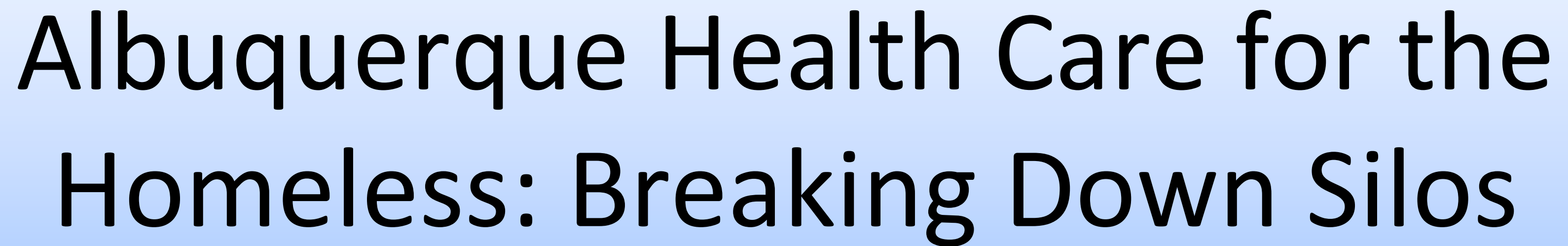

National Health Care for the Homeless Conference

May 16-18

TABLE 1: FOUR QUADRANTS OF CLINICAL INTEGRATION BASED ON PATIENT NEEDS

Axes: LOW ← BEHAVIORAL HEALTH RISK/COMPLEXITY → HIGH (vertical); LOW ← PHYSICAL HEALTH RISK/COMPLEXITY → HIGH (horizontal)

QUADRANT II	QUADRANT IV
Patients with high behavioral health and low physical health needs	Patients with high behavioral health and high physical health needs
Served in primary care and specialty mental health settings	Served in primary care and specialty mental health settings
(Example: patients with bipolar disorder and chronic pain) Note: when mental health needs are stable, often mental health care can be transitioned back to primary care.	(Example: patients with schizophrenia and metabolic syndrome or hepatitis C)
QUADRANT I	**QUADRANT III**
Patients with low behavioral health and low physical health needs	Patients with low behavioral health and high physical health needs
Served in primary care setting	Served in primary care setting
(Example: patients with moderate alcohol abuse and fibromyalgia)	(Example: patients with moderate depression and uncontrolled diabetes)

Source: Adapted from Mauer 2006.

COOR D INA T E D

Primary Care Provider to deliver brief behavioral health interventions.

Connections made between patient and community resources

CO- LOC A T E D

Consultation between behavioral health and medical providers to increase skills of both.

Increase in the level and quality of behavioral health services offered.

Significant reduction of no-shows for BH treatment

INT EGR A T E D

Teams composed of a physician and one or more of the following:
Medical assistant, nurse practitioner, nurse, case manager, client/family advocate, behavioral health therapist.

Use of database to track the care of patients who are screened into behavioral health services.

First adapted from Blount 2003.
Milbank.org/reports/2010
Chris Collins, Denise Levis Hewson, Richard Munger, and Torlen Wade

Improving Collaboration between Separate Providers

- *Minimal collaboration*. Mental health providers and primary care providers work in separate facilities, have separate systems, and communicate sporadically.

Milbank.org/reports/2010/
Chris Collins, Denise Levis Hewson, Richard Munger, and Torlen Wade

Medical Provided Behavioral Health Care

Basic collaboration at a distance. Primary care and behavioral health providers have separate systems at separate sites, but now engage in periodic communication about shared patients. Communication occurs typically by telephone or letter. Improved coordination is a step forward compared to completely disconnected systems.

- Screening, Brief Intervention, Referral and Treatment (SBIRT) programs
- Milbank.org/reports/10430EvolvingCare
- Chris Collins, Denise Levis Hewson, Richard Munger, and Torlen Wade

Co-Location

- *Basic collaboration on-site*. Mental health and primary care professionals have separate systems but share the same facility. Proximity allows for more communication, but each provider remains in his or her own professional culture.

- Milbank.org/reports/2010
- Chris Collins, Denise Levis Hewson, Richard Munger, and Torlen Wade

Delivering specialty mental health in primary care settings produces greater engagement of patients in mental health care, which is a prerequisite for better patient outcomes. Emerging literature on co-located substance abuse treatment and primary care has shown that patients have better outcomes, with the greatest improvement for those with poorer health (Craven and Bland 2006). Medical cost offset may occur when patients use less medical care because they are receiving mental health services. The reduced physical health care cost offsets the cost of the mental health care (Strosahl and Sobel 1996). And diagnosis and treatment may significantly improve in co-located models. This is attributed to behavioral health clinicians taking an active role in teaching and coaching primary care providers (Koyanagi 2004).

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Chris Collins, Denise Levis Hewson, Richard Munger, and Torlen Wade

Disease Management

- *Close collaboration in a partly integrated system*. Mental health professionals and primary care providers share the same facility and have some systems in common, such as scheduling appointments or medical records. Physical proximity allows for regular face-to-face communication among behavioral health and physical health providers. There is a sense of being part of a larger team in which each professional appreciates his or her role in working together to treat a shared patient.

- Milbank.org/reports/2010
- Chris Collins, Denise Levis Hewson, Richard Munger, and Torlen Wade

Unified Primary Care and Behavioral Health

- *Close collaboration in a fully integrated system*. The mental health provider and primary care provider are part of the same team. The patient experiences the mental health treatment as part of his or her regular primary care.

- Milbank.org/reports/2010
- Chris Collins, Denise Levis Hewson, Richard Munger, and Torlen Wade

Primary Care Behavioral Health

- In this fully integrated model, behavioral health is a routine part of the medical care. Strosahl (1998) notes that a patient is just as likely to see a behavioral health clinician as a nurse during a routine office visit in this model. The behavioral health clinician is part of the primary care team, not part of specialty mental health. The patient's primary care physician is the principal "provider" in the model. The behavioral health clinician does not take over responsibility for treating the patient, but rather temporarily co-manages the patient with the physician, who makes the initial referral.
- Milbank.org/reports/2010
- Chris Collins, Denise Levis Hewson, Richard Munger, and Torlen Wade

The 5-A Behavioral Counseling Framework

- **Ask about substance use.**
- **Advise to quit through clear personalized messages.**
- **Assess willingness to quit.**
- **Assist to quit.**
- **Arrange follow-up and support.**

Integration

- Randomized controlled trials (RCTs) show that disease management models using BH care managers are both clinically effective and cost-effective. Meta-analyses indicate that there is a cost offset of 20 to 40 percent for primary care patients who receive behavioral health services. Notably, fewer hospitalizations result in significant cost reductions for patients with chronic physical illness and those with psychiatric diagnoses (Blount et al. 2007).
- Milbank.org/reports/10430EvolvingCare
- Chris Collins, Denise Levis Hewson, Richard Munger, and Torlen Wade

AHCH - 1217 FIRST STREET

OVERALL SITE PLAN

MOUNTAIN ROAD

PARKING

PARKING

BUILDING 'B'
MEDICAL CLINIC

LANDSCAPED PATIO

BUILDING 'C'
DENTAL CLINIC
ART STREET

LANDSCAPED PATIO

BUILDING 'A'
TWO STORIES
ADMINISTRATION
BEHAVIORAL HEALTH

ROSEMOUNT AVENUE

FIRST STREET

AHCH Teams – Building A

1. Behavioral Health Therapist Team
- Four Independently Licensed Master Level Clinicians, Program Manager
2. Harm Reduction Outreach Team
- Four Harm Reduction Specialists, including Coordinator
3. Social Services Team
- Nine Case Managers, Three Client Advocates, one Coordinator and one Program manager, One Receptionist

AHCH Teams-continued-Building B

4. Medical Team

- Four Nurses, Nurse Manager, Five Medical Assistants, One Pharmacist, Two Pharmacy Technicians, Four Nurse Practitioners (includes a Psych specialist), Two MDs, One Billing Specialist, One Medical Records Admin., Two Receptionists

AHCH Teams-continued-Building C

5. Dental Team

- Chief Dentist/Program Manager, Three Dental Assistants, One Hygienist, Receptionist

6. ArtStreet Team

- Five Artists (MFA, LMSW, LPAT, BA)

AHCH Outreach

- Up to 18 Outreaches per/week
- Most are Integrated with Medical, Behavioral Health and Social Service Teams