Primary Care Behavioral Health

An introduction to integrated primary care

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Schedule for Today's Activities

- 8:30-8:50 Introductions: Your name, the clinic where you are now
- 8:50-9:00 Breakout group assignments: Introduction to the 5 issues you will help address
- 9:00-12:00 Didactics
- 12:00-1:00 LUNCH
- 1:00-2:30 Didactics
- 2:30-4:30 Breakout group work: Reply to your 5 questions

Learning Objectives

- Explain each component of GATHER
- Describe the Quadruple Aim and how it related to integrated care
- List at least three ways a BHC can improve primary care
- Discuss the rational for warm handoffs and same-day visits
- List at least three "Sinkholes" or "Trampolines" for PCBH

Help me supervise… we'll come back to these later for your advice

BREAKOUT GROUP #1

1. "This patient is not really appropriate for primary care. He needs specialty mental health."
2. "It's unethical for me to ask details about his sexual abuse trauma when all I have is 30 minutes."
3. "I don't have much experience with eating disorders so I don't see those patients."
4. "I wish the PCPs would stop asking me to help write all these letters for patients, I'm not a case manager!"
5. "30 minutes just isn't enough time for patients to develop a rapport and feel heard."

Help me provide supervision… we'll come back to these later for your advice

BREAKOUT GROUP #2

6. "I mostly do breathing or a handout during the first visit, then we'll get into more complex stuff at follow-up."
7. "My PCPs interrupt me for handoffs, but I wish they wouldn't; it's so bad for building rapport with my patients."
8. "My new patient reported a lot of relationship problems, so I recommended couples therapy at a nearby agency."
9. "We're doing education with our PCPs about what kinds of referrals are (in)appropriate for a BHC."
10. "I got a warm handoff, but the patient only had 10 minutes, so I suggested she come back next week instead."

Help me provide supervision… we'll come back to these later for your advice

WHOLE GROUP

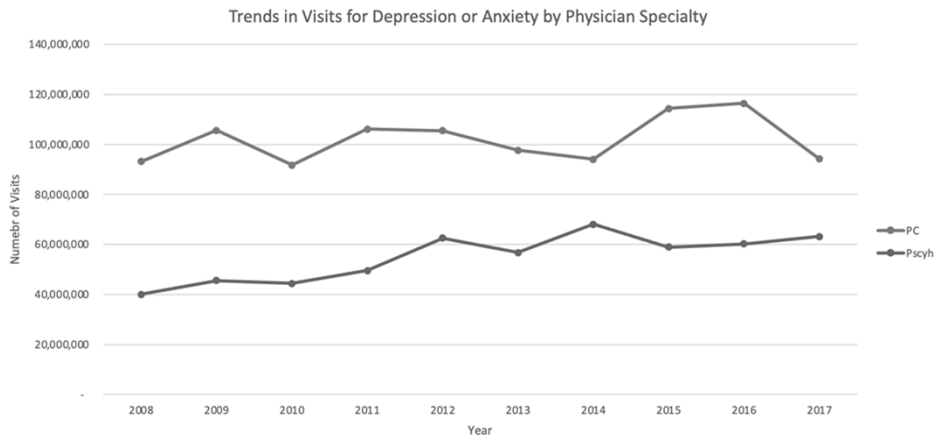
11. "I have a hard time terminating with patients who I know have so much ongoing stress."
12. "My patient is super depressed so I promised him that his PCP will get him onto meds that will help."
13. "These provider meetings in primary care are so boring. None of it has anything to do with a BHC's work."
14. "Our patients can't access specialty mental health, so parts of our BHCs' schedules are blocked for therapy."
15. "I give as many interventions as I can in the first visit, in case they don't show for follow-up."

The Why

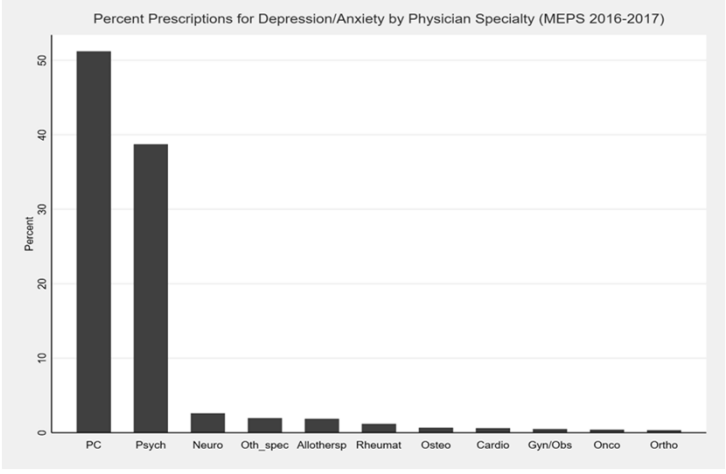
Rationale for Integrating Behavioral Health Into Primary Care

Q: Why Is Integration Occurring?

Primary Care: The De Facto Mental Health System (1/3)



Primary Care: The De Facto Mental Health System (2/3)



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Primary Care: The De Facto Mental Health System (3/3)

- 56% of all mental health care treatment is done in primary care [1]
- Visits for antidepressants, anxiolytics/hypnotics, antipsychotics, ADHD meds and bipolar disorder are increasing faster for PCPs than psychiatrists [2]
- 75% of children with a mental health disorder are seen by a pediatrician [3]
- 25% of pediatric primary care and ~ 50% of pediatric visits involve behavioral, developmental, emotional, educational and/or psychosocial concerns [3]

Takeaways: Primary care is the main source of mental health care, and integration must assist with the full range of ages and psychiatric conditions

1. Wang, P.S., Lane, M., Olfson, M., Pincus, H.A., Wells, K.B., et al. (2005). Twelve-month use of mental health services in the United States: Results from the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 629-640.
2. Olfson, Kroenke, Wan & Blanco (2014). Trends in office-based mental health care provided by psychiatrists and primary care physicians. Journal of Clinical Psychiatry, 75(3), 247-253.
3. Martini R, Hilt R, Marx L, et al. (2012). Best principles for integration of child psychiatry into the pediatric health health. Guidelines developed for the American Academy of Child and Adolescent Psychiatry.

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Mental Health (MH): The Access Problem (1/2)

- 66% of PCPs report having no access to specialty MH [1]
- 30% of US population has a MH disorder [2], but only 6% visit specialty MH [3]
- Only 20% of children with a MH problem see a MH provider [4]
  - But 75% visit a pediatrician [4]
- Only 34% of adults with a MH problem see a MH provider [5]
  - But 86% talk with a health care provider of some sort (e.g., a PCM) [5]

1. Cunningham, P. J. (2009). Beyond parity: Primary care physicians' perspectives on access to mental health care. Health Affairs, 28, 490–501.
2. Kessler, R.C., Demler, O., Frank, R.G., Olfson, M., Pincus, H.A., et al. (2005). Prevalence and treatment of mental disorders, 1990-2003. New England Journal of Medicine, 352, 2515-2523.
3. Han, B., Olfson, M., Huang, L. & Mojtabai (2017). National trends in specialty outpatient mental health care among adults. Health Affairs, 36(12), 2062-2068.
4. Martini R, Hilt R, Marx L, et al. (2012). Best principles for integration of child psychiatry into the pediatric health health. Guidelines developed for the American Academy of Child and Adolescent Psychiatry.
5. Cohen RA, Zammitti EP. (2016). Access to care among adults aged 18–64 with serious psychological distress: Early release of estimates from the National Health Interview Survey, 2012–September 2015.

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Mental Health (MH): The Access Problem (2/2)

Question: What are the barriers to patients accessing specialty MH?

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Obstacles to MH Access: Systems and Patient Factors 1/2

- Long waitlists, due at least in part to:
  - Lengthy visits (typically one hour)
  - Extended follow-up
- Limits on MHP's scope of practice
  - Restrictions on ages seen
  - Restrictions on type of problem seen
- Patient's lack of resources
  - Insurance/Financial limitations (many MHPs are cash-only)
  - Patient lacks time for ongoing, frequent visits
  - Lacks accommodations for visits (e.g., childcare, transportation)
- Lack of diversity in the MHP workforce
- Stigma

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Obstacles to MH Access: Systems and Patient Factors [1,2]

- Better familiarity, comfort with primary care
  - Primary care in general is familiar to most people (MH is not)
  - Patients may also be familiar with a specific clinic, staff
- Uneven geographic distribution of MHPs (mostly urban, coastal)
- Patient views problem as "physical" (low health literacy)
  - Stress may produce physical symptoms that prompt a PCP (rather than MH) visit
  - Patients may resist MH referral for perceived physical problem

Takeaway: minimizing these barriers is key to the success of integration

1. Cunningham, P. J. (2009). Beyond parity: Primary care physicians' perspectives on access to mental health care. *Health Affairs, 28*, 490–501.
2. Mojtabai, R., Olfson, M., Sampson, N.A., Jin, R., Druss, B., et al. (2011). Barriers to mental health treatment: Results from the National Comorbidity Survey Replication (NCS-R). Psychological Medicine, 41(8), 1751-61.

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The Frequent Intersection of Health and Behavior (1/2)

- Outside of psychiatric conditions, behavior factors into primary care visits in many other ways
  - Chronic disease management
    - Diabetes, hypertension, COPD, heart disease, etc.
    - PCPs assist patients with lifestyle changes
  - Somatic complaints with lifestyle/stress component
    - Chronic pain, obesity, chronic fatigue, headaches, etc.
    - PCPs assist with lifestyle change and counseling for stress
  - Psychosocial problems
    - Marital problems, IPV, child behavior problems, grief, etc.
    - PCPs counsel patients, connect them with resources

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The Frequent Intersection of Health and Behavior (2/2)

- Outside of psychiatric conditions, behavior factors into primary care visits in many other ways (cont'd)
  - Preventive health
    - Tobacco cessation, diet/exercise change, safe sex practices, etc.
    - PCPs educate, assist patients regarding preventive lifestyle change
  - Treatment non-adherence
    - Incorrect use of medications, lack of follow-through on referrals, etc.
    - PCPs educate, problem-solve with patients to improve adherence

Takeaway: Integrated care must help with more than psychiatric conditions

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The Financial Cost of MH Problems

- MH conditions can be costly to the system
  - Patients with psychosocial problems utilize more medical services [1]
  - Among patients with co-morbid physical and MH conditions:
    - Total healthcare cost is 2-3 times higher than those with only a physical condition (see next slide)
    - The most costly 6% of these account for 44% of <u>all</u> healthcare costs [2]
    - Yet only a small percentage of healthcare costs in these patients is MH care – almost all costs are medical care [2]
- Integrated primary care may reduce costs by 9-17% [2]

Takeaway: Improving identification, treatment of MH problems may reduce costs

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1. Simon, G., Von Korff, M., Barlow, W. (1995). Health care costs associated with depressive and anxiety disorders in primary care. *Archives of General Psychiatry, 52*, 850-856.
2. Melek, S. et al. (2018). Potential economic impact of integrated medical-behavioral healthcare. Milliman Research Report.

The Financial Cost of Psychiatric Co-Morbidity [1]

Diagnosis	Annual Cost w/o Psych	Annual Cost w/ Psych	Cost Increase
Asthma	$ 6,828	$ 16,668	+ 244%
Back Pain	$ 19,488	$ 24,740	+ 147%
Cancer	$ 16,320	$ 28,056	+ 172%
CHF	$ 15,288	$ 23,940	+ 157%
COPD	$ 11,904	$ 25,056	+ 210%
DM (uncomp)	$ 9,732	$ 16,236	+ 167%
DM (w/ comp)	$ 21,852	$ 32,172	+ 147%
HTN	$ 8,256	$ 13,884	+ 168%

19 1. Melek, Stephen P, et al. (April 2014). Economic Impact of Integrated Medical-Behavioral Healthcare. Milliman American Psychiatric Association Report.

Primary Care Takes a Team

- The work of a PCP has become too involved for one person
  - 10 or 15 minutes per visit is common
  - On average, patients have 3 complaints per visit [1]
  - Insufficient training in behavioral interventions [2, 3]
  - Over 3 dozen urgent but unpaid tasks everyday [4]
  - Insufficient time for completing all recommended preventive [5] and chronic care [6]
  - No clear organic etiology to many presenting complaints [7]
- There is a shortage of PCPs nationally [9]

Takeaway: Integrated care must involve a team approach that subtracts from the PCP workload and improves the team's behavior change skills

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To Recap…

- Integration is occurring because:
  - High volume of care-seekers
  - Frequent intersection of behavior/health
  - Economics
  - Primary care's need for help

The How

The Structure of Integrated Care

Integrated Care Emerges

- The move to integrate behavioral health services into primary care emerged synergistically with related movements
  - The Patient-Centered Medical Home (PCMH) was first proposed in 2002 as a means of transforming primary care [1]
  - In 2008, the Triple Aim laid out goals for improving the US healthcare system [2]
  - In 2014, the Quadruple Aim expanded the goals of the Triple Aim [3]
  - In 2022, the Quintuple Aim was proposed [4]
- These movements, and the realities outlined in earlier slides, led to the emergence of integrated care. Let's take a closer look these movements…

1. American Academy of Pediatrics. (2002). The medical home: Medical home initiatives for children with special needs project advisory committee [policy statement]. *Pediatrics, 110*, 184–186.
2. Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The triple aim: Care, health, and cost. *Health Affairs, 27*, 759–769.
3. Bodenheimer, T., & Sinsky, C. (2014). From triple to quadruple aim: Care of the patient requires care of the provider. *Annals of Family Medicine, 12*, 573–576.
4. Nundy, S., Cooper, L.A. & Mate, K.S. (2022). The Quintuple Aim for health care improvement. *JAMA, 327(6),* 521-22.

Question: What is primary care?

Defining Primary Care (1996)

Primary care is defined as: "…**integrated, accessible** health care services provided by clinicians who are **accountable** for addressing a large
majority of health care needs, developing **sustained partnership** with patients, and practicing in the **context of family and community.**" [1]

1. Institute of Medicine (1994). Defining Primary Care: An Interim Report. National Academy Press: Washington, DC.

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Defining Primary Care (1996)

- A closer look at the definition
  - **Integrated**: takes a holistic view of health and health care
  - **Accessible**: as the front-line resource for health care, access is critical
  - **Accountable**: coordinates, facilitates the care of specialists and others
  - **Majority of health care needs**: generalists providing birth-to-death care
  - **Sustained partnership**: collaborative approach to care often lasting years
  - **Context of family and community:** aims to understand the context of patients' lives and operates accordingly
- Primary care is unique in the healthcare system. No other part of healthcare has the same goals, functions and attributes

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Defining Primary Care (2021)

High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams that are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.

National Academies of Sciences, Engineering, and Medicine (2021). *Implementing high-quality primary care: Rebuilding the foundation of health care*. Washington, DC: The National Academies Press. https://doi. org/10.17226/25983.

The 4 C's of Primary Care

Primary care can also be summarized with the 4 C's:

- **C**omprehensive care (generalist care for both prevention and treatment)
- first **C**ontact of care (entry point to care)
- **C**oordination of care (coordinates and integrates specialty care)
- **C**ontinuity of care (longitudinal care, built on a strong patient-provider relationship)

Primary Care Services

- Preventive health care
  - Physicals visits (well-child, adult, Medicare Annual Wellness Visit)
  - Procedures (e.g, pap smears, immunizations)
- Front line for acute care
- Chronic disease management (e.g., diabetes, hypertension, COPD, asthma, heart disease, depression/anxiety, obesity)
- Provide a "medical home"
- Settings
  - Clinic, hospital, ED, nursing home, assisted living, in-home visits
  - Vast majority work in a single clinic setting [1]

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1. Petterson, S., McNellis, R., Klink, K., Meyers, D., Bazemore, A. (2018). The State of Primary Care in the United States: A Chartbook of Facts and Statistics. Accessed 1/15/2021 at https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/PrimaryCareChartbook.pdf

The Patient-Centered Medical Home (PCMH): Definition

- The "Patient-Centered Medical Home" (PCMH) transforms primary care in various ways [1]
  - Team-based model of service delivery
  - Utilizes registries to track care of certain populations
  - Takes a holistic approach to care
  - Emphasizes self-management of health
  - Optimizes data to track disease outcomes and care quality
  - Uses care coordinators to help navigate and integrate specialty care
  - Encourages payment based on improved outcomes, decreased costs
- Shifts care from a reactive mode (best for acute problems) to proactive, coordinated care (better for chronic and preventive care)

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1. McDaniel, S. H., & deGruy, F. V. (2014). An introduction to primary care and psychology. *American Psychologist, 69,* 325–331.

The Patient-Centered Medical Home (PCMH): Goals

The "Quintuple Aim" is the North Star of the PCMH

The goal is to optimize primary care to meet the Quintuple Aim

Integrated Care Approaches

Integrated Care Approaches

- Beginning in the 1990s, various approaches developed for integrating behavioral health into primary care
  - Co-Located Therapy
  - Primary Care Behavioral Health model (PCBH)
  - Population-specific approaches
    - Collaborative Care model (CoCM)
    - Medication-Assisted Treatment (MAT)
    - Screening Brief Intervention and Referral to Treatment (SBIRT)
- Let's explore some of these in a bit more detail on the subsequent slides

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Question: What is a co-located therapy approach?

Integrated Care Approaches: Co-Located Therapy

- Background
  - Representative of early integration efforts (though some systems still utilize this approach)
  - Overview: this is specialty mental health provided in primary care
- Advantages
  - Increased opportunities for PCP and MH collaboration
  - Increased access to MH care
- Limitations
  - Similar to those of regular specialty care
  - For example - poor access, limited MH provider scope, limited coordination of care with PCP, etc.

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Question: What is the Collaborative Care Model?

Integrated Care Approaches: Collaborative Care Model (CoCM)

- Background
  - Focused on specific populations (typically anxiety, depression)
  - Uses a registry to track care
  - "Care coordinator/manager" delivers brief phone-based behavioral interventions, psychiatric prescriber provides oversight
  - Patients are "treated to target" using standardized tools
  - This is the second of two approaches used in the DoD
- Advantage: Follow-up tracking helps keep patients engaged in care
- Limitations:
  - Limited capacity (i.e., the lengthy follow-up typically required for treating to target results in limits on the number of patients followed)
  - Limited scope (i.e., only used with a few select conditions)

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Integrated Care Approaches: Other Approaches

- Medication-Assisted Treatment (MAT)
  - Goal: treat opioid use disorder in primary care using suboxone
  - Overview: PCPs with specialized training provide structured care
- Screening Brief Intervention and Referral to Treatment (SBIRT)
  - Goal: prevent risky substance use from becoming problematic
  - Overview: universal screening for risky substance use, followed by brief behavioral interventions by a trained PCP (or other) for patients who screen positive
- Many clinics integrate care idiosyncratically, using no clear model or an approximation of a recognized model

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Question: How would you describe the PCBH model?

Integrated Care Approaches: Primary Care Behavioral Health (PCBH)

- Background
  - Overview: Team-based primary care approach to managing behavioral health conditions. Adds a "BHC" to the team
  - Goal: Enhance the primary care team's ability to manage and treat such conditions, with resulting improvements in primary care for the entire population
  - This is the model you are utilizing
- Advantages: Goals and practices promote an easy fit with primary care
- Limitations: No systematic tracking means patients can be lost to follow-up

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In Sum…

- Primary care has a unique role to play in the healthcare system, and engages in unique ways with patients
- The role of behavior in health is ubiquitous, and primary care needs help addressing the behavior change needs of patients
- Primary care is transitioning to team-based care (the "Patient-Centered Medical Home") to meet the goals of the Quintuple Aim
- Different approaches have been used to integrate behavioral health providers into primary care teams

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The PCBH model

The *How*? The PCBH Model

- Why focus on improving primary care broadly?
  - Primary care has high value if done well
    - Better health outcomes
    - Fewer healthcare disparities
    - Lower healthcare costs
  - But…behavioral issues of patients hinder primary care
    - Longer visits
    - High stress
    - This negatively affects care for all

Thus, improving management of behavioral issues in primary care is key to helping primary care realize it's potential – for all

The *How*? The PCBH Model

How can a BHC help primary care broadly?

- See patients before the PCP (reduce PCP visit time)
  - Or assist during the visit
- See patients instead of the PCP (improve access)
- Complete certain activities such as anticipatory guidance, cognitive screens (improve PCP efficiency)
- Assist with miscellaneous care needs (reduce PCP stress)
- Co-lead group medical visits (improve PCP productivity)
- Help develop metrics to track disparities (ensure health equity)

Remember the Quintuple Aim!

Question: What is GATHER and what does it stand for?

The *How*? The PCBH Model

Components (GATHER)

- Generalist
- Accessible
- Team-based
- High productivity
- Educator
- Routine

Clinical structure

- 30-minute visits
- Consultant follow-up

Question: What are the differences between a "consultant" and a "therapist"?

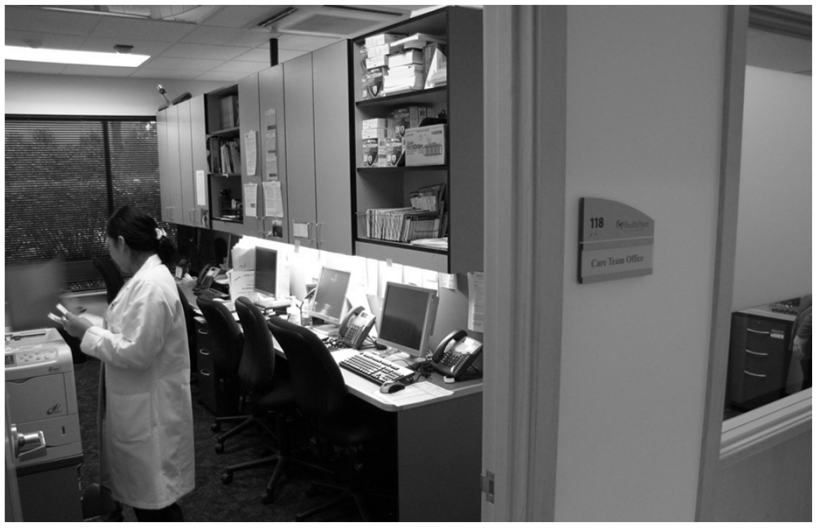
The Behavioral Health Consultant (BHC)

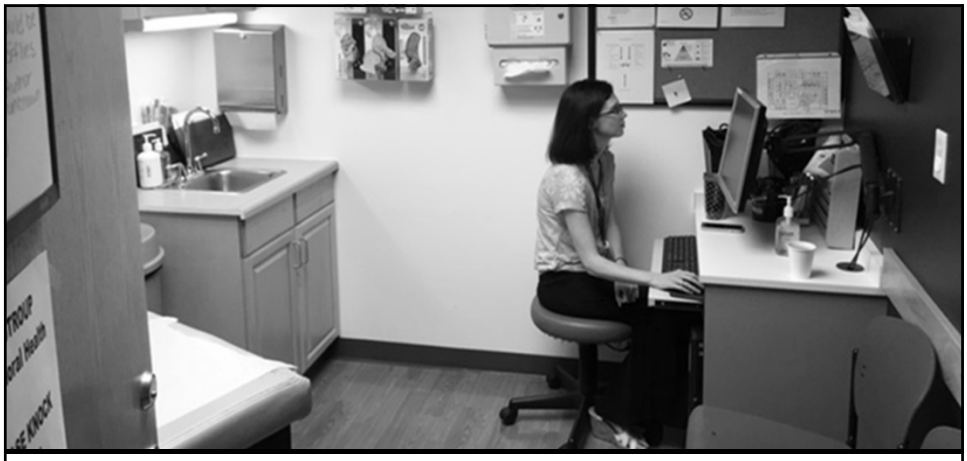
Dimension	*BHC*	*Therapist*
Primary consumer	PCP	Patient/Client
Care context	Team-based	Autonomous
Accessibility	On-demand	Scheduled
Ownership of care	PCP	Therapist
Referral generation	Results-based	Independent of outcome
Productivity	High	Low
Problem scope	Wide	Narrow/Specialized
Termination of care	Patient progressing twd goals, has plan	Patient has met goals

PCBH Model Nuts and Bolts

Location Option #1 (Optimal)

Shared Exam Room + Separate Workstation





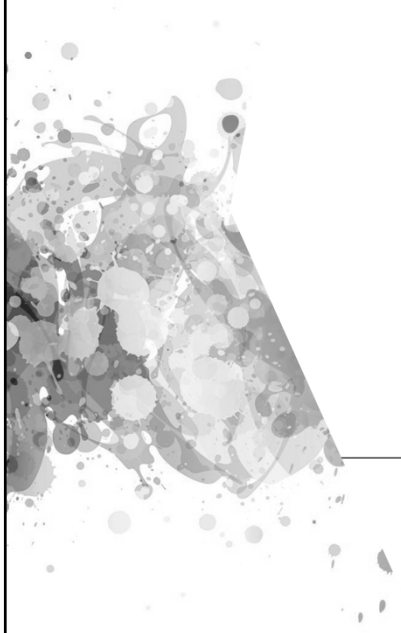
Location Option #2

Dedicated Exam Room

Location Option #3

Dedicated Office Space

Warm-Handoff Video



Day in the Life of a BHC

The BHC's Template

- ** Note the proportion of FTR vs 24HR slots varies based on many factors such as BHC experience level*
- ** Note also that start/stop times of visits may not match the schedule*

Time	Appt Type*	Time	Appt Type*
9:00	FTR	1:00	FTR
9:30	FTR	1:30	FTR
10:00	FTR	2:00	FTR
10:30	24HR	2:30	24HR
11:00	FTR	3:00	FTR
11:30	FTR	3:30	FTR
12:00	Lunch	4:00	FTR
12:30	Lunch	4:30	FTR

Sample Clinic Day: What to Look For

Timing of BHC visit *

- Before, after and with PCP
- Mix of scheduled and same-day visits

Variety of problems and ages

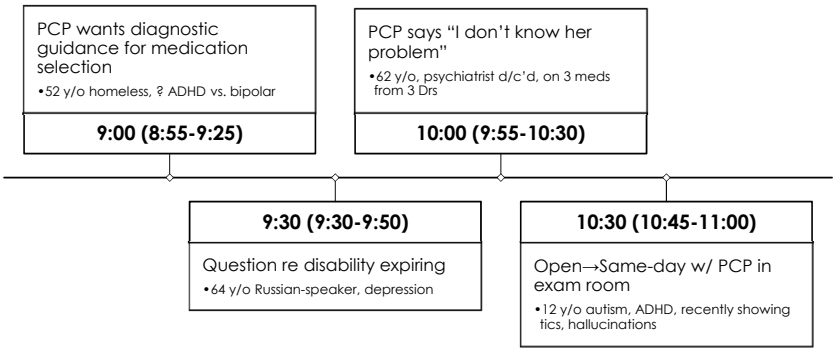
- Clinical ("mental" and "physical" conditions, all ages)
- Care management/coordination

Variety in the goals of visits

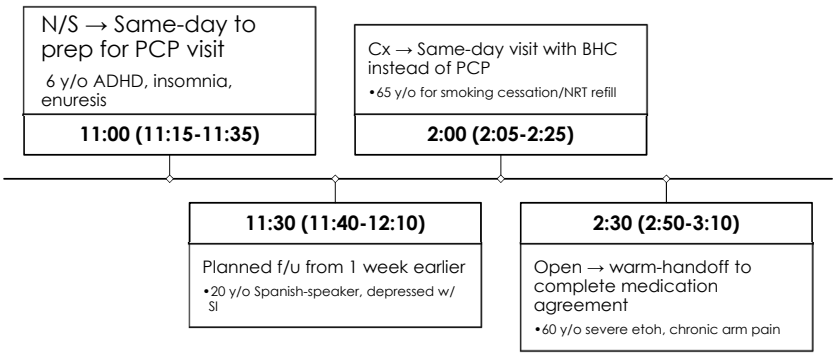
- Helping manage the patient
- Helping treat the patient

* Note the flexible visit length and start/stop times for visits

Sample Clinic Day

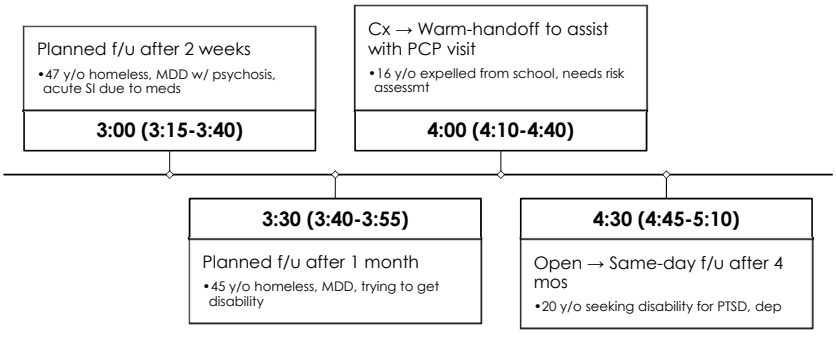


Sample Clinic Day (cont'd)



- 12:00 Lunch
- 1:00 Team meeting (15-min talk on pain, 5-min on tobacco cessation)

Sample Clinic Day (cont'd)



Making It Work:

The Sinkholes and The Trampolines

Reiter's Top 10 Sinkholes and Trampolines

Sinkholes

1. Isolated location
2. Passive approach
3. Triage and refer
4. Inefficient warm handoffs
5. Meet-and-greets

Trampolines

1. Be central and visible
2. Do today's work today
3. Believe in primary care
4. Limit PCP and room time
5. Be flexible with visit length

Reiter's Top 10 Sinkholes and Trampolines

Sinkholes

6. Over-emphasize BHC interventions
7. Limit problem scope
8. Emphasize time (more=better)
9. Treat "diseases"
10. Have low expectations for BHC ("nicety")

Trampolines

6. Emphasize ways to help the PCP/team
7. Be a generalist (learn)
8. Emphasize access
9. Teach skills
10. Have high expectations for BHC ("necessity")

Team-based care Strategies

Team-Based Care Rationale

- PCPs will always see more patients than BHCs
- Remember the Quintuple Aim
  - Improved health outcomes
  - Improved patient experience
  - Lower health costs
  - Improved health equity
  - Improved provider experience
- Improving the efficiency and effectiveness of the PCP and team will fulfill the Quintuple Aim

Sample Team-Based Care Targets

- Improved PCP access
- Increased PCP visit time
- Decreased PCP and team stress
- Decreased PCP turnover
- Increased PCP job satisfaction
- Improved PCP and team confidence for working with behavioral issues
- Increased PCP and team skill for working with behavioral issues
- Improved PCP and team perceived support for working with behavioral issues
- Increased clinic revenue
- Improved quality metrics for the clinic
- Improved patient satisfaction

PCBH Teamwork Example (1/5)

A BHC learned how to provide preventive education (aka "anticipatory guidance") during well-child checks, then received regular warm handoffs to complete this when PCPs were running behind. This resulted in patients receiving more anticipatory guidance than the PCP typically had time to provide, and allowed the PCP to have more time with other patients.

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PCBH Teamwork Example
(2/5)

A PCP was running late to see a man presenting for depression, so her MA (with the PCP's permission) engaged the BHC to see the patient first while the PCP met with a different patient. The BHC completed a visit and communicated pertinent history, impressions and recommendations to the PCP. The PCP was then able to complete her visit for the patient with depression efficiently to run on time for later patients.

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PCBH Teamwork Example (3/5)

A patient with PTSD asked his PCP (during a visit for a diabetes check) to complete paperwork to help him get disability for the PTSD. The paperwork involved 8 pages of questions for the provider, who was already running behind on his schedule for the day. The PCP paged the BHC for a warm handoff, the goal being to have the BHC complete the disability paperwork. When the PCP visit was finished, the BHC saw the patient. She completed adequate assessment to enable her to complete the paperwork; then she and the PCP co-signed the paperwork. The patient left satisfied and the PCP was able to save time that they spent with the next patient.

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PCBH Teamwork Example (4/5)

A PCP was called by a teenage patient's school who wanted to discuss some behavioral concerns the patient was having. The PCP was willing to call but had a very busy day, so she asked the BHC to call instead. The BHC was able to talk with the teacher to hear the concerns, and then worked with schedulers to get the patient back-to-back appointments with the BHC and PCP on the same day. The BHC also sent the school a Vanderbilt screener to complete in advance of the visit.

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PCBH Teamwork Example (5/5)

A patient presented with a new behavioral concern. The PCP gathered initial history then paused the visit for a warm introduction to the BHC. The PCP then proceeded to his next patient while the BHC conducted a visit with the handoff patient. The BHC then reconnected with the PCP to discuss impressions and a plan, after which the PCP completed the visit with the handoff patient. This process enabled good teamwork and allowed the PCP to remain generally on time for his other patients.

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Most Important ….Keep the Focus

Remember the goal of making primary care better

- (for everyone)

Think like a primary care team member

- Population goals

Small-Group Discussion

Discuss your group's questions separately then we'll reconvene

Help me supervise… we'll come back to these later for your advice

BREAKOUT GROUP #1

1. "This patient is not really appropriate for primary care. He needs specialty mental health."
2. "It's unethical for me to ask details about his sexual abuse trauma when all I have is 30 minutes."
3. "I don't have much experience with eating disorders so I don't see those patients."
4. "I wish the PCPs would stop asking me to help write all these letters for patients, I'm not a case manager!"
5. "Our patients can't access specialty mental health, so parts of our BHCs' schedules are blocked for therapy."

Help me provide supervision… we'll come back to these later for your advice

BREAKOUT GROUP #2

6. "I mostly do breathing or a handout during the first visit, then we'll get into more complex stuff at follow-up."
7. "I give as many interventions as I can in the first visit, in case they don't show for follow-up."
8. "My PCPs interrupt me for handoffs, but I wish they wouldn't; it's so bad for building rapport with my patients."
9. "My new patient reported a lot of relationship problems, so I recommended couples therapy at a nearby agency."
10. "We're doing education with our PCPs about what kinds of referrals are (in)appropriate for a BHC."

Help me provide supervision… we'll come back to these later for your advice

WHOLE GROUP

11. "I got a warm handoff, but the patient only had 10 minutes, so I suggested she come back next week instead."
12. "I have a hard time terminating with patients who I know have so much ongoing stress."
13. "30 minutes just isn't enough time for patients to develop a rapport and feel heard."
14. "My patient is super depressed so I promised him that his PCP will get him onto meds that will help."
15. "These provider meetings in primary care are so boring. None of it has anything to do with a BHC's work."

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- ADDITIONAL QUESTIONS?
- THANK YOU and ENJOY THE REST OF YOUR YEAR!