

**American Association of Community Psychiatrists**  
**Position Paper on Interface and Integration with Primary Care Providers**  
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**Introduction.** For a variety of reasons, too numerous to enumerate in this document, primary care providers can and should play a significant role in the care of persons with a wide range of psychiatric disorders. This especially pertains to the provision of mental health services for persons with less severe psychiatric disorders and appropriate medical-surgical services for the co-morbid non-psychiatric conditions that affect adults with severe and persistent mental illnesses and children with severe emotional disorders. It is essential and efficacious for community based mental health providers to participate in improving access and quality of care for patients who have psychiatric disorders who get some or all of their health care services from primary care providers. The importance of such integration efforts has been endorsed and emphasized by a wide range of national organizations and authorities, including three recent Surgeon General's Reports, the Healthy People 2010 campaign, and national initiatives led by the Health Resources Services Administration (HRSA) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

At an organizational level, administrators of community based behavioral health programs should incorporate a more systematic program for interfacing or integrating with primary care provider organizations in their communities. This includes provision of sufficient budget, training, and staff to accommodate the primary care interface initiatives. The consequences of not being proactive and assertive in developing improved relationships with primary care providers are poor communications and the likelihood that the primary care organizations will develop behavioral health projects on their own, thus fragmenting the array of behavioral health services in the community.

The following **training, organizational, and quality improvement** principles provide guidance for how to achieve these goals.

**Training Issues.**

1. Psychiatrists and other mental health professionals who work in community based settings must become aware of the clinical culture of primary care and the types of psychiatric disorders that are encountered in those settings.
2. Behavioral health programs need to train most of their providers to understand how to most effectively collaborate and communicate with their primary care colleagues, especially in the care of persons with severe and persistent mental illness.
3. These same programs should identify and train specific clinicians who can be used to more directly collaborate and consult with primary care providers, either through a co-location consultation model or in a more systematic behavioral health integration program (e.g., HRSA's Health Disparities

Depression Collaborative and grants for community health clinics to develop integrated behavioral health care services).

### **Organizational Issues.**

It is essential to work closely with local primary care provider organizations to help them determine the types of interface or integration initiatives that make the best sense for them.

Improving access to and quality of primary health care services for adults with severe and persistent mental illness and children with serious emotional disturbances may include the provision of effective communication and consultation with PCPs. These interface initiatives, at a minimum, require behavioral health providers to:

- Establish effective means of bi-directional communications with local PCPs.
- Determine what information is most essential to share on mutually served patients, e.g., diagnostic, lab, medication, and treatment planning information.
- Develop appropriate confidentiality and consent protocols

**Integration and co-location models.** In order to improve the behavioral health treatment provided in primary care settings, integration of behavioral health providers may be the preferred approach. The first steps of this process include:

1. Complete an environmental scan. The environmental scan should examine three key areas: resources, capacity of local behavioral health services, local and federal regulations. At a minimum, this should involve identifying who the local behavioral health providers are, what capacity for service they currently provide, what potential exists for collaboration or conflict, and how the former can be enhanced and the latter minimized as the primary care organization develops integrated behavioral health services.
2. Determine the primary care program's "capacity filter" based on information gathered in the environmental scan. Who should be eligible for the on-site integrated services and what level of care is to be provided? Should the pathway of care require prior primary care assessment and referral or allow for direct access to the on-site behavioral health provider and, if the latter, under what circumstances?

3. Establish buy-in that is systemic. It is essential to secure the understanding and support of both administrative and clinical leadership within the primary care organization in order to proceed with planning and implementation.
4. Make an initial decision about renting and/or owning behavioral health staff. This refers to whether the behavioral health staff are employed by the primary care organization or are contracted from the behavioral health organization. There is no one right answer to this question. Rather, it is dependent on the answers to the environmental scan and the philosophical and regulatory factors specific to the primary care organization and the local community. The implications of the rent/buy decision have significant implications on record keeping, enrollment and billing, communications, and referral processes. Effective operational integration can be achieved via both methods of staffing.

#### Components of the integrated model.

An integrated program may provide any or all of the following functions:

- Behavioral Health Triage. This is a quick and efficient, but comprehensive enough assessment to identify generally what the patient's presenting concerns are, sufficient to lead to one of the following provisional disposition recommendations.
- Comprehensive Behavioral Health Assessment. This should be reserved for those patients for whom the triage assessment is insufficient to make a relatively confident disposition recommendation.
- On-site Behavioral Health Treatment. This may include an array of services, the breadth of which is determined by the environmental scan, and clinical/budgetary capacity of the primary care facility based behavioral health staffing. It can include brief individual, group, and family counseling or psychotherapy as well as psychopharmacological assessment and treatment.
- Referral. This includes internal referral back to the primary care provider or other staff with behavioral management/treatment recommendations. It also includes external referral to specialty behavioral health providers or other social service supports (e.g., entitlements, housing, employment).
- Consultation. This includes ad hoc and ongoing medical/psychiatric and behavioral management consultation support and in-service training for primary care providers and other staff within the primary care facility.
- Care monitoring and chronic disease management protocols. This should be applied to chronic psychiatric conditions that can be effectively managed in the primary care setting, such as less complicated cases of depression. It is also for those patients who have other chronic health problems whose co-morbid psychiatric conditions result from, complicate, or interfere with the other health problems or their treatment, e.g., difficult adjustment to diabetes or somatoform disorder in persons with or without other "physical" illnesses. The care monitoring function is comparable to care monitoring for other chronic conditions, i.e., disease registry data management, periodic screening and outcomes assessment, supportive counseling, patient education, self-

management support, facilitation of treatment adherence (e.g., checking in with patient between appointments, prompting, assisting in tasks associated with adherence to medications, lab work support, etc.).

The staffing for the above functions can be quite variable, but should at least include:

- Masters or higher-level mental health professional, preferably capable of assessing persons from adolescence to older age for mental health and addictions disorders. This same person can provide the triage, comprehensive assessment, on-site psychotherapy, and some of the consultation and care monitoring support. This professional should also have a good working knowledge of and relationship with the specialty behavioral health providers in the community in order to manage the external referral process. Depending on the size of the facility and the resources available, more than one person can be utilized to perform these functions, thus allowing increased flexibility and accommodation of differing areas of expertise (child vs. adult, mental health vs. addictions). The prototypical position would encompass most or all of these functions, but must do so in such a way as to effectively manage the flow of patients and balance the various functions without reducing access to triage and assessment, i.e., they cannot develop too large an on-site treatment caseload.
- Mental health professional with prescribing privileges (preferably a psychiatrist). This function can be provided on-site or distance-based (via telephone, e-mail, or telemedicine link) and can provide some of the comprehensive (including medication) assessment, consultation, and back-up support to the on-site mental health professional.
- Nursing or other non-mental health staff trained to provide some or all of the care monitoring and chronic disease management protocol support services.

After establishing the functions and staffing patterns for the integration project, appropriate process flow diagrams, treatment algorithms, and other system supports can be designed and implemented.

### **Quality Improvement Issues.**

It is essential to develop ongoing methods for evaluating interface or integration initiatives to demonstrate their effectiveness and to provide guidance for progressive improvement in increasing access and quality of care. Community based psychiatric providers should be involved in the development and implementation of these evaluation and improvement activities. The following principles are specific to improving quality in the area of primary care interface:

- It is essential to demonstrate whether the project has an impact on increasing the frequency and accuracy of recognition of psychiatric disorders of persons seen in primary care settings.

- It is essential to demonstrate that more effective and cost-effective services are provided and unnecessary health care interventions are avoided for persons with psychiatric disorders seen in primary care settings.
- Access to data on access to services, encounter information, and service utilization is required in order to accomplish the above evaluation goals. Therefore, behavioral health and primary care programs should design and, when feasible, integrate their information systems to allow access to such information.
- Direct and indirect clinical outcomes indicators should be identified, which are correlated with improvement in the psychiatric conditions that are encountered in primary care settings.
- Satisfaction of all participants in the interface or integration efforts must be included in the evaluation process.
- Organizations involved in interface or integration initiatives must develop ongoing processes for incorporating the findings of these evaluations into the continuing improvement of clinical and logistical processes.

### **Implementation Issues**

In order to accomplish any of the above goals, several generic issues must be addressed:

- First and foremost, the various barriers to financing programs or reimbursing providers for consultation or direct services (such as payer rules which prohibit billing for activities by two different providers on the same day or provider to provider consultations in which a patient is not directly seen) must be identified and corrected.
- Cultural sensitivity and competence issues regarding both patients and providers must be identified and addressed.
- In order to assure broader awareness, increased clinical competence, and a sustainable supply of well-trained clinicians, any behavioral health consultation or integration initiatives should be linked to appropriate local professional training programs (e.g., psychiatry and family medicine residency programs and social work graduate schools).