Guest Consultant Donna Izor: Behavioral Health & Primary Care Integration: Make Your Practice a Leader

Like other medical conditions, behavioral health issues span the spectrum from mild to significant mental illness (SMI). There are many national studies, such as the **Impact Model**, showing the benefits of identification and treatment of depression in the primary care setting. Many practices have added a mental health clinician or social worker to their staff to expand on-site care for those needing lower level behavioral health services and to reduce the stigma for patients accessing mental health services. It is care for those with more significant mental illness that becomes challenging to the primary care practice.

What is the relationship of SMI to physical health?

The National Council for Community Behavioral Healthcare reports that 3 out of 5 individuals with a SMI die from a preventable health condition. In general, the life expectancy of a person with SMI is 25 years less than the average population. They have a higher incidence of chronic medical conditions for individuals exacerbated by smoking, obesity, homelessness, and sometimes by the very drugs used to treat their psychiatric condition. There are many reasons for the lack of medical care for these individuals including social isolation, cost, transportation, and inability to "fit in" to a primary care practice culture of focused discussions. **Many use the emergency department for routine care rather than**

establishing and maintaining a relationship with a primary care practice.

Barriers to behavioral health services and to primary care for behavioral health patients

From the primary care perspective, it is often difficult to obtain access for patients to specialty behavioral health services. Your patients may be hesitant to follow your recommendation or referral to a psychiatrist or behavioral health professional because of the stigma that still surrounds mental health. Cost may also be an issue as insurance coverage for mental illness is often "carved out" of private insurances and managed separately requiring pre-authorizations and other steps to access care. Finally, there may be limited access and availability of services for those with Medicaid or without insurance resulting in months before your patient can be seen.

From the behavioral health perspective, the community mental health center (CMHC) may have difficulty obtaining primary care for their clients. Clients may not want to change their life habits to improve their health. Engaging clients in the need for a primary care provider can be difficult and once done, a practice may not be available that will accept the client. These individuals often take longer to move through a visit and may not be able to provide an accurate medical or social history. Your staff may be anxious to have them in your waiting room or to deal with their mental health issues. The needs of these clients can be significant yet the skills of a medical home can benefit these individuals by coordinating their care, reducing the costs to the overall system, and engaging the individual to improve their health.

How collaboration with a CMHC can be a win-win

Collaborating with the Community Mental Health Center (CMHC) provides an opportunity to improve communication and move towards person-centered care where team members work with each other and the individual to provide the best care in the right setting. It has the potential to decrease costs to the overall healthcare system by reducing the number of unnecessary emergency room visits, reducing no show rates and reducing duplication in efforts. Most importantly, it can improve the quality of care for the individual through identification and treatment of chronic conditions, and promotion of preventative services and wellness.

For the past year I have worked with a statewide CMHC network and with medical centers and primary care practices to work toward bi-directional care. All providers want the best for their patients as well as to improve the overall care of residents in the communities they serve. This shared belief in person-centered care has led to successful collaboration. The group began by improving their referral system and having regular **care management meetings** to discuss shared patients. Education and group meetings have led to more comfort between the systems. Now they are planning to co-locate a primary care nurse practitioner within the CMHC, expand home visits for CMHC clients, and expand the information collected in the CMHC chart to include an up to date problem list and medication list.

Proven steps to successful collaboration:

- Work with the CMHC to **define the needs and the specific barriers to referrals** to and from your office
- **Include providers, clinicians and staff in planning** and understanding their new roles, processes and procedures
- Openly **discuss the cultural differences** between the

health systems and how the organizations can work together to maximize the value of the services offered
- **Establish regular meetings** to discuss shared clients (with proper consents) to assure collaboration and reduce duplication in care management
- **Script discussion points** for patients you are referring to the CMHC to reduce the stigma associated with care and encourage their engagement
- **Establish clear expectations for access**, defining what information is needed for a referral, and developing systems to share information after the visit to and from the CMHC
- **Provide educational materials** on chronic conditions and wellness at the CMHC and offer care opportunities such as flu clinics and health fairs at their site for their clients
- **Educate your staff** to the needs of individuals with SMI
- Ask the CMHC for their help in **managing clients with disruptive behavior** or assist the client in making and coming to scheduled visits
- Be open to learning more about management of individuals with SMI and **managing their drugs** through a collaborative relationship with the psychiatrist
- **Seek support for your actions** through State Offices of Primary Care, AHEC, FQHC, and State Department of Health resources

There are many excellent web sites and articles that can provide additional information and options for integration. These include the **National Council for Community Behavioral Healthcare** and **SAMHSA** (Substance Abuse and Mental Health Services Administration). I encourage you to research the options and begin the process of integration for the benefit of your patients, your practice and your community.

Donna Izor, MS, FACMPE *has more than 20 years of experience as*

a medical practice executive working with academic, community hospital and private practices, and local and state organizations. Izor's background included responsibility outpatient practices, inpatient physicians, and the development and management of a hospitalist program. Her scope included the authority to plan, lead and direct operational evaluation and improvement, financial management, and regulatory compliance and quality.

Donna founded West Pinnacle Consulting, LLC where she offers a variety of consulting services including project management, executive support, leadership coaching, quality and performance improvement, provider relations, physician and hospital integration, training, facilitation and practice operations. Her activities include research, reporting and presentation on the bidirectional model of care for local stakeholder, policy maker and statewide audiences and work with community mental health centers, hospital systems, practices and statewide organizations on primary care and behavioral health integration. She can be reached at (802) 734-6384 or at dizor@westpinnacle.com.