Providing Whole-Person Care:
Integrating Behavioral Health Into Primary Care

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Integrated primary care in a patient-centered medical home is the best way to invite patients to engage in better self-care, to move from provider-based care to team-based care, and to address whole-person needs. However, primary care—whether rural or urban, public or private—cannot become the default mental health system for North Carolinians with severe mental illness.

Rural Health Group (RHG) is a federally qualified health center that provides integrated medical and behavioral health care to residents of 5 counties in northeastern North Carolina. We have 25 medical providers covering 13 clinics and an approximate patient panel of 30,000 individuals. Our catchment area is also covered by 2 Community Care of North Carolina (CCNC) AccessCare networks (Northern Piedmont Community Care and Community Care Plan of Eastern Carolina) and by 3 managed care organizations (Cardinal Innovations Healthcare Solutions, Eastern Carolina Behavioral Health, and Eastpointe). Roanoke Rapids, a micropolitan community located approximately 20 miles south of the Virginia border, serves as the hub of our health care system and is the location of our largest practice and our administrative offices. Aside from our locations in Roanoke Rapids and Henderson, our clinics serve communities with populations of less than 1,500 residents each.

According to 2014 data from County Health Rankings and Roadmaps, 6 of the 7 counties served by RHG ranked in the bottom 7 of the 100 counties in North Carolina in terms of health behavior, environment, clinical care, and socioeconomic status [1]. For overall health outcomes, including length and quality of life, Halifax County is 99th out of North Carolina's 100 counties; Vance is 96th; Northampton is 89th; Warren is 85th; and Granville is 39th [1]. Many people in all of the communities we serve face multiple health disparities, yet each community has a unique combination of risks and barriers to care.

Being in a rural setting adds to the challenges faced by both patients and providers. Unfortunately, many communities in North Carolina have experienced upheaval in local specialty mental health services as these services have become increasingly privatized and fragmented. Private agencies have flourished and collapsed, and less trained and minimally supervised professionals and paraprofessionals have moved among agencies, which has contributed to a lack of continuity in quality mental health care. In our experience, this discontinuity in care is a predictor of poorer overall health outcomes. Thus, a continuum of care that provides specialty resources for primary care practices must include robust psychiatric and mental health specialty treatment services.

RHG patients commonly present with diabetes, obesity, hypertension, depression, and attention deficit disorder. Patients often expect quick and easy solutions to biopsychosocially complex conditions that have developed over many years. At RHG, we bear this in mind and do not arbitrarily differentiate between medical and mental illness: Illness is illness, and we treat it from the same whole-person paradigm.

While RHG can address some behavioral health issues, patients with serious mental illness require specialty care. For example, consider a patient with hypertension, obesity, borderline personality disorder, chronic substance use, an undifferentiated bipolar disorder, and a history of multiple psychiatric hospitalizations. In this case, RHG can respond ably to the patient's medical conditions, but we are not equipped to treat complicated and severe mental illness. Just as the treatment of cardiology, gastroenterology, endocrinology, or neurology patients is beyond the scope of primary care, so too is the management of patients with significant mental illness. Although we can be a part of the continuum of care for the typical health care patient, primary care cannot become the default mental health system, especially when it is already overwhelmed by management of basic health care issues. Patient-centered medical home (PCMH) integrated primary care provides basic, core treatment and management of common medical and psychosocial conditions, but it cannot also provide specialty care services without decreasing the quality of care to our designated population.

Behavioral Health Care at RHG

Beginning in 2007 with just one behavioral health provider coming in 1 day per week, we have now evolved into

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an integrated primary care practice in which every RHG patient has a behavioral health provider on their treatment team, just as they have a dentist, pharmacist, case manager, and nurse. We currently have 5 full-time behavioral health providers, who are either licensed clinical social workers or licensed psychologists. Each clinic has a behavioral health provider at least part of every week, and these providers are available during all clinic hours; when they are not physically present in a given clinic, they can be reached through our electronic medical record/instant messaging system or through the in-house help line. Behavioral health providers can be activated by any member of the patient's treatment team, including the patient, at any time. Appointments with the behavioral health provider typically occur on the same day and at the same time as the patient's primary care encounter. They also occur in the exam room used by the primary care provider. This makes it more convenient for the patient and reinforces a team-based approach, as does the inclusion of the behavioral health provider's notes in the patient's electronic medical record.

Rather than traditional psychotherapy, behavioral health providers offer assessments, brief interventions (ie, less than 6 sessions), and referrals for more intense treatment, as appropriate. A patient's action plan is established using the 5 A's model of behavior change—assess, advise, agree, assist, arrange [2]—and the patient's stage of change [3]

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is assessed at each encounter. Behavioral health providers are activated for health care management, whether it centers on stress, depression, or chronic illness (eg, diabetes), or when a new medical diagnosis will demand significant lifestyle changes. In addition, behavioral health providers engage in preventive strategies, such as intervening with new tobacco users or monitoring patients with diabetes for signs of depression.

RHG has been effecting substantial paradigmatic change that has allowed us to provide whole-person care using the integrated model. At the patient level, we focus on providing health care without arbitrary differentiation by diagnosis, geographic location, or any other filter. At the provider and cultural level, we focus on prescribing practices, openness to team-based care, and assessing a provider's stage of change within the PCMH model.

Regardless of the patient's specific circumstances or diagnoses, team concerns center on issues such as the patient's ability to keep appointments, health literacy, ability to obtain prescriptions, and readiness to participate in an action plan, as well as the identification of community and/or family resources. PCMH integrated primary care can respond to a variety of patients without immediately engaging specialty care. We can provide basic behavioral interventions in conjunction with medical recommendations from the patient's primary care provider. PCMH integrated primary care has the responsibility of drawing a more complete picture of a person's overall health at a particular moment in time, offering that picture to the patient, and outlining the resources and limitations that are particular to that patient. Because the whole team is activated and involved, our patient will be more likely to follow through on behavioral or medical treatments and to return to care.

Thanks to decades of research on behavioral medicine, we are beyond the point of simply telling our patients what to do. We now focus on assessing a patient's readiness to change, and our providers work to re-engage patients in taking responsibility for their own care. We have historically functioned under a power dynamic that emphasizes "telling" patients what to do and then blaming them when they do not follow recommendations. With respect, I believe the responsibility is on us as providers to shift to a team-based partnership with the patient; in this model, we can better present realistic options based on what we have learned about the patient's circumstances (psychosocial, biomedical, and material), as well as our knowledge of available resources.

As we seek to move away from the old dynamic of providers telling patients what to do, I ask myself, "How much do I like to be educated about something that I have already heard several times before? How do I respond to limited eye contact or competition with a computer when in conversation? How challenging is it for me to change a behavior that my primary care provider has recommended I change and that I know is in my best interest to change?" I am just as likely as any of my patients to choose salty or sweet snacks over carrots, to drive when I could walk, or to forget my medication without realizing it. Relative to most of my patients, I live a privileged, safe, and healthy life. So why would I expect patients to change when I myself do not respond to these old methods of patient interaction? In primary care, our presence in patients' lives may be small (for healthier patients) or perhaps even moderate (for chronically ill patients), but we are not the most important relationship in their lives, and we are not in charge of their decisions.

Within the PCMH integrated primary care setting, the patient is invited to participate in their own self-care as much as possible. We are responsible *to* the patient but not *for* the patient. I believe confusion about this point not only perpetuates the power dynamic between providers and patients but also reinforces the current fee-for-service environment. If we are to move to a value-based treatment model, I believe the biggest change has to be within the provider community. If providers reorient their practice to team-based, patient-engaged, relationship-emphasized care, then patients will be invited to engage responsibly in their own care. If patients do not accept this invitation, providers can re-invite patients at each appointment.

Our responsibility as primary care providers is to connect patients to services where possible and to lay out a realistic range of options. Although the range of choices we have to offer is rarely ideal, our hope is to steer the patient in a healthier direction and to provide follow-up and support in order to encourage full participation with a patient's specialty care.

PCMH integrated primary care is about a commitment of time, energy, and financial resources to provide team-based, whole-person care to patients in the exam room. It means that a patient can see not only their primary care provider and a nurse, but also their case manager and their behavioral health provider, all at the same appointment. It means that a patient knows that they have a team of professionals available who can be activated based on their acute or chronic needs, whether these needs are medical, psychological, or social. Most importantly, it means that their team will apprise them of their choices in a caring and realistic manner, providing appropriate services, referring to specialty care as needed, following up for additional appointments, and doing so without judgment or blame. It is this goal that drives me to persist in the message that we cannot be all things to all people; however, we can try to model what we hope to teach: that knowing our limitations is at least as important as knowing our strengths. NCMJ

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References

1. University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, 2012. Robert Wood Johnson Foundation Web site. http://www.countyhealthrankings.org. Accessed November 4, 2014.
2. Glasgow RE, Funnell MM, Bonomi AE, Davis C, Beckham V, Wagner EH. Self-management aspects of the improving chronic illness care breakthrough series: implementation with diabetes and heart failure teams. Ann Behav Med. 2002;24(2):80-87.
3. Prochaska JO, Velicer WF. The transtheoretical model of health behavior change. Am J Health Promot. 1997;12(1):38-48.