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Practice Management Strategies to Integrate Behavioral Health Care in a Primary Setting

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PRACTICE MANAGEMENT STRATEGIES TO INTEGRATE BEHAVIORAL HEALTH CARE IN A PRIMARY SETTING

by

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ABSTRACT

When individuals with mental disorders present to the primary care setting for physical health problems, mental health concerns are sometimes overlooked; thereby, affecting access to behavioral health care. Integrating behavioral care in primary care settings is a potential solution to providing quality, accessible, and cost-effective care to individuals with mental disorders. The purpose of this project was to: a) assess current level of integration/collaboration in a primary care setting by administering an assessment tool to providers and staff and b) implement strategies with providers and staff input to integrate behavioral health care in a primary care setting. To determine the level of integration/collaboration, 14 providers and staff completed the assessment tool. The results of the integration/collaboration assessment tool revealed that the primary care clinic was operating at basic collaboration at a distance. Practice management strategies enhanced the level of communication and increased the level of integration to basic collaboration onsite. Strategies implemented to improve access to behavioral health care were developing a referral form, implementing warm handoffs, developing a network of behavioral health referrals, and expanding collaboration with a behavioral health clinic. Findings from the project determined that the assessment tool was effective in improving practice management strategies to integrate behavioral health in a primary care setting.

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DEDICATION

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LIST OF ABBREVIATIONS

AACN	American Association of Colleges of Nursing
AAP	American Academy of Pediatrics
CIHS	Center for Integrated Health Solutions
CMHC	Community Mental Health Center
CHC	Community Health Centers
CMS	Centers for Medicare and Medicaid Service
EHR	Electronic Health Record
FNP	Family Nurse Practitioner
FQHC	Federally Qualified Health Center
FTE	Fulltime Equivalent
HMO	Health Maintenance Organization
HRSA	Health Resources and Service Administration
IOM	Institute of Medicine
IPAT	Integrated Practice Assessment Tool
LCSW	Licensed Clinical Social Worker
LPN	Licensed Practical Nurse
MA	Medical Assistant
MSBN	Mississippi Board of Nursing
NCQA	National Committee on Quality Assurance
NIMH	National Institute of Mental Illness

PHQ-2	Patient Health Questionnaire - 2
PHQ-9	Patient Health Questionnaire - 9
PBHCI	Primary and Behavioral Health Care Integration
PCMH	Patient-Centered Medical Home
PCP	Primary Care Provider
PMHNP	Psychiatric Mental Health Nurse Practitioner
PPACA	Patient Protection Affordable Care Act
SAMHSA	Substance Abuse and Mental Health Services Administration
SAMHSA-HRSA CIHS	SAMHSA-HRSA Center for Integrated Health Solution
CMS	Centers for Medicare and Medicaid Service
US	United States
USDHHS	United States Department of Health and Human Services
WMIP	Washington Medicaid Integration Partnership

CHAPTER I – INTRODUCTION

Overview

Comorbid diseases are frequently overlooked for individuals with a mental disorder that presents with physical illnesses in primary care settings (Valderas, Starfield, Sibbald, Salisbury, & Roland, 2009). Comorbidity is defined as the presence of two or more chronic diseases that occur simultaneously. The presence of comorbidities can worsen the prognosis, increase the amount and severity of complications making medical treatment more difficult and less effective (Valderas et al., 2009). Medical providers in primary care settings normally focus their attention to the physical illness in which they are more knowledgeable or the ones in their specialty and often neglect the mental disorders that are present (Everett et al., 2014). Mental disorders are overlooked in the primary care setting because:

- Increased patient load
- Medical providers feel as if the mental disorders will subside once the physical issues are resolved
- Lack of knowledge about mental disorders
- Lack of training and a lack confidence recognizing, diagnosing, and treating mental disorders
- Perceived stigma attached to mental disorders (Everett et al., 2014).

Treatment for mental disorders is projected to cost 300 billion dollars a year by the year 2020 (Substance Abuse and Mental Health Services Administration [SAMHSA],

2014). The increased health care spending on mental disorders has led researchers, organizations, and policymakers to think about ways to improve the overall health of individuals with a mental disorder while reducing health care costs. A possible solution to the treatment of mental disorders in primary setting is the delivery of integrated care. Integrated care is defined as the combination of general and behavioral health care (SAMHSA-HRSA Center for Integrated Health Solutions, 2014a) Integrated care improves access to care for individuals with co-morbid physical and mental disorders. To integrate behavioral care in a primary care setting, a recognized solution is to utilize the Integrated Practice Assessment Tool (IPAT) in the primary care setting to assess the level of collaboration/integration and to improve practice management strategies (Waxmonsky, Auxier, Romero, & Heath, 2013).

Background and Significance

According to the National Institute of Mental Health (NIMH), approximately 44.7 million adults experienced a mental disorder, with 10.4 million of those experiences limiting one or more major life activities (NIMH, 2017a). Of all adults nationwide, 1.1% are living with schizophrenia (NIMH, 2018), 2.6% live with bipolar disorder (NIMH, 2017 b), and while 18.1% have an anxiety disorder (NIMH, 2017c). Not only do mental disorders affect adults, they can also affect children. Mental disorders account for the highest dropout rate of any disability group, accounting for a 37% drop out rate for students 14-21 years of age. Statistics reveal that 50% of all chronic mental disorders start around age 14 and account for 90% of youth in the juvenile justice centers with 70% of youth having a mental disorder and 20% living with severe mental disorders (National Center for Mental Health and Juvenile Justice, 2007).

Individuals living with mental disorders in the United States have a shorter lifespan when compared to the general population (NIMH, 2018). The mortality gap for those with mental disorders has progressively increased from 10-15 years to 13-30 years lost (NIMH, 2018). In comparison to the general population, people with a mental disorder such as schizophrenia have at least a 28.5-year decrease of normal life span due to co-morbid conditions such as diabetes, hypertension, heart disease, obesity, and suicide (NIMH, 2018). In the United States, suicide is the tenth leading cause of death, which is highest amongst Veterans with a daily suicide rate of 18-22. Suicide is the number two cause of death for individuals ages 15-24, the third leading cause of death for people ages 10-24 (U.S. Department of Veteran Affairs Mental Health Services Suicide Prevention Program, 2012).

The Patient Protection and Affordable Care Act of 2010 and Integrated Care

In 2015, health care spending in the United States increased 5.8% totaling 3.2 trillion dollars, in which 200 billion dollars were spent on diagnosing and treating mental disorders (Centers for Medicare and Medicaid Services [CMS], 2015). The Patient Protection and Affordable Care Act of 2010 (PPACA) increased the government's position as a health care payer by improving Medicare and Medicaid coverage and reimbursement in the primary care setting (Abrams, Nuzum, Mika, & Lawlor, 2011). The PPACA was also designed to decrease the overall costs of health care, reduce health disparities, and increase access to health care and preventive services. The PPACA referred to integrated care as a model that can be used to decrease cost, improve quality of care, and increase accessibility to health care (Kaiser Family Foundation, 2013).

Regarding mental disorders, the PPACA encouraged a move towards the integration of care by:

- Enabling states and federal agencies to assess and evaluate enhanced financial and organizational tools to address the destruction of services that lead to poor quality care and high health care cost (Mechanic, 2012).
- Providing necessities directed toward chronic disease comorbidities. These necessities made it possible for health care providers to be more attentive to patients who do not only have serious mental disorders but those who have co-morbidities as well (Mechanic, 2012).
- Allowing health care providers, the chance to better organize behavioral services, supported by Medicaid, in conjunction with social service and housing programs that seek to prevent and manage homelessness among individuals with serious mental disorders (Mechanic, 2012).
- Encouraging the use of preventative services such as substance abuse education, evaluation, and treatment; allowing those health care providers who treat serious mental disorders to pay more attention to substance abuse issues (Mechanic, 2012).
- Finally, by extending the concepts of treatment and related supportive care to such entities as health homes, the Affordable Care Act provides new pathways for incorporating evidence-based treatments, such as supported employment, that are commonly neglected (Mechanic, 2012).

Providers and Integrated Care

Providers in the primary care setting are the driving force behind our healthcare delivery system. Previously, providers' main focus was on the individual's overall

physical health and well-being. Currently, many primary care providers are now playing an important role in identifying, initiating treatment, and making referrals for those individuals with mental disorders in addition to providing care for individual's physical needs. Many individuals with mental disorders have physical illnesses that are often over looked, making access to behavioral health diagnosis/treatment important in the primary care setting (Sartorius, 2007). The integration of behavioral health care into the primary care setting plays an important role in improving the health care experience of the patient, improving the quality, accessibility, and overall health of the population while reducing the per capita cost of health care (Whittington, Nolan, Lewis, & Torres, 2015).

The President's New Freedom Commission on Mental Health (2003) reported that an understanding of mental health is essential to overall health. The stigma of a mental illness and barriers to seeking mental health care exist in the United States. Reducing and eliminating barriers to mental health service is essential to overall health. Inequities exist in the delivery of medical services. Medical and mental health care should occur together, integrating mental health care in primary care (President's New Freedom Commission on Mental Health, 2003).

In addition to stigma of mental illness and seeking mental health care, individuals with mental disorders face challenges in education, employment, and access to health care, which can affect their roles in society. Access to behavioral health care is affected due to the lack of mental health workforce. The unmet and under treated needs of individuals with a mental disorder can have a negative impact on economic development (Ngui, Khasakhala, Ndetei, & Roberts, 2011). Attention to these unmet needs will entail better mental health services and initiatives as well as the integration of physical and

mental health services in the primary care setting. In the state of Mississippi, nurse practitioners provide care for individuals with mental health and physical health disorders. Nurse practitioners who are dual certified, as family nurse practitioners (FNP) and psychiatric mental health nurse practitioners (PMHNP) can meet the needs of individuals with both mental health and physical health disorders while potentially improving access to health care in a state with a mental health workforce shortage.

Providers and Integrated Care in Mississippi

The impact of untreated mental disorders in Mississippi is detrimental to the state's economy. There are about 2.9 million people in the State of Mississippi with at least 125,000 adults and 34,000 children living with a serious mental disorder. Total expenditures for mental health in the 2013 fiscal year was $39.5 billion. Mississippi spends $7,646 per person on health care and has the lowest median household income with a poverty per capita expenditure rank of 37, meaning the health care cost is not equal to the health care outcomes (National Association of State Mental Health Program Directors, 2014). Many policy and lawmakers are implementing a cost-effective solution to decrease the number of individuals with mental disorders that are being overlooked and undertreated.

Like most states, Mississippi suffers from a lack of prescribing providers, psychiatrists and PMHNP. According to data retrieved from the Mississippi Board of Nursing, in 2014, there were a total of 120 PMHNPs in the state (Mississippi Board of Nursing [MSBN], 2014). Mississippi has fewer than 6 psychiatrists per 100,000 people. The city where the DNP project was completed has 0.79 Psychiatrists per 100,000 residents (Dartmouth Atlas of Health Care, 2011). An integrated healthcare approach is

important to shorten the provider gap, decrease cost, decrease morbidity, and mortality of those with mental disorders (Huang, Meller, Kathol, & Kishi, 2014). Individuals with mental disorders often present to primary care settings. Integrating behavioral care in primary care settings is a potential solution to providing quality, accessible, and cost-effective care to individuals with mental disorders.

Needs Assessment

In the State of Mississippi, there are 20 community health centers that provide primary care to underserved populations. Many of the community health centers are Federally Qualified Health Centers (FQHCs) (Mississippi Primary Care Associations, 2017). The FQHC's are overseen by a physician, receive federal money that is renewable and can generate additional funding with every service that is added such as electronic health records (EHR), dental, vision, and pharmacy services (Pohl, Vonderheid, Barbauskas. & Nagerlkerk, 2004).

Federally Qualified Health Centers are community-established healthcare providers that receive federal funding from the Health Resources and Service Administration (HRSA) Health Center Program to supply primary care services in underserved areas (HRSA, 2017). A community health center that is centrally located in the State of Mississippi serves an urban population and is considered a FQHC. The FQHC, which has three clinic locations, received $1.3 million in grant funding. In the year of 2017, the FQHC treated 6,582 patients. Medical visits for chronic diseases such as asthma, diabetes, HIV, hypertension etc. accounted for 5,607 visits while mental disorders accounted for 1,157 total visits (E. Bluntson, personal communication, September 20, 2017).

The FQHC is not delivering integrated care and does not have a mental health provider, psychiatrist, or psychiatric and mental health nurse practitioner on staff. Staff members currently includes a total of seven physicians (one part-time and six full-time), five family nurse practitioners (FNP) (one part-time and four full-time), one full-time licensed clinical social worker (LCSW), four full-time licensed practical nurses (LPN), ten full-time medical assistants (MA), six full-time medical billing/coders, and medical clerks. Patients are not routinely screened for mental disorders upon arrival to the clinic. When applicable, the physician and FNP screen for depression and anxiety, and these are the only two mental disorders listed on the facilities medical encounter (billing and coding sheet). On average, the LCSW sees 0-1 patient a day for issues related to none mental disorders such as food and housing. During the last 6 months, the LCSW reported seeing an estimate of 75 to 100 patients with mental disorders that were referred by the primary care providers (R. Walker, personal communication, October 02, 2017). When a patient presents with signs and symptoms of a mental disorder, he/she is referred to the LCSW by a physician or a family nurse practitioner. The LCSW gives the patient a list of behavioral health facilities in their area and the patient decides which facility they would like to receive help. The LCSW then initiates the referral by placing a phone call to the behavioral health facility to schedule the patient for an appointment. The patient is given the location, date, and time for their appointment. There is no referral form or referral process used unless the patient is being referred to a private behavioral health facility, which has their own referral forms. After the patient is referred, there is no follow up process to track the patients' progress neither is there any form of collaboration nor follow up between the sites.

The identification of individuals with a diagnosis of a mental disorder is imperative and can improve access to care through an integrated care approach. The process of moving towards an integrated approach could possibly pique the interest of individuals in the area that would seek care on a continuous basis if they understood the organization, had knowledge about the services they provide, as well as available resources for individuals with a mental disorder. A FQHC is an ideal setting for integrating behavioral health into the primary setting due to the patient demographics, location, and the ability to reduce disparities, barriers, and stigma related to mental disorders (Jones & Ku, 2015; Sanchez, Chapa, Ybarra, & Martinez, 2014). The Integrated Practice Assessment Tool (Waxmonsky et al., 2013), in this primary care setting will be used to assess the health center's current level of collaboration with implications to improve practice management strategies for the integration of behavioral health into the primary care setting. The PICOT question for this DNP project is: Does the utilization of a tool to assess the current level of integration/collaboration in a primary care setting improve practice management strategies to integrate behavioral health in a primary care setting?

Review of Related Literature

Searches of online scholarly databases and search engines included Consumer Health Complete, SAGE journal, EBSCOhost, Google Scholar, CINAHL, Medline, Cochrane Reviews, Academic Search Premier, and reference lists to retrieve peer-reviewed articles reporting access to care, outcomes (cost and quality) related to integrated care delivery systems. Databases searches were conducted to find evidence-based articles related to the PICOT question: Does utilization of a tool to assess the level

of integration/collaboration and development of an integrated care approach in a primary care setting, improve access to behavioral health care for individuals with mental disorders seen in a primary care setting?

Key terms used related to the topic and problem statement such as integrated delivery system, integrated care, care coordination, coordinated care, primary care, behavioral health, and warm handoffs. Inclusion criteria included articles published after the year of 1990, applicable seminal articles, and articles related to integrated care. A literature matrix is included with information from each of the included articles (Appendix A).

Although there are no articles on the Integrated Practice Assessment Tool itself, integrating behavioral health into the primary care setting remains an important area of inquiry for this review of related literature. After reviewing the evidence on the integration of behavioral health into the primary care setting, the scientific literature states that the primary care setting is the first point of contact for all individuals with health issues and an ideal setting to integrate care (Walker & Collins, 2009). Successful integration of care should include early screening, detection, and treatment of mental disorders in a diverse environment that treats the patients holistically (Sanchez, et al., 2014). Community health centers are the gateway to medical and mental disorders (Jones & Ku, 2015). Integrated care services at community health centers in addition to "warm handoffs" can reduce barriers to care as well as the stigma that is attached to mental disorders (Jones & Ku, 2015). Articles reviewed concluded that the integration of behavioral health into the primary care setting can improve the overall health of the

population, better compliance, more satisfied patients, and reduction in costs (Walker & Collins, 2009).

Integrated Care

The integration of care became a topic of interest in the 1960s when it was noticed that patients with mental disorders were initially seen in the primary care setting. An integrated care approach resulted in lower costs, better health outcomes, and patient satisfaction (Walker & Collins, 2009). Unutzer, Harbin, Schoebaum, and Druss (2013) found that patients prefer an integrated approach in which primary care and mental health care providers work together to address medical and behavioral healthcare needs. Twenty percent of the adults with mental disorders preferred to receive treatment in a primary care setting when compared to a behavioral health setting. When patients were referred to a mental health facility by the primary care provider, only 50% of the patients kept their appointment (Unutzer et al., 2013). Integrating mental health providers into the primary care setting could possibly improve the treatment of the whole patient with enhancements in outcomes and reduced utilization (Butler et al., 2008).

Integrated Care Approaches

Integrated care approaches include integration of primary care in behavioral care settings and integration of behavioral care in primary care settings. The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) addresses behavioral health integration in the Patient-Centered Medical Home (PCMH). The PCMH model is focused on whole person care and address physical, behavioral, and psychosocial dimensions of care. The National Committee on Quality Assurance (NCQA) includes standards for PCMH behavioral health integration for clinical practices that are considering integrating

behavioral health and primary care (SAMHSA-HRSA, 2014c). There are four PCMH standards specific to behavioral health: team-based care, population health management, care management support, and care coordination and transitions. Care management and support identifies patients with behavioral care conditions who will benefit from care management support. Care coordination and care transitions coordinates care across specialty care through referral tracking and follow-up. Factors related to referral tracking and follow-up are implemented based on the three categories of integrated care (SAMHSA-HRSA CIHS, 2014a). The three categories for integrated care are: coordinated, co-located, or integrated (Heath, Wise, & Reynolds, 2013). Primary and behavioral health coordinated care is provided at different locations and care is coordinated through enhanced communication. Co-located primary and behavioral health care is offered at the same site, through referral and use of separate treatment plans. The behavioral health and primary care providers work together in a team and use one treatment plan in the integrated care category (Doherty, McDaniel, & Baird, 1996; Heath, Wise, & Reynolds, 2013; SAMHSA-HRSA CIHS, 2014a).

Coordinated Primary and Behavioral Health Care Services

The United States healthcare system is struggling to meet the needs of the ageing population (Ehrlich, Kendall, Muenchberger, & Armstrong, 2009). It is important to find a solution such as coordinated care. Coordinating care requires the least amount of change at the practice/organizational level (Koyanagi, 2004) and includes case managers who are used to coordinate care for those with serious health issues. Often times a mental health agency is used for mental health consultations via telephone. An example of coordinated care is the Washington Medicaid Integration Partnership (WMIP). The

WMIP is a pilot that consisted of coordinated care for disabled Medicaid patients aged 21 years or older. This group of individuals was provided with treatment for medical, substance abuse, mental health, and long-term care services. Care coordination teams were headed by RN's with access to mental health consultations as well as mental health clinicians (Collins, Hewson, Munger, & Wade, 2010). With WMIP, there was a decrease in arrest, mortality, hospital admissions as well as a decrease growth in prescriptions filled for mental illness among those patients enrolled in the program. One implementation for consideration included the fact that mental health agencies defaulted to restrictive state/federal laws and applied it to all patients to protect themselves from liability, making information sharing difficult (Collins et al., 2010).

Co-location of Primary and Behavioral Health Care Services

SAMHSA has several programs that focus on the integration of primary care and mental health. The Primary and Behavioral Health Care Integration program (PBHCI) supports the delivery of coordinated and integrated care using co-location of primary and specialty care services in a community based mental health setting (SAMHSA, 2016). This process started when North Carolina pediatricians were facing barriers when serving children with mental illnesses. To address these issues, the North Carolina American Academy of Pediatrics (AAP) formed a task force to address their concerns with North Carolina's Medicaid program. This act led to the direct enrollment of independent mental health providers into Medicaid and up to 26 unmanaged mental health visits a year per child that was billable by a primary care provider (PCP) or a mental health professional. Medicaid changes provided more options for patients seeking the services of a mental

health provider as well as increased the collaboration between the primary care and mental health providers.

After these changes, North Carolina became interested in the co-location of primary care and mental health (Williams, Shore, & Foy, 2006). One private company hired a mental health provider to provide services to patients and nonpatients of the pediatric practice. Scheduling was done by the mental health provider and staff and an additional chart for those receiving mental health services were kept separate from the medical charts. These charts were stored by the mental health provider in a secured area. The services of a licensed psychological associate were included to provide psychoeducational assessments and psychotherapy (William et al., 2006). The integration of co-located practices for a private pediatric clinic increased access to mental health care in the community, enhanced communication between providers, decreased the need for referrals, decreased the use of general healthcare services, improved outcomes, reduced costs, and less stigma with seeking treatment for mental health issues (Bernal, 2003).

Integrating health care is an essential and tough process for organizations and healthcare professionals. Co-located services may include warm hand-offs and referrals. A cross case comparative study was done to show how organizations integrate care. One strategy mentioned was warm handoffs. Warm hand off was defined as bringing another healthcare professional into the visit to introduce them to the patient as transition care. This process was quite challenging. This study found the act of warm handoffs difficult due to lack of staff as well as the lack of a fulltime mental health provider on staff (Davis et al., 2013). With proper staff and adequate time, the act of a warm handoff can reduce barriers and increase compliance for those with mental disorders (Jones & Ku, 2015).

When there is no mental health provider onsite to see those individuals with mental disorders, a referral must be made.

Referrals from primary care to behavioral care is an important aspect of co-located integrated care but is poorly understood. Many factors play an important role in the referral process such as patient factors, provider factors, the patient-provider interaction, or characteristics of the healthcare system. It was reported that providers with greater confidence and knowledge about mental health were less likely to refer (Williams et al., 1999).

Integrated Primary Care and Behavioral Care Services

A Colorado project known as the Advancing Care Together (ACT) demonstration project was piloted from 2011 to 2015 with the goal of integrating behavioral and physical health and it challenges (Davis et al., 2013). For this project, participants included single specialty, multi-specialty, and mental health facilities that were characterized by ownership such as FQHC's, community mental health centers (CMHC's), and HMO's. Participants in this study used the ACT demonstration project as an opportunity to develop an organization for integrated care that would be financially stable beyond the funding period.

Researchers used a grounded theory approach where multiple sources of data were collected from each participating facility (Davis et al., 2013). It was discovered that ACT participants faced challenges such as workflow development, managing access to new providers, culture, data usage, and tracking. Results concluded that integration requires changes within interpersonal relationships and the organization. The participants in this project achieved integration of behavioral and primary care services by developing

partnership with local and regional organizations, by hiring new personnel, by expanding hours for behavioral health and primary care providers, creating schedules that included mini counseling sessions with additional time for hallway consultations and warm hand offs (Davis et al., 2013).

Delivery of Integrated Care

The Report of the President's New Freedom Commission on Mental Health acknowledged the necessity for improved coordination between mental and primary health care and called for the distribution of evidenced based models to enhance care at the integration of general medicine and mental health (New Freedom Commission on Mental Health, 2003). The integration of care in the United States was found to be successful in setting with the same healthcare system such as Veteran Administration, Department of Family Medicine, Health Maintenance Organizations (HMO's), the Air Force and other branches of the military (Walker & Collins, 2009).

McDevitt, Braun, Noyes, Snyder, and Marion (2005) researched integrated care. Their research view integrated care from a diagnosis, fulltime equivalent (FTE) of staff, ratios of visits, and visit complexity. The top ten mental disorders and primary care diagnoses seen in this integrated care setting are listed in the table below.

Table 1

Mental Disorders and Primary Care Diagnosis

Table 1. The top ten mental disorders and primary care diagnoses seen in integrated care settings.

Mental Disorders	Primary Care Diagnoses
Schizophrenia	Diabetes
Schizoaffective Disorder	Hypertension
Bipolar Disorder	Obesity
Substance Abuse	High risk/long term medication use

Table 1 (continued).

Depression	Hyperlipidemia
General Anxiety Disorder	Tobacco abuse
Psychosis	Adult general medical exam
Conduct Disorder	TB screening
Post-traumatic stress disorder	Dietary counseling
Obsessive-compulsive disorder	One or more immunization

Regarding financial indicators, funding was applied towards salaries, equipment, and financial stability to integrate care. Most of the patients were underinsured and the facility was only receiving 20% in reimbursement. Most Community Health Centers (CHC) and Federal Qualified Health Centers (FQHC) are the safety net facilities/providers. These providers offer access to care regardless of the patient's ability to pay and whose population consist of vulnerable patients, Medicare, Medicaid, and those without insurance. CHC's and FQHC's often receive up to 89% in reimbursements. Almost 20% of FTE's were Mental Health Clinicians and 80% were Primary Care Providers. The majority of the visits (80%) were primary care while 18% was for mental disorders. The overall goal was to sustain and expand performance of the integrated care facility to continue to provide needed services and optimum outcomes for those with severe and persistent mental disorders.

Fully Integrated Care

More states are leaning towards a fully integrated care approach with managed long-term services and support for the elderly. This approach is gaining momentum in support of individuals who are dually enrolled in Medicare and Medicaid programs. Those individuals who are enrolled in Medicaid and receive long-term care services and support are thought to benefit from fully integrated care programs. Reason given is that

these individuals are older, sicker, have a lower level of education with little to no social support, which complicates their ability to manage their care. A fully integrated health care approach for these individuals resulted in better care management and coordination (Burwell & Saucier, 2013).

Outcomes of Integrated Care

A wealth of evidence suggests the integration of behavioral and primary health care to deliver quality care with optimum health outcomes (Mims, 2006; Walker & Collins, 2009). Mims (2006) provided integrated care to low income patients in North Carolina. Over 2000 of those patients had mental disorders that improved because they received proper care for their mental issues during their primary care visit. Over an eight-month time frame, patients with depression showed an increase in access and level of functioning, an improvement in their depression, as well as a decrease in the amount of time missed from work and school.

Walker and Collins (2009) conducted a pilot study, which also concluded that integrating behavioral health into the primary care setting could be beneficial. The study showed an increase in referral to mental health specialists, increased financial gain, increased follow-ups, patient adherence to treatment regimen, and a decrease in missed appointments. From the literature reviewed, research shows favorable reviews/outcomes from the integration of mental health into the primary care setting with positive effects on quality of care, controlling costs, and improved health outcomes.

Statistics indicate that the United States ranked high on health care expenditures and low on factors such as access and quality of care. As healthcare cost continue to rise, financial strategies are being used to change the approach to health care. Integration of

healthcare services resulted in better care/management, improved parenting, patient experience, enhanced outcomes, increase in quality and access to care, enhanced confidence, and a reduction health care costs (Rosenbaum, Rozenman, Wiblin, & Zeltzer, 2015).

Reimbursement for Integrated Care

One major concern and cause of resistance with the integration of care is related to billing and coding. Meadows, Valleley, Haack, Thorson, and Evans (2011), conducted a study where they observed 228 patient visits in an integrated pediatrician clinic located in a rural area. The purpose of this study was to assess reimbursement, the amount of time spent between those patients with and without mental disorders, and to determine if pediatricians could treat their patients holistically in a cost-effective manner. It was found that medical visits lasted 8 minutes with a maximum of 10 billing codes submitted for claims while the behavioral health visits only lasted twice as long with one billable code. On a timed basis, the pediatricians were billed more for the 8-minute medical visit than the 20-minute behavioral health visit or an integrated care visit. Physicians at FQHC have reported time wasted and denied claim payments when trying to bill for integrated care services. Since then, SAMHSA-HRSA CIHS has compiled a billing worksheet for each state to help clinic managers, billing/coding staff, etc. at CHC's bill for services related to integration of behavioral and primary care services (SAMHSA-HRSA, 2014b).

Nurse Practitioners Delivering Integrated Care

The integration of behavioral health and primary care is important to improve the overall health of the population (Nardi, 2011) with the help of nurse practitioners. To integrate successfully, the facility needs to mold the integrated care project to fit the

needs of their population, have a strategic plan in place for financial, professional, and political support. The author also states that the integration of care would be more successful especially in rural areas if states would allow APRN's to practice without restrictions. The results of the study proved that NP's working in an integrated care setting provided higher and better quality of care than physicians. As initiatives are growing rapidly to integrate mental health with primary care, many facilities are exploring the role of the nurse practitioner (McIntosh, Startsman, & Perraud, 2016). Advanced practice nurses, especially those trained in psychiatric mental health are expected to be the driving force in the development of the integrated care role. Advanced practice nurses who are PMHNP have the agility to screen and assess for mental conditions, increase access to care, as well as improve the quality of integrated care (McIntosh et al., 2016).

Nurse practitioners who are certified as a PMHNP and FNP with a practice doctorate, DNP, are prepared as clinical and organizational leaders to address the need to deliver integrated care to individuals with physical and mental disorders. A report by the Institute of Medicine calls for the collaboration between primary care NP's and public health workers in order to improve the overall health of the population (Institute of Medicine, 2012). DNP prepared NP's have the leadership skills needed to take charge in the act of integrating health care and improving the health of the population they serve (Swartwout, 2016).

Models of Integrated Care

Even though there are various models to help with the integration of care, no one model guarantees success. One integrated care model is known as the eReferral model.

This innovation is responsible for integrating primary and specialty care (Chen, Murphy, Phil, & Yee, 2013). This model is popular for using health information technology to connect specialist like those in mental health with primary care providers, improve information exchange, as well as increase access to care and utilization of resources (Chen et al., 2013). Additional integrated care models are available to help with the integration of care such as the IMPACT Model, the Four Quadrant Model, Chronic Care Model, and the IPAT (SAMHSA-HRSA, 2014a). A more recognized model is the SAMHSA-HRSA CIHS six levels of collaboration/integration (Heath et al., 2013).

The IPAT is a tool that uses a decision tree model to measure a facility level of integration (Doherty et al., 1996). A decision tree model is used to accurately mirror the six levels of collaboration/integration (Heath et al., 2013) tables to avoid the need for weighted responses to the decision tree questions to prevent an in-between assessment score (e.g., 1.75 coordinated). The decision tree model uses a yes or no question format that chutes to a specific level of integrated care determination (Waxmonsky et al., 2013). The IPAT model and A Standard Framework for Levels of Integrated Health care is the framework that is more applicable for this DNP project (Health et al., 2013; Waxmonsky et al., 2013).

The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) Standard Framework for Levels of Integrated Health care has five levels of integration to help health care organizations assess their current level integration and implement strategies to improve their integration efforts. Key differentiators at each level are clinical delivery, patient experience, practice/organization, and business model (Heath et al., 2013). Once the level of integration is determined using the IPAT, changes will be made for the

practice/organization based on whether the organization is at the coordinated, co-located, or integrated level of collaboration/integration.

Framework

The Standard Framework for Levels of Integrated Health care advances health care reform due to its ability to support political and service realisms (Berwick, Nolan, & Whittington, 2008). Since the original framework was released in 1996, several researchers have used parts of the framework in an attempt to resolve issues related to the integration of health care. Berwick et al (2008), stated the integration of health care is important to improve the patient's overall health care experience, improve the overall health of the population, as well as reducing health care cost. Doherty et al., (1996) original work produced in 1996 consisted of five levels of collaboration that paid special attention to collaboration type and implementation. The five-level differed by the case and patients seen at each level as well as the site of care. Doherty et al., five levels of collaboration are listed below:

- Level 1: Minimal Collaboration – Mental health and primary care providers work in different locations, have separate systems, and seldom ever follow or communicate about cases.
- Level 2: Basic Collaboration at a Distance – The mental health and the primary care providers have separate systems at different locations, but they agree to communicate periodically about the patients they share or refer via telephone and written communication. These providers review each other as resources for one another.

- Level 3: Basic Collaboration Onsite - The mental health and primary care provider have separate systems/organizations, but they share the same facility. The locations of the vicinities allow face-to-face meetings and improvement in communication.
- Level 4: Close Collaboration in a Partly Integrated System – The mental health and the primary care providers are located at the same site and share commonalities in systems such as charting and scheduling. During this level of collaboration, treatment plans are assigned for difficult patients, culturally sensitive face-to-face visits with the two providers are scheduled on a regular basis, and there is a basic understanding of each provider's role.
- Level 5: Close Collaboration in a Fully Integrated System – Mental health and primary care providers share common goals, visions, sites, and systems. Everyone is on the same page. All providers are on the same interdisciplinary team and have a profound understanding of everyone's role and area of expertise.

After the proposed work by Doherty et al., SAMHSA-HRSA CIHS proposed an updated version of the original levels of collaboration. Their framework merged new evidence that has surfaced since the original framework in 1996. The updated framework included multiple developments like giving facilities freedom to measure their level of collaboration and by creating a solid platform for the comparison between health care results and the level of integration. The updated framework is all-inclusive which makes it capable of serving as a nationwide standard for future conversations about the integration of health care. The updated framework includes, from the original work, the idea that the levels of integrations continued from a level of collaboration to full integration. The updated framework also included Blount's use of the terms

"coordination, co-location, and integration" as the main categories. The Milbank report (Gerrity, 2016) on behavioral health integration merged Blount's (2003) three main levels of coordination in conjunction with Doherty et al., five levels of integration to form a framework that can help facilities and organizations nationwide to assess and implement their current level integration and what can be done to improve their integration efforts. A description of each revised category is listed below:

Coordinated Care

Level 1: Minimal Collaboration – The two providers communicate on an as needed basis for specific information about the patient. The four key differentiations for this level of care include:

- Clinical delivery: Screening and assessments are completed using separate practice models and treatment plans with evidenced based practices implemented separately.
- Patient experience: The patients mental and physical needs are treated separately leaving the patient to find treatment for the other issues on their own.
- Practice/Organization: There is no management of integrated efforts with little buy-in from the provider.
- Business Model: At this point, there is separate funding and billing practices without the sharing of resources.

Level 2: Basic Collaboration at a Distance – The reasons for communication often differ at this stage. For example, the primary care provider may request a copy of the patient's chart to see if a psychiatric diagnosis was rendered. The four key differentiations for this level of care include:

- Clinical delivery: Screenings are based on separate practices, formal requests are made for information, and treatment plans are shared based on the established relationship amongst specific providers, separate responsibility for patient care.
- Patient experience: The patient's health needs are treated separately but their health records are shared to promote better provider knowledge. The patient may be referred but care is prevented due to several barriers such as access to services.
- Practice/Organization: There is more systematic information sharing with some provider buy-into collaboration with the value placed on having the information needed.
- Business Model: There is separate funding; facilities may share resources for a single project with separate billing practices.

Communication is the most important factor with the first two levels. A positive and open line of communication builds a bond between the providers and the facilities, which can create a strong and lasting relationship and a move in the right direction for integrating care.

Co-located Care

Level 3: Basic Collaboration Onsite - Being near each other increases the frequency of communication via phone or email with scheduled meetings to discuss patients who are receiving integrated care. The four key differentiations for this level of care include:

- Clinical delivery: Separate service plans with some shared information and knowledge on each other's evidenced based practices.

- Patient experience: Patient health needs are treated separately but within the same location which allows referral to be more successful and easier for the patients.
- Practice/Organization: Colocation is viewed as a project with provider buy-in to making referrals works with an appreciation of onsite availability.
- Business Model: The facility may share expenses in addition to separate funding and billing practices.

Level 4: Close Collaboration with Some System Integration – At this level of integration, there is a close collaboration amongst the providers. This level includes the behavior health provider being inserted into the primary care setting. All appointments are made by the primary care clerk while the behavioral health providers have access to all medical records. The four key differentiations for this level of care include:

- Clinical delivery: Agreeance on specific screening based on the ability to respond to the results, integrative treatment planning is done for specific patients with some shared training focused on the needs of the population of interest.
- Patient experience: Patients needs are treated separately at the same location with the use of warm hand offs to other treatment providers. Patients are referred internally with better follow up, but the level of collaboration may seem like separate services.
- Practice/Organization: The leaders support integration through mutual problem solving of system barriers, but all providers are not using opportunities for integration or its components.
- Business Model: Separate funding but may share grants, office expenses, staff costs, but there is separate billing due to system barriers.

A close physical location is the key to levels 3 and 4. Even though a close location reduces traveling time, it does not always render an increase in integration; this level of integration can be beneficial for the patient. Advantages of having a co-location include an increase in face to face visits and the opportunity to build rapport. This level marks the beginning of integration.

Integrated Care

Level 5: Close Collaboration Approaching an Integrated Practice – Mental health and primary care providers share common goals, visions, sites, and systems. Everyone is on the same page. All providers are on the same interdisciplinary team and have a profound understanding of everyone's role and area of expertise. The four key differentiations for this level of care include:

- Clinical delivery: Screenings are consistent, integrative treatment planning is shared available for all shared patients with some joint monitoring of health conditions for some patients.
- Patient experience: Patient needs are treated as a team for those who screened positive with screening measures. Care feels like a one stop and shop.
- Practice/Organization: Almost all providers are engaged in integrated model. Buy in, may not include change on practice strategy for individual providers.
- Business Model: Blended funding based on contracts or grants with a variety of WATS to structure the sharing of expenses.

Level 6: Full Collaboration in a Transformed/Merged Practice – Level six is the highest level of collaboration. This level of integration requires a practice change that can merge the two practices in a seamless manner so that one discipline does not out shadow

the other. At level six, the health care physicians and the patients view health care as a solo entity that treats patients holistically. This approach is applied to all patients not just those with mental health issues. The four key differentiations for this level of care include:

- Clinical delivery: Population based behavioral and medical health screening is standard practice with results available to all with response protocols in place, there is one treatment plan for all patients, evidenced based practices are implemented across disciplines as standard practice.
- Patient experience: All the patient's health care needs are treated effectively, and the patients experience a seamless level of care in a unified practice.
- Practice/Organization: Leaders strongly support integration as a practice model with expected change in service delivery with all components of integrated care embraced by all providers.
- Business Model: There is integrated funding based on multiple sources of revenue, resources are shared and allocated across the entire practice, billing is maximized for integrated model and single billing structure.

Implementing a practice change is the most important factor at levels five and six. At this level, all stakeholders are on board and agree that the integrated approach is the right direction to achieve the triple aim goals. The Integrated Practice Assessment Tool (IPAT) will be utilized to assess the level of integration in the primary care setting. After completing the assessment, practice management strategies will be implemented based on the current level of integration using the CIHS framework at the practice/organization level (Heath et al. 2013).

DNP Essentials

The DNP essentials outline foundational competencies fundamental to advanced nursing practice roles. These essentials include a scientific underpinnings for practice, organizational and systems leadership for quality improvement and systems thinking, clinical scholarship and analytical methods for evidence-based practice, information systems/technology and patient care technology for the improvement and transformation of health care, healthcare policy for advocacy in health care, interprofessional collaboration for improving patient and population outcomes, clinical prevention and population health for improving the nation's health, and advanced nursing practice (American Association of Colleges of Nursing [AACN], 2006). Refer to Appendix B for a more detailed description of the DNP essentials and competencies met for this DNP project.

Evaluation Plan

An evaluation plan serves as a channel between planning and evaluation by outlining project objectives and highlighting goals with a specific outcome in mind. The evaluation plan for this DNP project will determine progress made towards integrating behavioral health in the primary care setting. Evaluation activities include: engaging the staff at the primary care clinic, reviewing the IPAT with staff, discussing the results of the IPAT with staff, improving access to behavioral care, and discussing project results with staff.

Purpose

Over looked mental disorders in the primary care setting makes the integration of health care imperative. The main purpose of the project is to utilize the Integrated

Practice Assessment Tool (Waxmonsky et al., 2013) in the primary care setting to assess the current level of integration/collaboration. The next purpose of the project is to implement practice management strategies to integrate behavioral health in a primary care setting. The integration of health care services can be beneficial to patients and the economy.

Summary

The integration of health care services is a solution to many problems in a broken health care system. Integrated care improves access to services for those with co-morbid physical and mental disorders. The integrated care model can be used to decrease cost, improve quality of care, and increase accessibility to healthcare (Kaiser Family Foundation, 2013).

CHAPTER II – METHODOLOGY

Setting

The Doctor of Nursing Practice (DNP) project was conducted at a local community health center located in a southeastern state. The community health center is a United States (U.S.) Health Resources and Service Administration (HRSA) designated Federally Qualified Health Center (FQHC) located in an urban city. The FQHC is one of 20 community health centers in the county and provides low cost medical services to an underserved population.

Population

The population identified consists of physicians, family nurse practitioners, and staff members including licensed clinical social worker (LCSW), licensed practical nurses (LPN), medical assistants (MA), and medical billing/coders. These individuals are the stakeholders, will be a part of the integrated care team, and will be responsible for completing the Integrated Practice Assessment Tool (IPAT). The LCSW will be the main point of contact for identifying staff members to serve on the integrated care team when moving towards an integrated care approach. Inclusion criteria are physicians, nurse practitioners, and those staff members identified by the LCSW who are interested in integrated care, knowledgeable about mental health and diagnoses codes including LCSWs, LPNs, MAs, and medical billing/coders. Exclusion criteria are those staff members who are not interested in integrated care and do not have direct contact with patients.

Procedures

A letter of support from the Chief Executive Officer at the FQHC and approval from The University of Southern Mississippi (USM) Institutional Review Board (IRB) was obtained prior to beginning the project (Appendix C). The processes and detailed explanation of each step in the project is listed below.

Step 1: Engage Staff

A meeting with the physicians, nurse practitioners, and other members of the integrated care team was scheduled to share the vision along with the purpose of the project. A fact sheet on integrated care was provided and the importance of integrated care was discussed. The physicians, nurse practitioners, and staff members of the integrated care team were informed of the DNP project and informed consent was obtained to participate in the project.

Step 2: Review Screening Tool

During the monthly provider meeting with the physicians and the nurse practitioners, the IPAT was introduced and the physicians and nurse practitioners, who were in attendance, completed the IPAT. The LCSW recruited staff members (LCSWs, LPNs, MAs, medical billing/coders, and medical clerk) who met inclusion criteria to serve on the integrated care team. The integrated care team staff members completed the IPAT during individual meetings with the Project Director.

The Integrated Practice Assessment Tool (IPAT)

The Integrated Practice Assessment Tool (IPAT) that was updated by SAMHSA-HRSA (2013). A decision tree model was used to accurately mirror A Standard Framework for Levels of Integrated Health care issue brief tables to avoid the need for

weighted responses to the decision tree questions to prevent an in-between assessment score (e.g., 1.75 coordinated). The decision tree model uses a yes or no question format that cascades to a specific level of integrated care determination (SAMHSA-HRSA, 2013).

The IPAT was created to measure a facility level of integration as outline by A Standard Framework for Levels of Integrated Health care issue brief. The levels of integration are 1) minimal collaboration, 2) basic collaboration at a distance, 3) basic collaboration onsite, 4) close collaboration onsite with some system integration, 5) close collaboration approaching an integrated practice, and 6) full collaboration in a transformed merged integrated practice. Management strategies will be implemented based on the level of collaboration/integration with interventions targeted at the practice/organization key differentiator (Heath, et al., 2013).

Step 3: Discussion

After completion of the IPAT, the physicians, nurse practitioners, and integrated care team members were notified of their current level of integration, current key differentiators at the practice/organizational level, as well as strategies for implementation as defined by A Standard Framework for Levels of Integrated Health care issue brief. The goal was to increase the facilities level of collaboration by one level.

Step 4: Improve Access to Care

Based on the FQHCs current level of integration, moving forward with integration efforts at level 1 or 2, coordinated, is improved communication. Interventions at level 3 or Level 4, co-location, is the beginning of integration and may include developing a network of referrals for the catchment area, or collaboration with a local behavioral

health clinic to identify psychiatric and mental health providers to the primary care clinic to see patients diagnosed with a mental disorder. Interventions were targeted for the key differentiator and practice/organization, depending on the level of collaboration/integration identified on the IPAT. The integrated care team was provided with implementation/strategies to increase level of collaboration.

Step 5: Evaluation

The main intent of the project is to utilize the Integrated Practice Assessment Tool (Waxmonsky et al., 2013) for the desirable outcome. The project outcome was to increase the FQHC's current level of integration/collaboration through the implementation and strategies at the practice/organization level based on A Standard Framework for Levels of Integrated Health care issue brief (Heath, et al., 2013). Evaluation will be discussed in Chapter III, Results.

Ethical Protection of Human Subjects

The DNP project involved human subjects for research such as the physicians, nurse practitioners, and other members of the integrated care team who completed the IPAT. After obtaining IRB approval, staff members who provided consent to participate in the project completed the Integrated Practice Assessment Tool (IPAT) to get their opinion on the level of integration for their facility. Prior to obtaining consent, participants were informed that there were minimal risks to participating in the project, no identifying information will be asked, all information will remain confidential, and data will not be associated with individual participants. Participants were informed of the direct benefits from participating in the project, to assist the organization in determining the current level of integration and participating as a member of the integration team to

develop practice management strategies to move forward with integrating behavioral care in a primary care setting. Participation was voluntary, and participants could withdraw from the project at any time without penalty. The IPAT was collected from the integrated care team members who completed the tool. The consent forms were placed in a locked box by the project director to ensure confidentiality. Electronic data was stored on a password protected computer. The consent form, IPAT, and other data collected are accessible to the project director, only.

Data Analysis

The integrated care team completed the IPAT tool to obtain information about the facility's level of integration. The IPAT was created to measure a facility level of integration (Waxmonsky et al., 2013). The printable IPAT consists of a decision tree model that is in a yes or no format. This method is used to render accurate responses to prevent the need to measure the responses given; as well as to avoid an in between assessment score. After the IPAT was completed by the integrated care team, the IPAT scores were added and divided by the number of IPAT tools completed. Practice management strategies on improving access to care were evaluated using non-experimental descriptive statistics.

Summary

After a detailed explanation of the IPAT was rendered, a total of 14 participants volunteered to complete the IPAT. The IPAT tools were stored in a secure area by the LCSW after completion. The results will be discussed in Chapter III.

CHAPTER III – RESULTS

The purpose of the DNP project was to utilize the Integrated Practice Assessment Tool (IPAT) in the primary care setting to assess the current level of integration/collaboration and implement practice management strategies to integrate behavioral health in a primary care setting. The IPAT scores revealed that the FQHC is operating at a level 2, basic collaboration at a distance where mental health and primary care physicians are in separate facilities and have separate systems. The goal of the project was to increase the FQHC's level of operation by one level. Practice management strategies were implemented when transitioning from level 2, basic collaboration at a distance, to level 3, basic collaboration onsite. Key differentiators for the practice/organization at level 2 begins with select practice leadership in more efficient information sharing and provider buy in to integration and importance placed on having needed information. As the organization transitions to level 3, the organizational leaders are supportive but view basic collaboration on site as a project or program of system barriers and more buy in from providers on referrals and onsite collaboration (Heath et al., 2013).

The discussion of the DNP project methods focuses on the evaluation of the action plan to increase the level of collaboration/integration at the FQHC. The evaluation is based on the results of the IPAT in addition to the action plan with strategies to integrate behavioral health in the primary care setting. The stakeholders (administrators, physicians, and NP's), staff, and the integrated health care team were involved throughout the project in implementing the action plan.

Objective 1 Engage Staff

Needs Assessment

The first objective was to engage the primary care clinic staff. To accomplish this task, a need assessment was conducted to see which step during the patient and staff interaction could be improved. During this action step, the initial contact with the patient and medical staff was observed. After the patient completes registration with the medical clerk, he/she id then triaged where vital signs are taken by the LPN. Afterwards, the patient is taken to an exam room where he/she is examined by the provider. Once the examination is complete, the patient is given a follow-up appointment (if applicable) and exits the clinic. In conducting the needs assessment, it was determined that staff members were not communicating internally, lacked consistency when screening for mental disorders, lacked a clear understanding of each other's roles, and not utilizing the services of the LCSW during each patient visit.

Share the Vision: Integrated Care

After completion of the needs assessment, a meeting was held with the stakeholders, staff, as well as members of the integrated care team on an individual basis according to their work schedule and availability. The purpose of this meeting was to discuss the findings from the needs assessment, share the vision for the DNP project, to address the importance of integrated care, and provide them with a fact sheet on integrated care.

Objective 2 Reviewing Screening Tool

Introduction and completion of IPAT

The second objective was to review the IPAT screening tool. During this action step, the IPAT was introduced to key stakeholders in attendance at the monthly provider's meeting to determine the primary care clinics level of integration. The IPAT was completed by the medical providers (nurse practitioners and physicians), staff, and other members of the integrated healthcare team including the LCSW, MA's, medical billing, and coders. Over the next several weeks, each of the clinics locations were visited to meet with members of the integrated care team identified by the LCSW and those who voiced an interest in the integration of care.

Objective 3 Discussion

Review Results of IPAT

The third objective was to calculate the IPAT and notify key stakeholders, staff, and the integrated care team of the results of the IPAT. During this action step, all the completed IPATs were collected and the mean score of the IPAT was calculated. The results from the IPAT revealed that the FQHC was operating at a level 2 of integration or, basic collaboration at a distance.

Levels of Integrated Care Fact Sheet and Next Steps

The stakeholders, at a provider's meeting and individual integrated care team members were given a fact sheet on the levels of integrated care and informed that level 2 is defined as a basic collaboration at a distance. At this level of collaboration, improvement strategies based on the practice/organization level and in clinical delivery in addition to a detailed explanation of level 2 was provided to include:

- Screenings are based on separate practices
- Information is shared only when requested
- Treatment plans are done separately
- Each provider takes responsibility for the patient's care
- There is some practice leadership in information sharing
- Some provider buy into collaboration and value placed on having needed information

The next step involves informing the stakeholders and staff of their current level of integration. After notification of their current level, strategies were provided regarding steps to improve at this level. Afterwards, a detailed explanation about the FQHC's current level of collaboration/integration and answering questions, the stakeholders, staff, and integrated care team were informed of the next steps of the implementation process to improve access to care.

Objective 4 Improve Access to Care.

The next action step in the project involves informing the stakeholders, staff, as well as the integrated care team of ways to improve the current level of collaboration as well as the steps to becoming a level 3:

- Improve Communication
- Increase mental health screening by consistently performing the Patient Health Questionnaire-2 (PHQ-2) and the Patient Health Questionnaire-9 (PHQ-9) screens for depression (Kroenke, Spitzer, & Williams 2003, 2001).
- Improve communication within the facility
- Define and know staff members roles and limitations
- Utilize the services of the LCSW

- Develop a Network of Referrals
- Referrals
- Getting providers to buy into making referrals work
- Appreciation of available services onsite such as those of the LCSW
- Create a referral form for the organization
- Warm handoff Referral
- Introduce the possibility of warm handoffs / referrals
- Expand Collaboration with Local Behavioral Health Facility

Objective 5 Evaluation

Results and Next Steps

During the final stage of the project, follow-up was done with stakeholders and the integrated care team to evaluate changes in processes of care. The organization made the following improvements:

- Increased mental health screening: Screening for depression has been implemented. LPN's are administering the PHQ-2 or the PHQ-9 screening for depression upon the patient's arrival to the clinic.
- Improved communication within the FQHC: Improvements have been made by the stakeholders offering explanations and information about what is expected of their employees, what changes are required, upcoming projects, as well as the purpose of the proposed change(s) to gain more cooperation within the organization.

- Define and know staff roles and limitations: Changes were implemented by informing staff members via email and through staff meetings about the role of the LCSW and services provided in the LCSW role, and reimbursable LCSW services.
- Utilize the services of the LCSW: Improvements have been made by increased screenings for depression and increased in house referrals to the LCSW. The only barrier to this action step is the ability of the LPN's to consistently perform mental health screenings and refer positive results to the physicians, nurse practitioners, and LCSW.
- Getting providers to buy into making referrals work and appreciation of onsite resources. Staff increased referrals to the in-house se availability of the LCSW, increasing identification and referrals of patients with mental disorders.
- Create a referral form for the organization. The implementation step was completed when the LCSW created a simple referral form when referring patients to outside behavioral health services. External warm hand offs with outside mental health providers/facilities was not established during this time. A potential solution for the external handoffs should include hiring a part-time assistant, social worker, or community outreach worker to assist the LCSW with external warm hand offs/referrals.
- Introduce the possibility of warm handoffs / referrals: Warm hand offs are now being performed in house between the LPN and LCSW. Upon receiving a positive screening on the PHQ-2 or PHQ-9, the LPN starts the process of an internal warm handoff by walking the patient to the office of the LCSW. At this time, the LPN will

introduce the patient to the LCSW with a short description about the reason for the visit with the LCSW.

- Expand collaboration with a local behavioral health facility: The primary care clinic is in the process of expanding collaboration with a local behavioral health facility that an established memorandum of understanding exists. The next steps are meeting to discuss sending a PMHNP provider to the primary care clinic to provide services for patients with mental disorders.

After the components of level 3 were implemented and successfully completed, the stakeholders were informed on what steps are needed to achieve a level 4 of integration/collaboration. These steps included agreeing on specific screening based on the ability to respond to the results, plan patient treatments collaboratively, meet face to face about shared patients, and shared training that is focused on the needs of the population. At a level 4, there is a need for more buy in to the concept of integration, and more opportunities for integration, as organizational leaders support the process through mutual problem solving of organizational barriers (Heath et al., 2013).

Summary

Integrating health care is an important and difficult process for organizations and healthcare professionals. To progress towards becoming a fully integrated facility in the near future, the FQHC must successfully implement strategies at the coordinated, co-located, and fully integrated levels of care. At the fully integrated level of care, the main focus is on collaborating with local and regional behavioral health organizations to provide continuous care for those individuals presenting with mental disorders in the primary care setting (Davis et al., 2013).

CHAPTER IV – DISCUSSION

The DNP project aim was to: a) assess current level of integration/collaboration in a primary care setting by administering an assessment tool to providers and staff and b) implement strategies with providers and staff input to integrate behavioral health care in a primary care setting. The Integrated Practice Assessment Tool (IPAT) (Waxmonsky et al., 2013) in the primary care setting was used to assess the primary care setting current level of integration/collaboration to improve practice management strategies for the integration of behavioral health into the primary care setting. Once the level of integration was determined using the IPAT, changes were made at the practice/organization key differentiator based on whether the organization was at the coordinated, co-located, or integrated category and level of collaboration/integration (Heath et al., 2013).

Limitations

Limitations noted for this project include administration of the IPAT, a small sample size, and stigma related to mental health. The original plan was to administer the IPAT as a group to the medical providers who attended the monthly providers meeting. None of the physicians and FNPs attended every meeting, which led to several IPATs completed on an individual basis. The administrators were interested in integrating behavioral health into the primary care setting, but administrators did not complete the IPAT. The primary care clinic employs a total of 12 medical providers and 20 staff members. Only 14 of the 32 employers were interested in integrated care and participated in the project by completing the IPAT. The staff and providers identified as the integrated practice team for this project were interested in integrated care. Although communication

regarding integrated care and the project was not shared with providers and staff, the Project Director informed all potential participants about the project, the IPAT, and integrated care. Some providers and staff chose not to participate in the project and 2 providers and 1 staff resigned which resulted in a small sample size. However, size was not an important factor for this DNP project and did not skew the results or the direction of the project.

Even though the IPAT was easy to administer, some staff members found the questions difficult to answer because they did not fully understand the roles of members of the health care team; thereby, identifying the need for improved communication. An unexpected barrier in completing the project was identifying that some providers and staff were not interested in integrating behavioral health care in the primary care setting. This barrier was due to the stigma attached to mental disorders causing resistance from providers and staff. The lack of education and training on mental disorders and behavioral healthcare services as well as the other limitations noted had an impact on implementation of the project but did not affect the outcome.

Implications

Implications for future practice

Implications for future practice are to increase the primary care setting level of integration/collaboration and implement practice management strategies based on the level of collaboration/integration. Another practice implication is increase provider, staff, and administrators' knowledge on administration and scoring the IPAT to integrate behavioral health into the primary care setting. Strategies will take into consideration the key differentiators: practice/organization, clinical delivery, patient experience, and

business model. These strategies include improving administration of the PHQ-2 or PHQ-9 by paper or electronic health record (EHR), creating a workflow design for warm handoffs after administration of the PHQ-2 or the PHQ-9, and expanding collaboration with community based mental health centers. Implementing these strategies will be important in increasing early screening and treatment for individuals with mental disorders. As more integration efforts are implemented into the primary care setting, the risk of overlooking mental disorders should decrease as screenings and treatment increase.

Implications for nursing

Like most primary care settings, the primary care setting where this DNP project was conducted does not have a mental health provider, either a psychiatrist and/or a psychiatric and mental health nurse practitioner (PMHNP). Dual certified nurse practitioners who are certified as a FNP and PMHNP can function in the primary care setting to screen, detect, and treat those individuals with mental disorders while filling the shortage of mental health providers. Since most primary care settings are safety net health care facilities, the dual certified FNP and PMHNP would fulfill the need of individuals with co-morbid physical and mental disorders. A study was conducted to view integrated care from a diagnosis, full-time equivalent (FTE) of staff, ratios of visits, and visit complexity (McDevitt et al., 2005). In the study, it was determined that 20% FTE for mental health providers were needed based on FTE staff and ratio of primary care visits and visits for mental disorders. Similarly, at the primary care setting where this project was conducted, the majority of the visits (82%) were primary care while 18% of the visits were for mental disorders. The ratio of visits and the number of mental health providers

based on the FTE for primary care providers should consider the role of the dual certified FNP and PMHNP as a primary care and mental health provider.

Recommendations for future research

Further evaluation of utilizing the IPAT tool and implementing strategies at the business model key differentiator regarding billing codes and billing for integrated care services. Strategies at the key differentiators, clinical delivery and patient experience, would not only screen for depression but also identify the needs of children and adults with more severe mental illness. More research is needed on the processes, benefits, outcomes, challenges, and sustainability of integrating behavioral health into a single, diverse primary care setting. Studies exist on integrated care in large health systems (Walker & Collins, 2009).

Summary of Major Findings and Interpretation of Results

Level of Integration/Collaboration

To determine the level of integration/collaboration, 14 providers and staff completed the assessment tool. The IPAT met the purpose for the project. Each question yes or no response chutes to a category determination of coordinated, co-located, and integrated. Additional responses mirror the six levels of collaboration/integration (Heath et al., 2013). The results of the integration/collaboration assessment tool revealed that the primary care clinic was operating at level 2, basic collaboration at a distance. The tool was successful at measuring the facilities current level of integration/collaboration at a level 2. At level 2, the primary care clinic has separate systems, screenings are based on separate practices with separate treatment plans, with little provider buy-into the integration of behavioral health in the primary care setting. To increase the primary care

setting current level of collaboration/integration, several practice management strategies had to take place at the organizational and clinical delivery key differentiator (Heath et al., 2013).

Practice Management Strategies

Practice management strategies were implemented with providers and staff input to integrate behavioral health care in a primary care setting at level 2, basic collaboration at a distance and level 3, basic collaboration onsite. Practice management strategies enhanced the level of communication and increased the level of integration to basic collaboration onsite. Strategies implemented at the practice/organization key differentiator to improve access to behavioral health care were developing a referral form, developing a network of behavioral health referrals, improving care coordination and communication between local primary care and behavioral healthcare providers, and expanding collaboration with a behavioral health clinic. Strategies implemented at the clinical delivery key differentiator included increasing screenings for mental disorders by administering the PHQ-2/PHQ-9, improving care coordination and communication within the organization, increasing onsite availability with the LCSW, and increasing internal referrals via warm handoffs.

The coordinated category of collaboration/integration focuses on communication that consist of Level 1, Minimal Collaboration, and Level 2, Basic Collaboration at a Distance. The coordinated category of integration requires the least amount of change at the practice/organization key differentiator (Koyanagi, 2014). In previous studies, case managers coordinated care for individuals with serious health issues. RNs headed care coordination teams, with access to mental health consultants and clinicians, and

telephone consultations with mental health consultants (Collins et al., 2010: Koyanagi, 2004).

The co-located category of collaboration/integration focuses on the location of services and consist of Level 3, Basic Collaboration on Site, and Level 4, Close Collaboration Onsite with Some System Integration. Williams et al., (2016) conducted a study at the co-located level of integration. Mental health providers and staff scheduled appointments. Charts for individuals receiving mental health services were kept separate from the medical charts and stored in a secured area. Services provided by the licensed mental health provider were assessments and psychotherapy (William et al., 2006). Integration at the co-located category in a private pediatric clinic increased access to mental health care in the community, enhanced communication between providers, and improved outcomes. There was also decreased need for referrals, use of general health care services, stigma with seeking treatment for mental health issues, and costs (Bernal, 2003). Strategies at the co-located category include warm hand offs and referrals. Davis et al., (2013) reported that warm hand-offs are difficult due to lack of staff and a full-time mental health provider.

Conclusions

Integrating behavioral health care in primary care settings has shown to be beneficial in improving patient's outcomes, increasing access to health care, and decreasing health care costs. Findings from the project determined that the assessment tool was effective in improving practice management strategies to integrate behavioral health care in a primary care setting. The assessment tool was successful in measuring the primary care setting current level of integration/collaboration. Practice management

strategies enhanced the level of communication, increased the level of integration, and improved access to behavioral health care.

APPENDIX A – Literature Review Table

Table A1. *Literature Review Table*

Citation / Year	Design	Framework	Sample	Findings/Significance
Bernal, 2003	Systematic review	NA	NA	The integration of co-located practices for this private pediatric clinic increased access to mental health care in the community, enhanced communication between providers, decreased the need for referrals, decreased the use of general health care services, improved outcomes, reduced costs, and less stigma with seeking treatment for mental health issues
Chen et al., 2013	Systematic review	NA	NA	Decreased wait times, Increased efforts to improve coordination and co-management between primary care and specialty services
Collins et al., 2010	Systematic review	NA	NA	Eight models described several ways to integrate health care providing a variety of services that ranged from minimal collaboration to full collaboration of care.
Davis et al., 2013	Systematic review	NA	NA	Warm handoffs were difficult due to lack of staff as well as the lack of a fulltime

				mental health provider on staff
Doherty et al., 1996	Systematic review	A Standard Framework for Levels of Integrated Health care issue brief	NA	The hierarchy of the five levels assumes that the greater the level of systemic collaboration.
Everett, A. S., Reese, J., Coughlin, J., Finan, P., Smith, M., Fingerhood, M., & ... Lyketsos, C., 2014	Systematic review	J-CHIP B design framework	NA	Lack of psychiatric care was due to barriers such as lack of availability, lack of effective referral process, and stigma of being seen at a mental health facility.
Heath et al., 2013	Systematic review	NA	NA	Integrated care improves access to care for individuals with co-morbid physical and mental disorders. In order to integrate behavioral care in a primary care setting, a recognized solution is to utilize the Integrated Practice Assessment Tool in the primary care setting to assess the level of collaboration/integration and to improve practice management strategies.
Huang, H., Meller, W., Kathol, R. G., & Kishi, Y., 2014.	Systematic review	NA	NA	Increased health care spending is due to untreated mental disorder. More than 440 billion dollars was spent on mental health.

				Integrating care can decrease the overall cost of health care spending and improve the health of the population.
Jones, E., 2015	Noncom-parative Descriptive analysis	56-item Assessment of Behavioral Health Services in Federally Qualified Health Centers survey	NA	Integrated care at FQHC's in addition with warm handoffs and appropriate follow ups can decrease barriers, reduce stigma for those with mental disorders.
McDevitt, Braun, Noyes, Snyder, & Marion, 2005	Noncom-parative, descriptive	NA	NA	Almost 20% of FTE's and about 80% FNP's worked in an integrated care setting that could expand access to care with the help of government funding.
McIntosh et al., 2017	Three systematic reviews	NA	NA	Strategies of integration ranged from activities such as care management, depression medication management, and access to care.
Meadows, Valleley, Haack, Thorson, & Evans, 2011	Cross-sectional study; quantitative	"basic on-site" collaboration continuum	228 pediatric patients encounter in a rural pediatric primary care facility	One-way ANOVA disclosed the comparison between medical, behavioral, and blended visits (M=$118.92, SD =97.02); behavioral visit (M=$78.74, SD =35.82); blended visit (M=$96.08, SD =65.88).

				Reimbursement dollars a minute: medical minute (M=$18.00, SD =$18.02); behavioral minute (M=$4.36, SD =$1.97); blended minute (M=$5.86, SD =$2.93). Conclusion: pediatricians lost money by treating behavioral and medical issues
Mims (2006)	Noncom-parative, descriptive study	NA	2,177	Integrating primary and behavioral health showed improvement in depression, follow up rates, and days missed from work/school.
Nardi (2011)	Noncom-parative, descriptive study	NA	7,200 patients over a 5-year period	Due to the shortage of mental health providers some states have a 3-month waiting list for mental health services; NP's provided integrated care but did not receive full reimbursement rates because APRN's are not recognized as providers of care by certain insurance companies; Many individuals with severe and critical mental disorder did not receive care due to restrictive practice

				and collaboration laws in conjunction with a shortage of collaborating psychiatrists.
SAMHSA, 2016	Systematic review	NA	NA	Improved access to primary care services; Improved prevention, early identification, and intervention to reduce the incidence of serious physical illnesses, including chronic disease; Increased availability of integrated, holistic care for physical and behavioral disorders; and Improved overall health status of patients.
SAMHSA-HRSA Center for Integrated Health Solutions, 2014	Systematic review	NA	NA	A wealth of evidence, examples, and models exist supporting and illustrating primary and behavioral health care integration as a means for delivering quality care and improving overall health outcomes.
SAMHSA-HRSA Center for Integrated Health Solutions, 2014b.	Systematic review	NA	NA	CIHS compiled state billing worksheets to help integrated care at community mental health centers and community health centers.
SAMHSA-HRSA Center for	Systematic review	NA	NA	PCMH model provides whole person care that is

Integrated Health Solutions, 2014c				proactive, evidence-based, and coordinated, with attention to high-quality care.
Sanchez, K., Chapa, T., Ybarra, R., & Martinez Jr., O. N., 2014	Systemic review	A framework for improving access to care	NA	This framework displayed a possible solution for eliminating racial and ethnic disparities and an improvement in mental and physical health with treated simultaneously with an integrated care approach.
Walker & Collins, 2009	Noncomparative descriptive study.	"basic on-site" collaboration continuum	NA	A pilot study was done to test the outcomes of integrating care. The results revealed an increased utilization of services, decreased no show rates, increased adherence to treatment by using the biopsychosocial model of wellbeing.

APPENDIX B – DNP Essentials and DNP Project

Table A2. *DNP Essential and DNP Project*

DNP Essential American Association of Colleges of Nursing [AACN], 2006	DNP Project Application
DNP Essential I: Scientific Underpinnings for Practice	The first DNP essential represents the scientific foundation for the DNP project. This essential applies to this DNP project by integrating knowledge from nursing science, evidence-based guidelines, and research to develop new practice approaches to determine the current level of integration, utilizing the IPA tool and implement an integrated care approach in a primary care setting
Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking	The second DNP essential revolves around organizational and system leadership. These two elements are important in improving patient health and quality of healthcare. The second essential applies to the DNP project by developing and evaluating care delivery approaches, the integration of behavioral health into the primary care setting. Leadership and advanced communication skills are employed while working with providers and staff to improve the overall health of individuals with physical illness and mental disorders, as well as reduce health care cost/expenditures.
Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based for Practice	The third DNP essential involves the DNP scholar translating evidence in practice to improve practice and patient outcomes. This essential applies to the DNP project because the DNP scholar designs evidence-based interventions to apply and evaluate in the primary care practice site with an outcome of improved access to behavioral care for individuals with physical illness and mental disorders.
Essential IV: Information Systems/Technology and Patient Care	The fourth DNP essential is information systems/technology. This essential's focus is on emerging technology to

Technology for the Improvement and Transformation of Health Care	support practice and administrative decision-making. This essential applies to the DNP project because the outcome of the project is to improve access to care. Development of the DNP project and the project evaluation plan involves information obtained from the IPA tool and current practice information.
Essential V: Health Care Policy for Advocacy in Health Care	The fifth essential is health care policy for advocacy which emphasizes the need for understanding and educating others about policy and policy making. The standard framework for this DNP project will influence the health policies of the organization by influencing a move towards integrated healthcare that is safe, culturally sensitive, easily accessible, and quality in nature. Advocating for the nurse practitioner that is prepared to deliver primary and behavioral care will help influence policy on integrated healthcare delivery.
Essential VI: Interprofessional Collaboration for Improving Patient and Population	The sixth DNP essential places emphasis on collaborative care that is safe, effective, efficient, and timely. The DNP scholarly project director assumed a leadership role on an interprofessional team to establish an integrated care practice model for individuals with mental disorders in the primary care setting. Collaborative and effective communication skills were required to lead interprofessional teams in analysis of current levels of integrated care.
Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health	The seventh DNP essential is clinical prevention and population health. This essential includes health promotion and disease prevention as it relates to elements of populations including environmental, occupational, cultural, and socioeconomic aspects of health. Evaluation of care delivery models is reflected in this essential through integrated care. Integrated care interventions can achieve the nationwide

	goal of improving the overall health status and access to care for individuals with physical illness and mental health disorders.
Essential VIII: Advanced Nursing Practice	The eighth essential focuses on the advanced nursing specialty practice. The DNP project reflects DNP essential eight by supporting the DNP prepared dually certified family nurse practitioner (FNP) and psychiatric and mental health nurse practitioner (PMHNP) level of proficiency/expertise in designing, implementing, and evaluating integrated care delivery interventions.
Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health	The seventh DNP essential is clinical prevention and population health. This essential includes health promotion and disease prevention as it relates to elements of populations including environmental, occupational, cultural, and socioeconomic aspects of health. Evaluation of care delivery models is reflected in this essential through integrated care. Integrated care interventions can achieve the nationwide goal of improving the overall health status and access to care for individuals with physical illness and mental health disorders.
Essential VIII: Advanced Nursing Practice	The eighth essential focuses on the advanced nursing specialty practice. The DNP project reflects DNP essential eight by supporting the DNP prepared dually certified family nurse practitioner (FNP) and psychiatric and mental health nurse practitioner (PMHNP) level of proficiency/expertise in designing, implementing, and evaluating integrated care delivery interventions.

APPENDIX C – IRB Approval

THE UNIVERSITY OF
SOUTHERN MISSISSIPPI.

INSTITUTIONAL REVIEW BOARD
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NOTICE OF COMMITTEE ACTION

The project has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services (45 CFR Part 46), and university guidelines to ensure adherence to the following criteria:

- The risks to subjects are minimized.
- The risks to subjects are reasonable in relation to the anticipated benefits.
- The selection of subjects is equitable.
- Informed consent is adequate and appropriately documented.
- Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects.
- Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data.
- Appropriate additional safeguards have been included to protect vulnerable subjects.
- Any unanticipated, serious, or continuing problems encountered regarding risks to subjects must be reported immediately, but not later than 10 days following the event. This should be reported to the IRB Office via the "Adverse Effect Report Form".
- If approved, the maximum period of approval is limited to twelve months.
  Projects that exceed this period must submit an application for renewal or continuation.

PROTOCOL NUMBER: 17111604
PROJECT TITLE: A Practice Management Strategies to Integrate Behavioral Health Care in a Primary Care Setting
PROJECT TYPE: New Project
RESEARCHER(S): Shameca Hudson
COLLEGE/DIVISION: College of Nursing
DEPARTMENT: Leadership and Advanced Nursing Practice
FUNDING AGENCY/SPONSOR: N/A
IRB COMMITTEE ACTION: Exempt Review Approval
PERIOD OF APPROVAL: 12/07/2017 to 12/06/2018
Lawrence A. Hosman, Ph.D.
Institutional Review Board

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