Integrated Primary Care in Practice

Integrated Primary Care is at one end of a continuum of ways medical and mental health practitioners collaborate (see Doherty, et. al. below). Nationwide, when patients are treated by both medical and mental health clinicians, there is collaboration between these clinicians in only a minority of cases. By locating a behavioral health provider in the site of a primary care practice some level of collaborating is almost assured. To go further, however, requires a shift in paradigm for both medical and behavioral health provider.

The shift in paradigm is from usual mental health care "parachuted" into medical settings (as Nick Cummings terms it) to primary behavioral health care as part of the medical services. Primary behavioral health care often helps physicians provide mental health care by consultation rather than having most cases referred for therapy. Primary behavioral health care is brief and problem or solution focused. Commonly the cognitive behavioral model is used, but that is not required. It is briefer, averaging about half as many visits per episode of care as specialty mental health care. It is flexible, providing patient education or case management when necessary. It can treat the body, using one of the relaxation response therapies, such as mindfulness meditation, relaxation training, biofeedback or hypnosis. It is often provided as part of pre-designed integrated protocols of care for patients with particular diagnoses. Check out the integrated protocol for depression developed by Katon and his colleagues described on the Clinical Effectiveness page.

Here is a set of stories that illustrate the way people present behavioral health needs in primary care, why most will not be referred to specialty

mental health services, and how the addition of a Behavioral Health Clinician changes what is possible for their care.

William Doherty, Ph.D., Susan McDaniel, Ph.D., and Macaran Baird, MD. FIVE LEVELS OF PRIMARY CARE/BEHAVIORAL HEALTHCARE COLLABORATION

New evidence from the Agency for Healthcare Research and Quality on integration of mental health and substance abuse into primary care.

Four Quadrant model of Behavioral Health/Primary Care Integration

HHS Integrated Primary Care Community Based Health System Chart.

Intermountain Healthcare Model of Integration of Mental Health and Primary Care

Washington Community Mental Health Council: Guiding Principles for Integration: Mental Health and Primary Care

Integrating Primary Care and Mental Health Services in Rural America: A Policy Review and Conceptual Framework

For another description of Integrated Primary Care, see Frank deGruy's seminal article, Mental Health Care in the Primary Care Setting, Or see Mental Health Care: From Carve-Out to Collaboration in *Family Practice Management*.

Efforts to coordinate care on a large scale have usually added work for providers with little additional information exchange. Here is one imaginative try at coordination. Web-based communication between primary care and behavioral health providers.

Rural integrated care projects.

The U.S. Air Force has begun an implementation of behavioral health in all of its primary care centers world wide. Have a look at the slides of Maj.Mark Oordt, PhD. This was presentation at the Society for Behavioral Medicine Conference in March,2009.

Check out Programs listed by state and country.

Clinical Effectiveness **Cost Effectiveness**

Integrated Primary Care HOME

FIVE LEVELS OF PRIMARY CARE/BEHAVIORAL HEALTHCARE COLLABORATION

William J. Doherty, Ph.D.
University of Minnesota

Susan H. McDaniel, Ph.D.

University of Rochester

Macaran A. Baird, M.D.

HealthPartners, Minneapolis, Minnesota

Behavioral Healthcare Tomorrow, October, 1996, 25-28.

As progress continues towards the development of feasible and effective models of collaboration, integrative care, we saw the need for a model to delineate the degree of collaboration achievable in different kinds of settings. Thus was born the Levels of Systemic Collaboration Model. The model describes degree of involvement and sophistication in collaborative health care involving mental health professionals and other health professionals, particularly medical physicians and nurses. The levels refer both to the extent to which collaboration occurs and to the capacity for collaboration in a health care setting as a whole, rather than to particular collaboration interactions between, for example, a physician and a therapist. The extent of collaboration on particular cases will be a function of the nature of the case, the collaboration skills of specific providers, and the collaboration capacity (level) of the health care setting and team. This model refers to systemic and organizational issues that facilitate or impede collaboration.

The hierarchy of the five levels assumes that the greater the level of systemic collaboration, the more adequate the management of very demanding cases is likely to be. Conversely, very demanding cases will generally challenge less collaborative settings beyond their ability to manage adequately. On the other hand, the model does not prescribe an optimal model for all health care settings, but rather describes the strengths and limitations of a variety of options.

This description of the model is adapted from Doherty's address to the Collaborative Family Health Care Coalition Conference in July, 1995, and published in Family Systems Medicine 1995, 13, 283-298.
(Note: the new name for the journal is Families, Systems & Health: The Journal of Collaborative Family Health Care.)

Level One: Minimal Collaboration

Description: Mental health and other health care professionals work in separate facilities, have separate systems, and rarely communicate about cases.

Where practiced: Most private practices and agencies.

Handles adequately: Cases with routine medical or psychosocial problems that have little biopsychosocial interplay and few management difficulties.

Handles inadequately: Cases that are refractory to treatment or have significant biopsychosocial interplay.

Level Two: Basic Collaboration at a Distance

Description: Providers have separate systems at separate sites, but engage in periodic communication about shared patients, mostly through telephone and letters. All communication is driven by specific patient issues. Mental health and other health professionals view each other as resources, but they operate in their own worlds, have little sharing of responsibility and little understanding of each other's cultures, and there is little sharing of power and responsibility.

Where practiced: Settings where there are active referral linkages across facilities.

Handles adequately: **Cases with moderate biopsychosocial interplay, for example, a patient with diabetes and depression where the management of both problems proceeds reasonably well.**

Handles inadequately: **Cases with significant biopsychosocial interplay, especially when the medical or mental health management is not satisfactory to one of the parties.**

Level Three: Basic Collaboration On-Site

Description: Mental health and other health care professionals have separate systems but share the same facility. They engage in regular communication about shared patients, mostly through phone or letters, but occasionally meet face to face because of their close proximity. They appreciate the importance of each other's roles, may have a sense of being part of a larger, though somewhat ill-defined team, but do not share a common language or an in-depth understanding of each other's worlds. As in Levels One and Two, medical physicians have considerably more power and influence over case management decisions than the other professionals, who may resent this.

Where practiced: **HMO settings and rehabilitation centers where collaboration is facilitated by proximity, but where there is no systemic approach to collaboration and where misunderstandings are common. Also medical clinics that employ therapists but engage primarily in referral-oriented collaboration rather than systematic mutual consultation and team building.**

Handles adequately: **Cases with moderate biopsychosocial interplay that require occasional face-to-face interactions between providers to coordinate complex treatment plans.**

Handles inadequately: **Cases with significant biopsychosocial interplay, especially those with ongoing and challenging management problems.**

Level Four: Close Collaboration in a Partly Integrated System

Description: **Mental health and other health care professionals share the same sites and have some systems in common, such as scheduling or charting. There are regular face-to-face interactions about patients, mutual consultation, coordinated treatment plans for difficult cases, and a basic understanding and appreciation for each other's roles and cultures. There is a shared allegiance to a**

biopsychosocial/ systems paradigm. However, the pragmatics are still sometimes difficult, team-building meetings are held only occasionally, and there may be operational discrepancies such as co-pays for mental health but not for medical services. There are likely to be unresolved but manageable tensions over medical physicians' greater power and influence on the collaborative team.

Where practiced: Some HMOs, rehabilitation centers, and hospice centers that have worked systematically at team building. Also some family practice training programs.

Handles adequately: Cases with significant biopsychosocial interplay and management complications.

Handles inadequately: Complex cases with multiple providers and multiple larger systems involvement, especially when there is the potential for tension and conflicting agendas among providers or triangling on the part of the patient or family.

Level Five: Close Collaboration in a Fully Integrated System

Description: Mental health and other health care professionals share the same sites, the same vision, and the same systems in a seamless web of biopsychosocial services. Both the providers and the patients have the same expectation of a team offering prevention and treatment. All professionals are committed to a biopsychosocial/systems paradigm and have developed an in-depth understanding of each other's roles and cultures. Regular collaborative team meetings are held to discuss both patient issues and team collaboration issues. There are conscious efforts to balance power and influence among the professionals according to their roles and areas of expertise.

Where practiced: Some hospice centers and other special training and clinical settings.

Handles adequately: The most difficult and complex biopsychosocial cases with challenging management problems.

Handles inadequately: Cases where the resources of the health care team are insufficient or where breakdowns occur in the collaboration with larger service systems.

We suggest that the Levels of Collaboration Model can be used by organizations to evaluate their current structures and procedures in light of their

goals for collaboration, and to set realistic next steps for change. We suspect that these goals should reflect the developmental nature of the levels, for example, moving from Level One distance to Level Two offsite linkages, or moving from level two to level three onsite collaboration as the first step, with provision being made for development of closer teams at level four. Level five would almost certainly require significant amount of time at level four teamwork.

The model can be used for research purposes to assess the outcomes and cost-effectiveness of different kinds of collaborative arrangements with different kinds of populations. For example, an implication is that Level Four utility might be best demonstrated on complex patients. Finally, the model suggests that significant efforts will have to be put into blending the cultures of medical and mental health professionals if higher levels of collaboration are to be feasible.

Return to Collaborative Care in Practice
IPC Home