Integrating primary care into a community mental health center

Our initiation of a reverse-integration practice model revealed numerous advantages and rewards, as well as many challenges, for which we found solutions.

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THE CASE

John C* is a 57-year-old man with hypertension, hyperlipidemia, and schizophrenia who followed up with a psychiatrist monthly at the community mental health center (CMHC). He had no primary care doctor. His psychiatrist referred him to our new Integrated Behavioral Health (IBH) clinic, also located in the CMHC, to see a family physician for complaints of urinary frequency, blurred vision, thirst, and weight loss. An on-site fingerstick revealed his blood glucose to be 357 mg/dL. Given the presumptive diagnosis of diabetes, we checked his bloodwork, prescribed metformin, and referred him for diabetes education. That evening, his lab results showed a hemoglobin A1C > 17%, a basic metabolic panel with an anion gap, ketones in the urine, and a low C-peptide level. We were unable to reach Mr. C by phone for further management.

HOW WOULD YOU PROCEED WITH THIS PATIENT?

** The patient's name has been changed to protect his identity.*

Coordination of behavioral health and primary care can take many forms, from simple synchronized care via referral, to co-located services, to fully integrated care.[1] Reverse integration, the subject of this article, is the provision of primary care in mental health or substance use disorder treatment settings. Published evidence to date regarding this model is minimal. This article describes our experience in developing a model of reverse integration in which family physicians and nurse practitioners are embedded in a CMHC with psychiatric providers, counselors, and social workers to jointly address physical and behavioral health care issues and address social determinants of health.

The rationale for reverse integration

Many individuals with serious mental illness (SMI), including schizophrenia and bipolar disorder, have rates of comorbid chronic physical health conditions that are higher than in the general population. These conditions include obesity, diabetes, metabolic syndrome, cardiovascular disease, chronic obstructive pulmonary disease, HIV, viral hepatitis, and tuberculosis.[2] Outcomes in the SMI group are also considerably worse than in the general population. People with SMI have a demonstrated loss of up to 32 years of potential life per patient compared with the general-population average, primarily due to poor physical health.[2] Maladaptive health behaviors such as

poor diet, lack of physical activity, tobacco use, and substance use contribute to this increased mortality.[2,3] Social determinants of poor health are more prevalent among individuals with SMI, and a relative inability to collaborate in one's own health care due to psychiatric symptoms further exacerbates the challenges.

Many individuals with SMI receive psychiatric care, case management, counseling, and psychosocial services in CMHCs. Their psychiatric caregiver may be their only regular health care provider. Family physicians—who receive residency training in behavioral health and social determinants of health in community settings—are distinctively capable of improving overall health care outcomes of patients with SMI.

Patients at a community mental health center may grow tired of conversation or feel overwhelmed in completing multiple tasks. Visits may need to be shorter and more frequent.

THE ADVANTAGES OF A REVERSE-INTEGRATION PRACTICE MODEL

Delivering primary care in a CMHC with a behavioral health team can benefit patients with SMI and be a satisfying practice for family physicians. Specifically, family physicians

- find that caring for complex patients can be less stressful because they benefit from the knowledge and resources of the CMHC team. The CMHC team offers case management, counseling, employment services, and housing assistance, so the primary care provider and patient are well supported.
- see fewer patients per hour due to higher visit complexity (and coding). In our experience, team-based care and additional time with patients make complex patient care more enjoyable and less frustrating.
- benefit from a situation in which patients feel safe because the CMHC support staff knows them well.

Other benefits. When primary care is delivered in a CMHC, there are "huddles" and warm handoffs that allow for bidirectional collaboration and care coordination between the primary care and behavioral health teams in real time. In addition, family medicine residents, medical students, and other learners can be successfully included in an IBH clinic for patients with SMI. The behavioral health team provides the mentorship, education, and modelling of skills needed to work with this population, including limit-setting, empathy, patience, and motivational interviewing.

For their part, learners self-report increased comfort and interest in working with underserved populations and improved awareness of the social determinants of health after these experiences.[4,5] Many patients at CMHCs are comfortable working with learners if continuity is maintained with a primary care provider.

Challenges we've faced, tips we can offer

For primary care providers, the unique workplace culture, terminology, and patient population encountered in a CMHC can be challenging. Also challenging can be the combining of things such as electronic medical records (EMRs).

Culture. The CMHC model focuses on team-based care spearheaded by case managers, in contrast to the traditional family medicine model wherein the physician coordinates services. Case managers provide assessments of client stability and readiness to be seen. They also attend primary care visits to support patient interactions, provide important psychosocial information, and assess adherence to care.

Terminology. It's not always easy to shift to different terminology in this culture. Thus, orientation needs to address things such as the use of the word "patient," rather than "client," when charting.

The complexities of the patient population. Many patients treated at a CMHC have a history of trauma, anxiety, and paranoia, requiring adjustments to exam practices such as using smaller speculums, providing more physical space, and offering to leave examination room doors open while patients are waiting.

In addition, individuals with SMI often have multiple health conditions, but they may become uncomfortable with physical closeness, grow tired of conversation, or feel overwhelmed when asked to complete multiple tasks in 1 visit. As a result, visits may need to be shorter and more frequent.

It's also worth noting that, in our experience, CMHC patients may have a higher no-show rate than typical primary care clinics, requiring flexibility in scheduling. To fill vacant primary care time slots, our front desk staff

uses strategies such as waiting lists and offering walk-in visits to patients who are on site for other services.

Ideally, IBH clinics use a single, fully integrated EMR, but this is not always possible. If the primary care and CMHC EMR systems do not connect, then record review and repeat documentation is needed, while care is taken to adhere to the confidentiality standards of a particular state.

Standards of care and state policies. Written standards of care, procedures, and accreditation in CMHCs rarely include provisions for common primary care practice, such as vaccines, in-clinic medications, and implements for simple procedures. To provide these services in our clinic, we ordered/stocked the needed supplies and instituted protocols that mirrored our other outpatient family medicine clinical sites.

Some states may have policies that prevent reimbursement for mental health and primary care services billed on the same day. Seeing a family physician and a psychiatry provider on the same day is convenient for patients and allows for collaboration between providers. But reimbursement rules can vary by state, so starting an IBH clinic like this requires research into local billing regulations.

WANT TO START AN INTEGRATED BEHAVIORAL HEALTH CLINIC?

Detailed instruction on starting a primary care clinic in a CMHC is beyond the scope of this article. However, the Substance Abuse and Mental Health Services Administration provides guidance on integrating primary care services into a local CMHC.[6] Start by performing a baseline needs assessment of the CMHC and its patients to help guide clinic design. Leadership buy-in is key.

Leadership must provide adequate time and financial and technological support. This includes identifying appropriate space for primary care, offering training on using the EMR, and obtaining support from Finance to develop a realistic and competent business plan with an appropriate budgetary runway for start-up. (This may include securing grants in the beginning.)

We recommend starting small and expanding slowly. Once the clinic is operational, formal pathways for good communication are necessary. This includes holding regular team meetings to develop and revise clinic workflows—eg, patient enrollment, protocols, and administrative procedures such as managing medications and vaccinations—as well as addressing space, staffing, and training issues that arise. The IBH transitional leadership structure must include clinicians from both primary care and behavioral health, support staff, and the administration. Finally, you need the right staff—people who are passionate, flexible, and interested in trying something new.

THE CASE

The next day, an outreach was made to the CMHC nurse, who had the case manager go to Mr. C's house and bring him to the CMHC for education on insulin injection, glucometer use, and diabetes nutrition. Mr. C was prescribed long-acting insulin at bedtime; his metformin was stopped and he was monitored closely.

Mr. C now calls the CMHC nurse every few weeks to report his blood sugar levels, have his insulin dose adjusted, or just say "hello." He continues to see his psychiatrist every month and his family physician every 4 months. The team collaborates as issues arise. His diabetes has been well controlled for more than 3 years.

The IBH clinic has grown in number of patients and family medicine providers, is self-sustaining, and has expanded services to include hepatitis C treatment. JFP

The community mental health center model focuses on team-based care spearheaded by case managers. This contrasts with the family medicine model, in which the physician coordinates services.

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