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Initiative to facilitate the development of the PMHNP role in an integrated behavioral health and primary care setting

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DNP Project Report: Initiative to facilitate the development of the PMHNP role in an integrated behavioral health and primary care setting

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Abstract

The purpose of this DNP quality improvement project was to facilitate the development of the role of the psychiatric mental health nurse practitioner (PMHNP) within a rural primary health care system. A full time PMHNP had been hired by the Center for Human Development (CHD) and Greater Oregon Behavioral Health (GOBHI) to provide mental health services to adults at three primary care clinics managed by the local hospital including the Regional Medical Clinic in La Grande and two rural health clinics in Union County which has a total population of 25,700 (Union County Census, 2015). The expectations of the role and how it would be implemented was not fully developed and there was a request by administration for assistance. The project was in part directed by administrative staff at the primary care clinics and the community mental health setting. It was identified by these groups that there was a limitation in psychiatric provider time and there was often lack of coordination between providers in community mental health and primary care that ultimately has affected the availability and quality of care.

The project design involved a survey of inter-professional personnel including licensed medical providers, behavioral health and support staff. The methods included development of survey questions, a telephone or face to face interviews and a final written report. The results of this survey are that details emerged that have provided direction to initiate the new service, including strategies for the PMHNP to integrate mental health care within the primary care system, and that continue to interface effectively with the local community mental health clinic. The information discovered was used to guide the design of a collaborative care model that will be used in this setting

Introduction: The Clinical Problem

There is often lack of coordination between providers in community mental health and primary care. This systems related problem was identified by primary care providers including physicians and nurse practitioners, and community mental health staff. Even in an integrated system there may be a lack of understanding regarding the role of the mental health practitioner (Laderman & Mate, 2014). This lack of awareness and coordination affects the overall quality of care for clients (Klein & Hostetter, 2014). With the current referral structure, the time frame from identification of a mental health need and the patient being seen is often over two months, and the patient may be lost to follow up and never seen until a crisis develops (Laderman & Mate, 2014). The problem ultimately affects the quality and safety of patient care.

There was minimal behavioral health care offered with in the clinics but there were gaps in services. At the time, integration of mental health within the primary care clinics involved Behavioral Health Specialists who provide care to persons within the primary care setting. The specialists included Clinical Social Workers and Mental Health therapists but there was no one providing psychiatric medication management which was what had been requested by the providers.

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Population affected by the problem

The population affected by this project are persons covered by the Oregon Health Plan who are in need of psychiatric medication management. Clients who are seen in both the community mental health setting and primary care rural health clinics are included. These are individuals who are seen for care by Grande Ronde Hospital primary care providers and also the psychiatric providers from community mental health including the new provider who was to be hired to

provide psychiatric care. In addition, the providers and staff at all sites are being affected by this practice change model.

The clinics are located in Union County, in rural northeast Oregon, which has a total population of 25,790. As in most small, rural communities there had been very few psychiatric providers. The community mental health setting has had two part time PMHNPs and also utilizes tele-psychiatry two days per week for providing care to children and adolescents. There is also one psychiatrist in full time private practice.

The inclusion of all of the stakeholders in this project was and continues to be essential to facilitating success and full support. These stakeholders include the medical providers at the clinics, the psychiatric provider at the community mental health clinic, administrators and support staff at both sites. Also involved were behavioral health specialists from the hospital, and the therapists at the CHD.

Demographically, the proportion of the population with mental illness is higher in rural areas as compared to urban. The incidence of suicide in the rural area is higher in men and adolescents with some estimates that rates are as much as 30% higher (Smalley et al., 2011). The rates of PTSD related to child abuse and domestic violence are higher than in urban areas. Substance abuse is found in 40% of persons who have mental illness by some estimates. Veteran's services are limited in most rural areas and the rates of PTSD, depression and other mental illness are also very high in this population (Smalley et al., 2011). Many seek care first in a primary care setting, or may present with a physical problem initially.

Literature Review

A literature review was done using CINAHL, PsyInfo and Cohcrane data bases looking at various models of care that address integration. The primary search words used were integration

of care, mental health and primary care, and collaboration. A systematic review of the literature done by Butler et al (2008) for the agency for Healthcare Research and Quality (ARHQ) included a review of multiple studies done from 1950-2007 on the topic. This will be addressed in greater depth as it provided a range of information and comparisons, as well as defined outcomes for integration. The Substance Abuse and Mental Health Services Administration (SAMHSA) website defines various models of care including referral off and on site, co-located and fully integrated (SAMHSA, 2017).

In Smalley, Warren and Rainer (2011), it is reported that work towards the integration of physical and mental health in the primary care setting has been longstanding in rural primary care and was being addressed beginning in the 1970's. There are many statistics that demonstrate that the majority of persons seeking help for mental health related problems do so in the primary care setting (Smalley et al., 2011, p 131). In 1989 the development, of Federally Qualified Health Centers (FQHC) included an integrated model of care with physical, behavioral and dental care in one facility (Smalley et al.,2011). These clinics are now thriving throughout the country, though one does not exist in La Grande. The proposed model will be similar to an FQHC.

The model of the patient centered primary care home now makes it mandatory for persons to have access to behavioral health care (Smalley et al., 2011). The Butler (2008) study states that "Integrated care occurs when the mental health specialty and general medical care providers work together to address both the physical and mental health needs of their patients" (Butler et al., 2008 p 9).

The Four Quadrant Clinical Integration model which was originally developed for dual diagnosis alcohol and drug and mental health clients is being adapted to integration of primary

and mental health care settings. “The ARHQ Butler 2008 study found that integrated programs have more positive outcomes for symptom severity, treatment response, and remission compared to usual care” (Butler et al., 2008).

It has been seen that persons with severe mental illness, such as bipolar disorder and schizophrenia, are better served with other models that includes wrap around services provided in community mental health centers (Unetzer et al., 2013). In these situations a reverse integration model is desirable but may not be financially feasible in a small setting (Maragakis, Siddarthan, Rachbeisel, & Snipes, 2016).

Butler et al (2008) define integration in their study and differentiated it from collaboration. The study went further to describe two areas of collaboration being between patients and providers and the second being among providers. This particular project looked at the collaboration between providers. Also described are various levels and definitions of integration to be broad requiring only a partnership or interactions to narrow with a shared treatment plan. The common thread is the collaboration of mental health and physical health to best meet the need of the clients (Butler et al., 2008).

Other aspects of integration have been defined by Klein and Hostetter (2014). Mentioned in their article is that in some settings mental health providers co-located in a clinic make themselves available to consult with the PCPs on behavioral health issues, including joining in a patient visit. Also, when providing care the mental health provider may ask the physician to join the client visit to address a particular medical concern.

. Programs of integration have been shown to work well with pain management and general management for some chronic illness, most notably diabetes (Summergrad & Kathol, 2014). In an integrated model referrals are more successful when there is a “warm handoff” where the

primary care and or mental health provider introduces the client. Emergency department settings also benefit from having a mental health provider and can avoid utilizing crisis workers from community mental health in many situations, keeping the full scope of care at the ER (Okafor et al. 2013). It is also highlighted that when all providers have access to the same electronic medical record (EHR) and the full medical and mental health life history, it facilitates a more holistic care model (Unetzer et al., 2013).

According to Butler et al. (2008), there are many ways by which mental health can be integrated with physical health care. For example, there can be some adoption of a medical model when treating mental health. Also, patients who are seen primary for somatic illnesses for which there is not physical cause may benefit from a primarily mental health model but can also benefit from self-management skills and patient education (Laderman & Mate, 2014). These are examples of specialty mental health adopting medical model processes of care for certain conditions.

Primary care providers have a wide range of comfort levels when it comes to prescribing and managing medications. Many are often reluctant to take on anything beyond treatment for depression and anxiety and prefer to refer to specialists for further assessment and medication management (Butler, et al., 2008).

Other relevant sources of evidence

National health policy also provides evidence and direction for this type of model. Guidelines in the Affordable Care (ACA) that specify integration of behavioral health and primary care are focused mostly on payment parity and insurance coverage. Expansion of Medicaid insurance in many states increased the population that now has access to mental health coverage. It is uncertain what the results of a repeal of the ACA might look like if it occurred. As mentioned in

the literature review, the Wagner CCM and the Four Quadrant Clinical Integration Model (Butler et al., 2008) will be used as guideline for survey development. Another policy that is still in process is a bill that has been introduced in the US House of Representatives. This bill proposes to amend the Public Health Service (PHS) Act to authorize a primary and behavioral care integration grant program. It is entitled HR 2336, "Behavioral Health Care Integration Act of 2017" (US Congress.gov).

Connecting the literature to the problem

The focus of this project had been on a systems change with integration of care between primary care and behavioral health. The Social Ecological Theory is one that worked well as a framework, because it looked at multiple perspectives in regards to behavior change (White, Dudley-Brown, & Terhaar, 2016). The theory describes five levels that include Intrapersonal, Interpersonal, Institutional, Community and Public Policy. The proposal addressed all levels of influence in the change process and recognized the importance each had on the development and success of the project. The strengths of this model in guiding the project included the attention paid to multiple levels of influence and how they impacted each other in positive and negative ways.

The goal was to further define the process that needed to develop to coordinate the care between the primary care providers and the mental health provider. The intent was to define the perceived and actual gaps, and the impact this has on care. The design included a qualitative survey of interdisciplinary staff including licensed medical providers, behavioral health and support staff**.**

Approach to the conduct of the project/methods

The project setting was the Grande Ronde Hospital Regional Medical Clinic (GRHRMC) and the Center for Human Development (CHD). GRHRMC is a primary care clinic and the CHD is a Community Mental Health Center. Other sites involved are the Union and Elgin Family Health Centers which are rural health clinics in the area and both are managed by the GRH. Initial survey work had been planned to begin in January with development of the survey questions and the initiation of interviews. It had been proposed that there would be a total of 12 interviews done over a three week period. One important aspect of this project regarding timing was that the new provider had been planned to start sometime in February. Inclusion in the final development of the role was to be done in collaboration with the new provider utilizing the information gained from the survey.

Organizational readiness to change

The GRHRMC had expressed a strong desire for this role to be developed to enhance care for the community and to ease the challenges faced by the primary care providers in providing mental health care to complex clients. In the past, providers have expressed frustration at the limitations of the community mental health care system and current referral model. In addition, not all clients want to be seen at CHD for mental health services. What was not clear had been the interest and expectations of the individual providers which became a main focus of this project.

Anticipated barriers, facilitators and challenges

There are several anticipated barriers and challenges with this project. Lewin's Change Management Theory identifies several areas where challenges could occur (White et al., 2016). An anticipated barrier could have been existing perceptions of providers in this setting which

might impact the communication and role development for the PMHNP. A full understanding of the current system and level of behavioral health integration, how is it utilized and what are the gaps had been needed. Also important had been determining the best role for community mental health. Barriers that had been anticipated included those related to bias and lack of understanding of the role of the PMHNP and the mental health model of care.

Proposed Implementation

Participants were to have been all primary care providers and behavioral health staff working at the primary care clinics with the option allowed to not participate. This included the providers at the Regional Medical Clinic, and the rural Union and Elgin Clinics. Also included had been the new psychiatric provider with CHD and existing providers. Specialty care physicians and those working exclusively in pediatrics were not included. Recruitment of participants was to be done via email announcement as well as a written letter. Answers to the survey were confidential and recorded in a collated document.

Qualitative data attempts to study phenomena as "they naturally occur" (Mateo & Foreman, 2014). This type of data collection is best for studying the unique aspects of nursing that are focused on the individual and the interactions and experiences that occur in providing and receiving care. This type of survey provided rich detail on the given situation. "Qualitative data can provide depth of understanding to the experiences of patients and caregivers and how a given intervention or experience either contributes to or detracts from the health of that individual or population (Neergaard, Olesen, Andersen, & Sondergaard, 2009). Leeman & Sandelowski (2012) discuss that qualitative research is best suited for practice based inquiry, and that it will generate real work evidence to guide health care. Qualitative inquiry also looks at the contextual and external variables which are key components in translating research into practice

and assuring validity of interventions. In the real world there are multiple biases, factors and situations that are unique to each situation. Some of the areas that qualitative data can measure effectively and ultimately contribute to health care improvement include cultural biases, the experience of the patient in responding to and managing illness and caregivers attitudes (Leeman et al., 2012).

Proposed intervention procedures

In January 2018 a survey was developed with up to six key questions. Providers were contacted in January to prepare for a schedule in February of administering the survey. Interviews were to be scheduled for a half hour of time but this varied. Included were to be all primary care providers including Physician and Nurse Practitioners at the Regional Medical, Union and Elgin Clinic the new psychiatric provider with CHD and existing mental health providers. Recruitment to participate was to be done via email announcement as well as a written letter. Responses of participants were not individually identified and were included as an aggregate report in order to maintain confidentiality unless otherwise indicated. Participants were clearly informed of the option not to participate. Specialty care physicians and those working exclusively in pediatrics were not included in the survey.

Outcome measures

The project design involved the development and administration of a survey of interdisciplinary staff including licensed medical providers and care coordination staff in both the primary care and community mental health setting. The benefits of this design were that those directly interviewed provided details to direct the development of the PMHNP role and how to facilitate best practices in integration and collaborative care. It was planned for the

provider who is to be working at the RMC to utilize the same electronic health record to maximize integration potential but there has not been definition of what data was to be part of the combined record and what, if any would be kept separately. A question regarding documentation was to be included in the survey.

Plans were for the results of the survey to be reviewed with agency staff and then transcribed into a document collating the findings. Oversite for this was to be from the clinical mentor and a designated staff member from CHD. The final outcome of the project was to be the development of guidelines for the initiation of the PMHNP role and was to take the form of a written document that would be presented to the primary care and community mental health clinics. Establishing the role of the PMHNP at the GRHRMC had the ultimate goal of improving the continuity and quality of health care for the client with both physical and mental health problems.

Project Implementation

The initial steps of the project included the development of a series of open ended questions that were directed at several points and included the following:

- What are the patient conditions and situations that you would plan to refer to the PMHNP for continued care
- In what situations would you see the PMHNP as a consultant only?
- Have you worked in other settings where this has been the model, and if so how was it successful? Challenges?
- Questions on charting, space and scheduling.

An introductory email was sent to each primary care provider (PCP) announcing the plan for the project as well as a request to arrange a face to face interview for further information. The interviews with primary care providers and staff took place over a three week period and involved visits to four clinics. Due to the nature of the open ended questions an online survey was not felt to be adequate. Each provider received the option of a follow up phone call to discuss some of the questions further, and three opted to do this.

Several aspects of this project evolved over time and resulted in some modifications since the project proposal was originally written. These include the timeline, the number of providers who were contacted and the hiring of added staff. Modifications also involved the number of face to face interviews with each of the providers and the engagement of administration in the project at various stages. It has also been a challenge to contact some of the providers who were very busy and did not often feel they had the time to participate and five out of fourteen did not respond or participate.

The timeline for the PMHNP beginning work shifted several times due to the difficulty in finding a provider to fill the role. A provider had been hired almost a year ago, though never started working at the clinics and withdrew from the position before starting. At this time the providers at the main clinic were made aware of the decision to have a psychiatric provider at the primary care clinics, though due to length of time and some provider changes this plan was partially forgotten. Providers are now being made aware again of the plan to have psychiatric services at the clinic. This was the initial phase of the plan-do-study-act cycle. The PDSA model is a methodology of quality improvement that focuses on analysis that is effective for rapid cylce improvement processes. Steps for improvement are carried out, studied and evaluated on a frequent basis. The plan is continuously adapting as needed (Zaccagnini & White, 2017).

Timeline of activities

September 2017: Project initially proposed by administration and in coordination with primary care clinics.

February and March: face to face surveys were completed at the Elgin and Union Clinics and contact made with a provider at the Family Practice Clinic, a non-hospital based clinic.

April: Another e-mail was sent to providers announcing the survey and request for information from those who had not yet participated. Several planned follow up calls took place.

April: a provider has now been hired to fill this role and will be starting in July. Several meetings with the new provider took place in April and one in May. The provider has experience in integration of care in another system.

One PMHNP has already started to work at one of the small rural clinic one half day per week as the pilot for the project. This clinic already has some outreach from therapists and other mental health providers from the community mental health clinic, and has a dedicated room where therapists and case managers have been providing outreach to these sites. The model at this site and the other rural health clinic will be co-location and not full integration.

Unintended consequences

One unintended consequence involved several communication problems. Some providers expressed concerns that they did not know this was going to happen and also regarding not having much say in it until now. The PMHNP originally hired last July withdrew in January and never moved to the area. It was discovered that the administration at each clinic had communicated with each other about the proposed service but it became clear as the project unfolded that the clinicians had not had the opportunity to be part of the planning discussion. Though all were ultimately supportive of the idea each had specific ideas and expectations that

were addressed. One cost that has yet to be fully addressed is the issue of rent for clinic space which was not in the original agreement and only one clinic brought this up as a question. It is clear from the interviews that many of the logistical details still need to be refined by staff and providers.

Missing data or information

The initial plan was to interview all PCPs including five physicians and eight family nurse practitioners (FNPs), as well as 1-2 key staff from each clinic. However only six of the FNPs and two physicians participated. Key persons initially involved in the design of the role have retired or are planning to retire soon.

Some of the original planning had not been documented and this project was intended to bring the providers into the equation and allow their awareness and buy in to the project. The next PDSA cycle will involve the newly hired provider meeting with the providers at the hospital based primary care clinic to discuss referrals, and other logistics. There has already been one change that occurred along the way in that the community mental health director who had originally arranged this has retired, the some institutional leadership and historical memory has changed. There is also new leadership coming on board at the primary care clinics and some of the original negotiations for the integrated care model were verbal and have not been passed on. However, the new leadership has embraced the general concepts of inclusion of a PMHNP within the primary care clinic system.

Key findings: relevance, ethical issues

Strengths of the project include interest from all parties and commitment to adding the provider to the staff which has been done. There have been behavioral health specialists already in the clinics but the prescriber role has been missing. Challenges are that hiring the PMHNP is

only one portion of the larger picture, and there is continued need to facilitate effective use and understanding of the role.

There were some key findings from the interviews at the rural clinics

- Minimum one day per week of PMHNP time
- Consultation between providers and full management of patients are anticipated scenarios
- Knowing more about CHD services and programs
- Referral process issues; “warm handoffs” are desired
- Providers in rural primary care are stretched “to the max” with complex clients; they feel that 50-60% could use mental health services
- Not comfortable with how law enforcement handles mental health related situations
- Want to know more about the crisis system.
- Access and intake process for CHD is needed prior to seeing a client and currently clients would need to come to La Grande for this which creates another barrier to services for those who cannot obtain transportation.
- Findings matched most of what was found in the literature
- Providers do want a more integrated approach and are asking for this with open arms.

The interviews in general revealed a variation of expectations and generated further questions. Some providers/staff were expecting a full time provider in the clinic where there will only be a part time provider. Others are unclear about how to best refer to and receive patients back from the PMHNP.

Different responses were found at the Family Practice Clinic, the only one not affiliated with the hospital. This interview included two staff persons and a physician’s assistant. They were more interested in counseling services than medication management, the physician’s

assistant there reported that she felt comfortable prescribing medications for psychiatric issues which is not always the case as most primary care providers express discomfort with psychiatric prescribing. The providers at the Family Practice Clinic do not see a large Medicaid population and also asked about paying rent for the space. The other clinics are considered rural health clinics and they get a higher reimbursement rate for services. One staff member said that many of their patients do not want to go to CHD, that they would likely say that there is a counselor here at the clinic. The provider said that if they sensed that the client did not want to be see a community mental health provider they would not mention that it was a CHD provider. This is consistent with literature that finds there is stigma associated with seeking mental health care (Mullin & Stenger 2013).

Although there is strong support for this effort and most clinics would like a psychiatric provider present one to three days per week, there is limited staff to provide this level of care in all sites. The service that is agreed upon and matches the Agency for Healthcare Research and Quality AHRQ (2008) definition of integration of care is that "integrated care occurs when mental health specialty and general medical care providers work together to address both the physical and mental health needs of their patients." Smalley et al (2013) state that to provide integrated care in rural areas "we must move beyond structure to function". Another perspective on this is to move from planning to doing.

Ethical concerns were discussed during the interviews, with the following being reviewed including dual relationships, and other challenges such as competence and confidentiality. Each discipline approaches these in a different way (Mullins & Stenger, 2013) and this could be reflected in the nature and content of notes for mental health that touch on more sensitive and

personal topics that patients may not wish to be shared with those mainly dealing with their physical health.

Comparison to the Literature

The situation in this rural community matches much of what is seen across the country in both urban and rural settings. Despite the evidence that integrated care is the approved and higher quality approach, recommended by the Institute of Medicine over 20 years ago (Klein & Hostetter, 2014), the local health care system has only partially implemented this model. As the project was unfolding much that was found in the literature supported what the other providers have said in the interviews. Clearly, both mental health and primary care NPs want better collaboration that will suit the needs of their clients. Providers also discussed scenarios that were consistent with the findings in the literature including the high rate of smoking related deaths and metabolic syndrome among the severely mentally ill (Bentham, W., Ratzliff, A., Harrison, D., Chan, Y., Vannoy, S. & Unutzer, J. 2015).

Another finding that matched the literature was that most primary care providers interviewed said that they were comfortable with treating anxiety and depression in the primary care setting, but that when the usual treatments failed, the client was suicidal or there was psychosis involved that they would prefer to refer to a specialty care provider (Bentham et al. 2015). It was also found that there is collective intent to treat the mental health and physical health needs equally and to avoid diagnostic overshadowing. This is a phenomenon that occurs with the severely mentally ill when symptoms are mistakenly attributed to the mental illness which delays proper diagnosis and treatment. This delay leads to increased morbidity and mortality for individuals with severe mental illness (Knaak et al. 2017). This will improve outcomes for all health related

This matches the literature in that there are multiple reasons for integration of care, and few negative outcomes. Patients are still given the choice to be seen at separate sites if they do not wish for their mental health and physical health care to be combined in one documentation system (Butler et al. 2008.) SAHMSA (2018) has provided some definitions and facts about integration as well which include the following:

- Coordinated Care**,** which concentrates on communication
- Co-located Care, which focuses on physical proximity
- Integrated Care, which emphasizes practice change.
- Primary care settings provide about half of all mental health care for common psychiatric disorders such as anxiety and depression
- Adults with serious mental illnesses and substance use disorders also have higher rates of chronic physical illnesses and die earlier than the general population
- People with common physical health conditions also have higher rates of mental health

The differences between expected and observed results are minimal. A finding that differed from the original intent of the project was that one clinic was wanting to see a counselor or therapist in the clinic rather than a prescriber. Two providers expressed confidence in managing psychiatric medications but felt that the therapy portion was missing. Information was also shared about the concerns some clients have about going to a Community Mental Health setting and the stigma this creates, which is consistent with the findings in the literature.

Impact of project on the system including costs

The provider who is working at the hospital managed RMC is being contracted through the Regional Medical Clinic and all billing for services there will go through their system. The

provider at that setting will be using the charting system the GRH uses versus using what is used in other areas. In other settings the CHD electronic medical record (EMR) will be used and billing for provider time will go through the CHD system. Opportunity costs are changes in the referral process, increases in caseload of the Community Mental Health Center may stretch other mental health care providers such as those doing therapy and case management.

Practice-related implications, recommendations and limitations

There are other limitations which could be in the areas of threats and barriers. Some of these are predictable and others are not. Predictable implications include varied expectations, decreased funding over time, employee turnover, reduced interest over time, time frame barriers and technology challenges (Zaccagnini & White, 2017). The technology could be a barrier in that there are different charting systems, however this is already in the discussion phase. Though the broad design and some factors will be generalizable, the details of implementation are unique to the setting. Some of the unpredictable limitations are centered on varied expectations and personalities involved in the project from all agencies.

Dougherty, McDaniel and Baird (1996) described five levels of integration. These are minimal collaboration, basic collaboration for a distance, basic collaboration on site, close collaboration/partially integrated and fully integrated model. Currently the relationship between the medical and mental health providers is at a basic collaboration from a distance with some basic collaboration on site. Hoping to move to a close collaboration model or fully integrated model. (SAHMSA, 2018)

Numerous barriers to integration have been defined in Smalley et al., (2012) and include those at a national and systems level including lack of specialty providers and payment parity.

There are also reimbursement barriers because Oregon Health plan and Medicaid can only be billed through CHD providers, and community mental health rarely bills private insurance. There is a grant from GOHBI as start up until billing allows for funding of the position. Practice and cultural barriers may include language, diagnostic time line, practice parameters, the use of separate records, approaches to charting and communication with other providers. Many of these have been identified in the interviews. The last are patient level barriers where there is a perception of stigma related to accessing mental health services (Smalley et al., 2012). These have all been addressed at various levels in the initial discussions and the planning phase and will continue to be topics that will need refinement.

Conclusions

It is clear that the addition of the PMHNP to the primary care clinic has the support of the staff and clinicians. The benefits of an integrated model of care has been well documented in the literature and in practice. It is also sustainable the grant funding will provide bridge funding until billing brings in the revenue to fund the provider. There is no indication that the need for mental health services will diminish. The potential to influence change is substantial as care will occur in the same setting and with the same documentation system. This integration could potentially reduce confusion and other difficulties related to continuity, medication interactions, and other complications of care. A summary of findings from the interviews at the clinics included enthusiastic interest, plans for space utilization and start up timeline for services.

The potential to influence the system by this model extends beyond medication management and prescribing. It allows for the improvement of care to patients in all areas. There is strong agreement that the main goal is to “improve communication between behavioral health and primary care providers and thereby improve care coordination” (Klein & Hostetter, 2014

p. 3). “It is important to understand the functional elements of integration which are clinical, administrative; and structural aspects of the care process can be managed to improve access, quality, patient and provider satisfaction and efficiency” (Smalley et al., 2012 p. 145). This will also align with the Primary Care Medical Home model that is part of the Affordable Care Act and meets benchmarks for rural mental health care statutes (Unutzer et al., 2013).

Summary and Next Steps

The focus of this project was to gather information to guide the process of psychiatric provider integration, and has been described as a starting point for communication. The implementation and development of the psychiatric provider role will take place over several months. There will be aspects of the system that will require modification as it proceeds and this it is anticipated that as the project continues to unfold that there will be continuous PDSA cycles to test the change process. Providers are anxious to see this become a reality and the majority feel it is reasonable to embark upon it with some of the details worked out but to also revisit as a group on a biweekly to monthly basis to reevaluate and address issues and challenges that may arise.

The new PMHNP is targeted to begin practicing in July. Another provider has already been seeing patients at one of the rural clinics and is utilizing the “co-located collaboration” model of charting in the CHD system and verbally collaborating when it is appropriate. The focus of this project is one element of integration of behavioral health into a primary care system. Two integration models will be in use and these include side by side /co-located and the other is full integration (SAMSHA, 2017).

Addressing the whole person and his or her physical and behavioral health is essential for positive health outcomes and cost-effective care. Many people may not have access to mental health care or may prefer to visit their primary health care provider for these problems. Although

most primary care providers can treat mental disorders, particularly through medication, that may not be enough for some patients. Historically, it has been difficult for a primary care provider to offer effective, high-quality mental health care when working alone. Combining mental health services and expertise with primary care can reduce costs, increase the quality of care, and ultimately improve the quality of life for clients (NIMH, 2017).

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