback, progressive muscle relaxation, stress management)
	+ Motivational interviewing to promote change in problem behaviors, such as weight gain, poor academic achievement, drug or alcohol misuse, bullying, etc.
	+ Family therapy for adolescents with oppositional, aggressive, bullying or other antisocial behaviors using an evidenced-based model
	+ Grief therapy in individual or group settings
	+ Cognitive behavioral therapies for depression and anxiety
	+ Promoting positive communication skills and healthy dating relationships in a group setting
	+ Anger management
	+ Medical Family Therapy- helping adolescents and parents cope with chronic illness, using *Medical Family Therapy and Integrated Care, 2nd ed* by McDaniel, Doherty, and Hepworth (2014)
	+ Crisis intervention/suicide assessment and prevention
	+ Initiating/monitoring medication therapy for depression, anxiety, ADHD, psychosis (PMHNP only)

*For Adults:*

* + Behavioral strategies to promote health life style (weight loss, smoking cessation, medication/dietary or other medical regimen adherence, biofeedback, progressive muscle relaxation, stress management)
	+ Motivational interviewing to promote change in problem behaviors, such as weight gain, drug or alcohol misuse, bullying, etc.
	+ Anger management
	+ Strategies for insomnia and promotion of sleep hygiene
	+ Couples therapy
	+ Medical Family Therapy- helping couples and families cope with chronic illness, using *Medical Family Therapy and Integrated Care, 2nd ed* by McDaniel, Doherty, and Hepworth (2014)
	+ Crisis intervention/suicide assessment and prevention
	+ Initiating/monitoring medication therapy for depression, anxiety, adult ADHD, and psychosis (PMHNP only)

*Integrated Behavioral Health Interventions*

* In level 5 and some level 4 integration, the student provides the same therapeutic interventions as above but in a time-limited format using as a guide *Integrated Behavioral Health in Primary Care: Step-by-step Guidance for Assessment and Intervention, 2nd ed* by Hunter, Goodie, Oordt, and Dobmeyer (2017).
* Universal screening for depression, suicidal ideation, anxiety and cognitive deficits using standardized tools, and for drug and alcohol using SBIRT, reviewing results with providers and caregivers, following up with diagnostic assessment interview and use of focused diagnostic tools as necessary, developing an integrated therapeutic treatment plan (including psychotropic medications if an NP student) and/or facilitating a referral for specialty treatment and/community resources, are additional elements of care that may be provided in integrated settings. In-person education on behavioral health topics for staff and practitioners may also be available.
	+ For longer term and/or more psychiatrically complex or specialized conditions, facilitation of referral to a qualified specialty provider is indicated according to this model, in order to assure continued timely access to behavioral health care within the PCP setting. Patient contact by students in these settings may be indirect or direct, and preventative, curative, or rehabilitative.

The lists in the chart below are examples, and not exhaustive.

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| --- | --- | --- | --- |
| **Indirect** | **Preventative** | **Curative** | **Rehabilitative** |
| *examples* | Review behavioral health screening practices/policiesSBIRT to identify and reduce risky drug/alcohol use Assist to implement universal screening for general behavioral health, or for specific conditions of interest (eg, eating disorders, autism, ADHD, etc.)Practitioner/staff education | Consultation to PCP regarding client specific diagnosis and treatment issuesAssistance to PCP in executing a referral to specialty treatment, or self-help resourceConsultation to PCP regarding psychotropic medications (PMHNP only) | Consultation to PCP regarding monitoring of stable behavioral health conditionsConsultation regarding elapse prevention strategies |
| **Direct** |  |  |  |
| *examples* | Pt. psychoeducation Stress reduction Motivational Interviewing to reduce risky drug/alcohol useBullying prevention/anger managementGrief counselingDiagnostic evaluation Readiness assessment | Crisis interventionBrief psychotherapy Time-limited group and family therapiesBehavior managementSkills trainingProgressive muscle relaxation BiofeedbackDrug and alcohol counseling | Relapse preventionReferral to longer term specialty treatment Assessment of patients returning to PCP from higher level specialty care |

**Supervision**

According to SAMHSA, one of the major culture shifts in integrated care is how supervision is defined and performed. Healthcare disciplines define supervision differently with commonalities and genuine distinctions. For example, in all disciplines there is supervision provided if required for licensure or practice requirements. However there is added focus on supervision in behavioral health for issues of self –care, clinical assistance, and professional development. As disciplines integrate and work as a single team, supervision models are shifting and having to blend cultures. As the integration of the clinical care continues to be refined, models of supervision will also advance and grow and attention to this aspect of workforce development will be essential to continued successful care.

Integrated care requires revisions and additions to the traditional way in which health care providers are educated and trained to practice. This applies to all forms of clinical care, including family practice, primary care, and behavioral health. Providers need to refine some skills with minor adjustments, and they need to learn new interventions to assist in whole person healthcare. Initially this education has been “on the job training,” however, as integrated care models increase, educational systems will need to shift to adequately prepare an integrated workforce for the future. This includes graduate education programs teaching an integrated knowledge base and shifting the cultural expectations about clinical practice. Certificate programs and post-graduate training will be needed for professionals who want to adjust their skills mid-career. In addition, integrated care may always require a certain degree of onsite training as part of the team care development process. Similarly, patient education about the model and patient activation to engage in healthcare will be an ongoing core feature of successful integrated healthcare.  *SAMHSA/HRSA Center for Integrated Health Solutions (2017).*

Students providing integrated care are supervised by a Behavioral Health Professional qualified to supervise students in that discipline. In addition, students receive supervision and guidance from the faculty member coordinating clinical courses, and have access to the Grant PI (Rob Rice, PhD, LMHC) and Co-PI (Kathy Plum, PhD, RN, NPP).

**Resources for Practice Partners**

In order to facilitate the implementation of integrated behavioral health interventions in primary care, pediatric, or FQHC settings, additional resources are available to practitioners who provide clinical placements for the Mental Health Counseling and/or Psychiatric Mental Health Nurse Practitioner students participating the HRSA grant. This includes expansion of the current SBIRT website ([www.sjfcsbirt.com](http://www.sjfcsbirt.com)), the availability of interactive and archived webinars on topics of interest for students, practitioners and/or clinical site staff (such as on EBPs in integrated care), and the provision of additional support and supervision for students. Students may provide lunch ‘n learn educational topics for office staff, LPNs, and technicians on topics of interest as requested. For more information, contact the Health Integration Coordinator, Dr. Kathy Plum, at kplum@sjfc.edu.