POINTERS IN STARTING A PRIMARY CARE PRACTICE IN A BEHAVIORAL HEALTH CENTER

Why even *start* a primary care practice in a behavioral health center?

Since it is not easy to do, a clear answer is essential for a behavioral health organization's success. When considering whether or not to even start a primary care practice it is essential to remember that too often people experiencing serious mental disorders do not experience adequate primary medicine. Multiple studies show that behavioral health patients often do not have access to primary care—and thus chronic conditions go untreated leading to a shortened life span. Simply telling the patient to "see their doctor" does not result in their accessing needed care. The effect of untreated chronic disease among the mentally ill population is striking. Average life expectancy in the US is 78 years *unless you are seriously mentally ill*. People with a serious mental disorder experience an average lifespan of 53-57 years making it the biggest life span disparity in the US. Morbidity and mortality has been detailed in recent years with minimal change in our health care delivery system.*

Another answer is that with the co-location of primary and behavioral health practitioners in primary care settings, the possibility of integrated care is much enhanced. Co-location does not guarantee integration but with the commitment of leadership and the goodwill and intent of the practitioners it has a fighting chance. If you add to the intent, a commitment to continually review and search out what works, the success quotient improves. Integration of care leads to better outcomes. Screenings become more holistic, complementary strategies respond to co-morbid conditions, no show rates are significantly reduced, and improved access results in improved health outcomes.

While the approaches to integrated care are diverse and "messy" at this time, the overall trend is omnipresent. Experimentation in the industry is widespread while diverse models are under development. Ignoring the trend would be a bad business decision in the current environment. Emerging models of care operate on the assumption that integrated care is the future of health care. The trend is to have multiple practitioners with routine face to face interaction provide coordinated care to a shared patient. The patient experiences the service as one in which all their health care needs are addressed. We need to remind ourselves that the disease was integrated from day one. Our challenge is to structure and provide care to match the disease.

But given the benefit of having a primary practice available to persons with mental illness, why embed the practice *within* the behavioral health center?

- Co-location of a behavioral health practitioner in a primary care practice works—but still leaves "spaces" between and among the various providers and the two cultures (primary care and behavioral care) are still separate.
- Co-location of a primary care practitioner within a behavioral health center also works—but

essentially replicates the other form of co-location but with a higher degreed practitioner. There is also the continuing potential of conflict between the medical and psychiatric practitioners given their differing clinical assumptions, patient relationship approaches, and different cultural assumptions.

- However, if a primary care practice is *embedded within* the behavioral health center, several positive elements will occur:

  —Primary Care Physicians will become more familiar with the mental health practice culture
  —Psychiatric Physicians will become more attuned to the practice needs of Primary Care Physicians
  —Primary care Physicians are able to become desensitized to their own fears of the mental health patient
  —Primary Care and Psychiatric Physicians can operate an integrated medical staff that is able to develop clinical policies and procedures that are integrated at the start
  —Healthcare treatment planning becomes truly holistic
  —Patients' with mental illness will have their chronic medical needs identified and addressed more consistently
  —All practitioners within the behavioral health system increase their awareness of the medical needs of their patients and are responsible to do more for them than just referring them
  —The existence of an embedded primary care practice creates pressures for the behavioral health center to "retrofit" itself as a look-alike primary care practice (i.e., becoming a more integrated delivery system)
  —All of these elements mean that the patients within the behavioral health center are now better-positioned to have their health status improved—and their lifespan lengthened

These are the reasons Summit Pointe worked to embed a primary care practice within its behavioral health center.

Thinking It Through

A sponsoring organization deciding to embed a primary care practice within a behavioral health center would be wise to complete several essential preparatory steps. The purpose of these steps is to provide direction and support for both patients and staff and they embark on a new and complex system of care.

Look at the Data

Establish as complete understanding of the need for the primary care practice as data will permit. Describe the patient population and the type and incidence of untreated medical challenges. If the data system of the behavioral health center does not document untreated medical needs of the pa-

tients, then base your estimates on one of the numerous studies that have documented estimates of the type and frequency of medical needs of patients with a mental illness and/or abusing substances. For example, several chronic medical illnesses are a common issue for behavioral health patients. “Mental health problems are 2 to 3 times more common in patients with chronic medical illnesses such as diabetes, arthritis, chronic pain, headache, back and neck problems, and heart disease (Katon, 2003; Katon, Lin, and Kroenke, 2007; Scott et al., 2007)”.

Build a Roadmap

Develop a roadmap for the sponsoring organization(s) that can answer or provide direction on key issues. What outcomes are important and how will you measure them? What is your organization committing to the Practice? Is it part of your vision and mission? What financial commitment are you making? Do you have a plan for integrating financing and reimbursement mechanisms? Are you looking for a cost offset? How will you determine if the Practice is sustainable? Have risk management issues been assessed and addressed? Are there policies that need to be implemented over and above what you currently have for your organization? How will you promote and market the new service? Who is designated to provide administrative support and guidance from the sponsoring organization?

Detail the Roadmap

Develop a roadmap for the Practice. A staged approach to implementation and to integration can help deal with the numerous challenges so they do not become overwhelming. Questions that beg for answers include the desired outcomes sought for the patients and how the performance of the practice will be measured? How will the patient and their family be involved in managing their care? How many patients will be cared for? How will the provider document the care provided so all directly involved share information as well as meet the requirements of payers and reviewing authorities? How many and what type of staff will be needed to provide integrated care and management of chronic health issues? What is the expected level of integration for patients and staff? What training will the staff need? What type and size of facility and hours of operation be needed? The roadmap should be sufficiently detailed to answer questions or challenges of wide range of priorities and will need the service of a “GPS” on their journey.

With integrated practices relatively new on the horizon and within behavioral health centers even more so, there is not yet many evaluative studies of the implementation process. One that was completed with the focus on diabetic patients is illustrative of the challenges of integrated care.

> “….this study seeks to provide a comprehensive *understanding* of the process by which an "ideal" model of integrated care is effectively implemented. As such, and aside from the specific local scope of the project, this investigation provides four intertwined insights to those who seek to integrate primary care networks. First, the supply of new resources appears a necessary but insufficient condition for promoting integration. The great investment that the project's sponsors made in information technology, with very poor or no results, properly illustrates this point. Second, the lack of adequate clinical leadership and consensus regarding the philosophy of intervention hindered

> the construction of a truly cooperative interprofessional relationship between physicians and nurses, and precluded the elaboration of a joint disease management plan. Third, implementing integration is an evolutionary process that requires an adequate temporal frame to succeed; stopping the project after only one year constituted a waste of resources and energy. Finally, the project suggests that healthcare integration, whatever form it takes, requires the health professionals involved to give sense to the conceived plan in order to be able to implement it." (Rodriguez et al, 2006).

The under utilization of technology, lack of clinical leadership, a short timeframe to document success, and involved professionals not making the integration process their own all contributed to an unsuccessful integration.

Another evaluation focused on the need for a stable infrastructure and funding.

> "Substantial resources are required to build an infrastructure within health care that integrates primary care practices and communities. The sources of funding to establish this infrastructure and their long-term sustainability are unclear... For integration to be truly viable...resources to which clinicians might refer patients require stable funding; in addition, clinicians and health systems will expect reimbursement for the added work entailed in establishing and maintaining ties with diverse community services." (Woolf et al, July 2005).

Answering the question about how the sponsoring organization will address the competing and confusing financing and reimbursement mechanisms is essential. Staff need to know what they must do and have administrative support as well.

A third evaluation identified the need for training. One study which focused on an integrated care project in a VA hospital (which was not financially hamstrung for the project) stated that cultural problems needed to be overcome for a successful integration. These included:

> "... lack of education, funding limitations, and expanding workload have challenged efforts. For instance, BHPs are often ill prepared to understand how to deliver therapeutic services in the fast-paced environment of primary care. Similarly, PCPs often need a certain amount of education to help them shift focus from a traditional medical model to a more collaborative model." (Fuderburk, 2010).

Answering the question about needed training is critical. Primary care and behavioral health professions are trained with divergent approaches to their work and will not automatically integrate if in the same practice. Training needs to be designed to enhance skills and foster an integrated approach.

On NOT Reinventing the Wheel

One good thing about building a primary care practice is that many other have trod the same road—and recommended solutions won through multiple trial-and-error experiences. Some of the most useful resources are described below.

Medical Group Management Association

104 Inverness Terrace East
Englewood, CO 80112-5306
Phone: 303.799.1111
Toll-free: 877.ASK.MGMA (275.6462)
Website: http://www.mgma.com/

Comment: One of the oldest and most useful of the resources. Membership gets access to a range of practice management data; implementation data; vendors; cost and pricing surveys; benchmarking; and so on. They address the needs of any size primary and specialty medical practice.

American Medical Group Association

One Prince Street, Alexandria, VA 22314-3318
Phone: (703) 838-0033
Fax: (703) 548-1890
Website: http://www.amga.org/

Comment: AMGA provides educational and networking programs, publications, benchmarking data services, and financial and operations services. They are focused mainly on multispecialty medical groups and other organized systems of care.

Bureau of Primary Health Care (BPHC)

Health Resources and Services Administration
Department of Health and Human Resources
Website: http://www.bphc.hrsa.gov/index.html

Comment: Although this is geared to Federally Qualified Health Centers (FQHCs), Community Health Centers (CHCs), and Rural Health Clinics (RHCs), it offers a wide range of material and practice information regarding primary care. It also afford a good window into FQHCs for those considering co-location or other forms of partnership.

American Academy of Family Physicians

11400 Tomahawk Creek Parkway
Leawood, KS 66211-2680
Phone: (800) 274-2237
Website: http://www.aafp.org/online/en/home.html

Comment: Geared to the needs of Family Practice physicians, the site has a range of resources of interest to physicians. There is also a useful section on "Running a Practice" that

Ideal Medical Practice Organization

Website: http://impcenter.org/

Comment: A virtual grassroots non-profit organization of small or solo primary care practitioners who want a more humane and less production-oriented style of medical practice. Offers some significant details on the nuts-and-bolts of practice management. Good for building a small practice. Membership required.

Using Checklists to Get the Work Done

There are many recommended processes for starting up a primary acre practice. These usually come in the form of a Checklist. Some of the most useful ones are found below:

Medical Group Management Association

Checklist for Starting a New Medical Practice

Website: http://www.mgma.com/WorkArea/DownloadAsset.aspx?id=5566

Michigan Primary Care Association

Federally Qualified Health Center Start-up Checklist

Website: *www.mpca.net/Client/MPCA/Files/Newstartupchecklist20Widsconsin.doc*

Nisivoccia, LLP (Certified Public Accountant Group)

Medical Practice Startup Checklist

Website: http://www.nisivoccia.com/depcms/uploads/Medical-Practice-Startup-Checklist.pdf

FPIC Insurance Group, Inc. (a Subsidiary of the Doctors Company)

New Medical Office Start-Up

Website: http://www.apacinsurance.com/templates/New%20Med 0Of-fice20Checklist.pdf

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The Ideal Medical Practice Model: Improving Efficiency, Quality and the Doctor-Patient Relationship. ,American Academy of Family Practice http://www.aafp.org/fpm/2007/0900/p20.html

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