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| **Physical Health Care Needs** |  | **Behavioral Health Care Needs** | | |
| **At risk** | **Common** | **Complex** |
| **At risk** | * Everyone is at risk for physical and behavioral health conditions. * Evidence-based screening tools should be embedded in the routine practices of primary care practitioners. * Identification of Adverse Childhood Events (ACEs) should be incorporated into practices. | **Sarah**, 34, receives MH treatment at the local community mental health agency (CMHA) for bipolar disorder. In addition to her routine lab work, Sarah’s BMI is monitored. She participates in a peer-led wellness group where she has developed a walking program and learned healthy cooking techniques. | **Justin**, 25, diagnosed with schizoaffective & substance abuse disorders, has a history of cycling from county jail to the state hospital and release to homeless shelters where he goes off meds and repeats the cycle. At discharge from the state hospital, instead he is returned to the jail with the option of participating in the MH court- where he connects with MH services, CD treatment and supportive housing and employment services. |
| **Common** | **Caleb**, 6, has the diagnoses of asthma and eczema. He lives with his grandmother and his younger siblings after his mother and father were unable to care for him due to their drug involvement. His pediatrician operates as part of a team in a primary care home. The pediatrician screens for ACEs, recognizes the risk factors and refers the child and grandparent to the Behavioral Health Consultant within the practice. | **Carol**, 70, is diagnosed with high blood pressure and high cholesterol. Her husband passed away 2 years ago. On a routine visit to her PCP she reports disturbed sleep and receives an SBIRT screening. The screening identifies the development of problem drinking and symptoms of depression. Her PCP provides a “warm hand-off” to the in house behavioral health specialist who provides psycho-education re: alcohol use & older adults and engages her in group treatment for bereavement. | **George**, 46, diagnosed with schizophrenia lives with his sister. He has developed Type II Diabetes due to usage of antipsychotic medication and now takes an atypical antipsychotic which requires frequent blood draws. He has a hard time remembering his treatment regimens. The med department of his CMHA coordinates with his endocrinologist to simplify his medications, labs, and communicate a shared care plan with George, his MH case manager, and his sister. |
| **Complex** | **Kim**, 25, is discharging from the hospital following a very serious car accident where she fractured multiple bones. She lives alone and her family is on the other side of the country. She receives opioid pain medication and a prescription for physical therapy. Her PCP receives an electronic update to her medical record at the time of discharge. The PCP’s nurse calls Kim at home to ensure that there are not unmet needs during the transition home and tracks Kim’s usage of pain medication and physical therapy. | **Martha**, 50, is diagnosed with COPD, CHF, and Panic Disorder without Agoraphobia. She lives with her daughter who is also her paid, live-in caregiver. Her panic attacks often prompt symptoms of her COPD- and vice versa. After repeated after-hour trips to the ED, her physician refers her to a mental health therapist who teaches her skills for managing her anxiety and panic attacks. In collaboration with the physician, the therapist helps Martha develop a care plan that identifies the steps she needs to take to manage both her physical and mental health conditions including self-care techniques, warning signs, and when to get further help. | **Harry**, 52, is homeless. His diagnoses include: Major Depression, PTSD, alcohol dependency, Type II Diabetes (poorly controlled), spinal cord injury and is wheelchair bound. He has chronic catheter-related urinary tract infections (UTIs). He has made 78 Emergency Department visits in 15 months, primarily to treat his chronic UTIs. His only MH services have been crisis contacts in the ED when intoxicated. He has not connected with a primary care physician, CD provider, or on-going MH provider. He says his primary problem is housing. Active engagement at the ED by a peer specialist connects him to a “wet” housing project. There he gradually accepts MH & CD services. His stable setting allows him to better manage his catheter & diabetes. |

**WHOLE PERSON INTEGRATED CARE DELIVERY MODEL**

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| **Physical Health Care Needs** | **Behavioral Health Care Needs** | | |
|  | Note: Integrated care for those who use any combination of medical, mental health or substance use disorder services will be supported by an infrastructure that may be at the health plan or provider level: shared care plans, identification of gaps in care, communication expectations, referral needs, etc. Other services that may require coordination include LTSS, community supports, emergency department, and crisis services. | |
|  | * Full-scope primary care practice (FSPCP) with standard screening tools and behavioral health practice guidelines) * Access to behavioral health provider (BHP) and/or specialty behavioral health services consultation, including psychiatry and chemical dependency provider | * Specialty behavioral health:   + BHP   + Psychiatric consultation   + Chemical dependency services   + Residential behavioral health   + Behavioral health inpatient * Behavioral health care manager with responsibility for coordination with medical provider * Access to medical provider (physician/ARNP/PA) and FSPCP |
|  | * FSPCP * Nurse care manager with responsibility for coordination with LBHP * Access to BHP and/or specialty behavioral health services consultation, including psychiatry and chemical dependency provider * Coordination with medical specialists | * Specialty behavioral health:   + BHP   + Psychiatric consultation   + Chemical dependency services   + Residential behavioral health   + Behavioral health inpatient * On-site medical physician/ARNP/PA with backup FSPCP or co-located with FSPCP * Care Manager: Behavioral health or nurse care manager as appropriate is lead, with access to support of the other as needed * Coordination with medical specialists |

Modified from, “The Four Quadrant Clinical Integration Model,” *Behavioral Health / Primary Care* *Integration and the Person-Centered Healthcare Home*, National Council for Community Behavioral Healthcare, April, 2009.