NPTC – Great Lakes Region: Welcome to Integrated Behavioral Health in Primary Care

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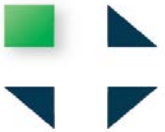
Agenda

- Lots to do today!
- Introductions
  - To us and you
- Overview of the history of integrated behavioral health into primary care
- Introduction to integrated IBH: The Primary Care Behavioral Health (PCBH) model
- Break for lunch
- Overview of our internship/fellowship
- Break out groups
  - What are your goals for internship?
  - How do you see the interns being utilized?
  - What are your next steps to be successful?
- Large group discussion
- How we can help?
- Questions/comments

Objectives

1. Attendees will be able to identify and describe the philosophy of primary care/population-based health and how this differs from traditional specialty mental health centers.
2. Attendees will be able to describe how and why primary care is the de facto mental health system in the US.
3. Attendees will be able to identify the core features of HRSA's Level 5 and 6 of integrated care.
4. Attendees will be able to identify the core features of the Primary Care Behavioral Health model, including the GATHER acronym and the Trident Approach.
5. Attendees will be able describe a PCBH "clinic" in action, particularly metrics utilized to distinguish fidelity to the PCBH.
6. Attendees will be able to describe core tenets an integrated care internship, including program objectives/goals, onboarding process of interns, experiences for interns, and the supervision process.
7. Attendees will be able to formulate and articulate specific goals related to their own training programs in integrated care.



Who we are

- Bridget Beachy, PsyD
  - Director of Behavioral Health for Community Health of Central Washington
  - **Roles include:** PCBH clinical, admin, and faculty for FM residency residents and psych interns
- David Bauman, PsyD
  - Behavioral Health Education Director for Central Washington Family Medicine
  - **Roles include:** PCBH clinical, core faculty for FM residency, RTD of PCBH psychology internship
- We both live and breathe PCBH and contextual approaches (e.g., Acceptance and Commitment Therapy)

Who you are:

- Name?
- Where are you located?
- What are your roles?
- Background/interest in integrated care?
- What are you hoping to glean from today?

Before we go on…#ourwhy

- Our *why*…*seeing patients that otherwise we'd never see…*

…we care just as much about the patients we don't see as the ones we do…

Also before we go on…

- We may say some things today that challenge assumptions
  - That's okay!
  - We are contextual people and are coming from a specific context
  - Let's talk it out today…
  - …we are with you

Where did integration come from?

- Why are we starting to integrate BH into PC, from your perspective?

Where did integration come from?

- About 40 years ago…the biopsychosocial model was introduced to medicine
- Where do patients go for the MH care? (Wang et al., 2005)
  - 20% – SMH
  - 21% – PC
  - *59% No treatment*
  - HOWEVER (NHSC, 2012) …
    - 80 – 95% (kiddos) go to PC

Why do we need BHPs in Primary care?

- **80%** of individuals w/BH disorders will visit PCP >1 time in calendar year (Narrow et al., 1993)
- **48%** of the appointments for all psychotropic agents are with a non-psychiatric primary care provider(Pincus et al., 1998)
- **84%** common physical complaints have no identifiable organic etiology(Kroenke et al., 1989)

45% of patients who commit suicide have contact w/ their PCP in the past month, 2x's that of SMH provider(Schreiber & Culpepper, 2016)

Chronic health conditions

- Let's make a list, what are the most common chronic conditions in primary care?

Chronic health conditions

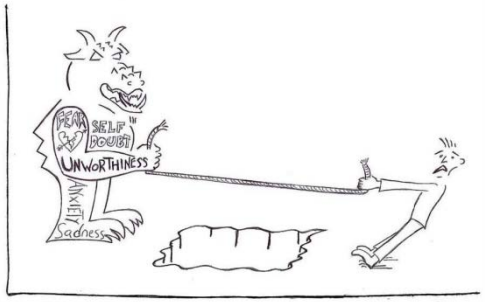
- Chronic health conditions?
  - Diabetes
  - CVD
    - Hypertension
  - Chronic pain
  - Obesity
  - Smoking status
  - Headaches
  - Sleep concerns
  - Etc.
    - What do all of these things have in common?
    - How does MH play a role with these conditions?

Why integrate BH into PC?

- Primary care providers cannot do it alone (Mechanic et al., 2001; Beasley et al., 2004; Baron, 2010; Yarnal et al., 2003)
  - 10 or 15 minutes per visit
  - 3 complaints on average/visit
  - Often unsure or low confidence on how to deliver EBT bx interventions
  - Over 3 dozen urgent but unpaid tasks everyday
  - Need 7.3 hrs/day to implement all USPSTF and related recommendations
  - Need 10 hrs/day to implement chronic care recommendations
  - Overworked, underpaid—stressed!

Why not just refer? (Friedman et al., 1995)

- Why not just refer to SMH?
  - 6-10% of population goes to SMH[9]
  - 20% of referred patients follow-through
- Why don't people go to specialty MH?
  - Lack of insurance
  - Stigma
  - View their problem as "physical"
  - Inconvenience (including long waitlists)
  - Better familiarity, comfort with PCP
  - Prior negative experiences



Well, the solution is EASY, just integrate MH providers into PC… well, maybe not that easy

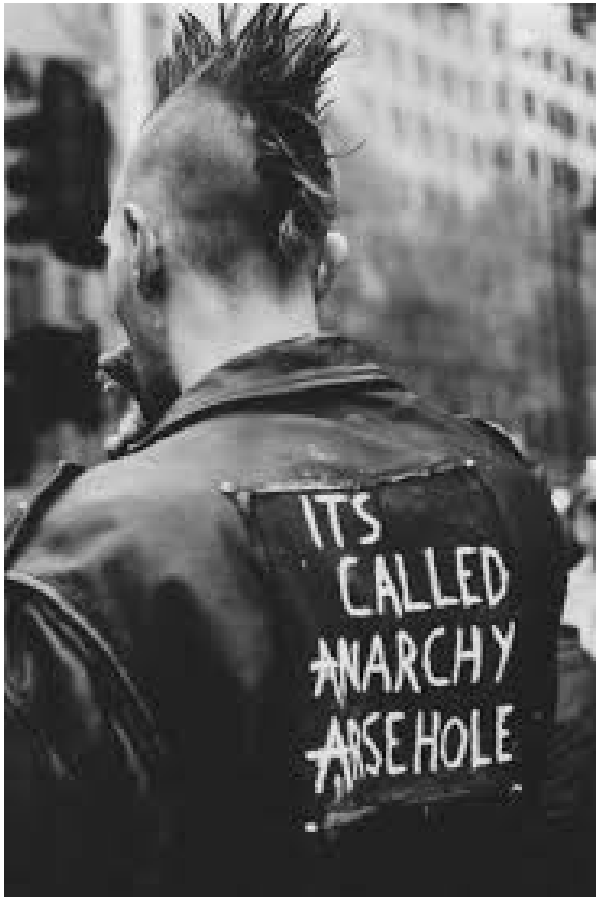
Need to *be different*

- From what you know about MH interventions:
  - How long are typical visits?
  - How frequently do patients meet with providers?
  - For how many visits do providers typically meet with patients?
  - Would that work in PC?
- *So, just taking our SMH approach to PC is not the answer… we not only need to BE in PC but we need to change HOW we practice*

Let’s take a break

- 15 minutes

Comments and thoughts from what we have discussed?



Models/philosophy of integrated care

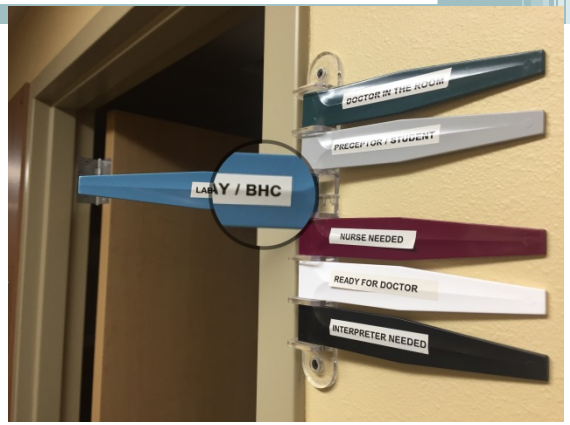
- Let's review:
  - MH concerns prevalent in PC
    - People often seek out treatment at PC offices
  - Chronic conditions, rooted in lifestyle factors, plague the PC system
  - PCPs are overburden
  - Taking our SMH system into PC creates the same access issues that SMH has

HRSA's Six Levels of Integration

Six Levels of Collaboration/Integration (SAMHSA-HRSA)

Coordinated Key Element: Communication		Co-Located Key Element: Physical Proximity		Integrated Key Element: Practice Change	
Level 1 Minimal Collaboration	**Level 2 Basic Collaboration at a Distance**	**Level 3 Basic Collaboration Onsite**	**Level 4 Close Collaboration with Some System Integration**	**Level 5 Close Collaboration Approaching an Integrated Practice**	**Level 6 Full Collaboration in a Merged Integrated Practice**
Behavioral health, primary care and other health care providers provide care:					
Separate systems; Communicate rarely; Have limited understanding of roles.	Separate systems; Communicate periodically; Appreciate each others roles.	Separate systems; Communicate regularly; Collaborate; Part of informal team.	Share some systems; Communicate in-person; Collaborate; Have basic understanding of roles/culture.	Seek system solutions; Communicate frequently in-person; Collaborate frequently; Have in-depth understanding of roles/culture.	Function as one integrated system; Communicate at system, team, individual levels; Collaborate driven by shared concept of team care; Blended roles/cultures.

Our model of care:



- The Primary Care Behavioral Health model
  - Of course we think it's the best, we wouldn't be operating in this manner if it didn't
    - Doesn't mean you have to do EVERYTHING that we do
- Developed in mid to late 90's
  - Seminal books, reading suggestions:
    - Robinson, P., & Reiter, J. (2016). *Behavioral consultation and primary care: A guide to integrating services* (2nd ed.). Springer: New York.
    - Hunter, C. L., Goodie, J. L., Oordt, M. S., & Dobmeyer, A. C. (2016). *Integrated behavioral health in primary care: Step-by-step guidance for assessment and intervention* (2nd ed). American Psychological Association: Washington, D.C.
    - Reiter, J. T., Dobmeyer, A. C., & Hunter, C. L. (2018). The Primary Care Behavioral Health (PCBH) Model: An Overview and Operational Definition. *Journal of Clinical Psychology in Medical Settings*, 1–18. https://doi.org/10.1007/s10880-017-9531-x

PCBH Philosophy: *Be Different*

- Consultant model
- Member of primary care team, work side-by-side
- Goal is to improve PCP mgmt of behavioral issues
  - Wide variety of interventions and goals
  - Brief visits, limited follow-up
  - Immediate feedback to PCP
  - Any behaviorally-based problem, any age
- Aim for immediate access, minimal barriers
- Rooted in population health principles

Primary Care Behavioral Health (PCBH) Model

(Robinson & Reiter, 2016)

Philosophy & Setting	• Team-based, population based health approach • Improve efficacy & efficiency of primary care • Share pods, office centrally located, exam rooms • Routine part of care
Behavioral Health Consultants (BHCs)	• Doctoral level psychologists • LCSWs, MHCs, LMFTs and other master's level clinicians
BHCs' Interventions	• Functional improvement vs symptom reduction • CBT, ACT & SFBT; Psychoeducation & coping skills
BHCs' Qualities	• Accessible (on demand, warm handoffs) • Generalist (sees all patients) • Highly productive (average 8-10 pts per day) • Educator (provide formal & informal training)
Nature of Visits	• < 30 minutes • Episodic care • 10-15% long term

GATHER Approach to PCBH

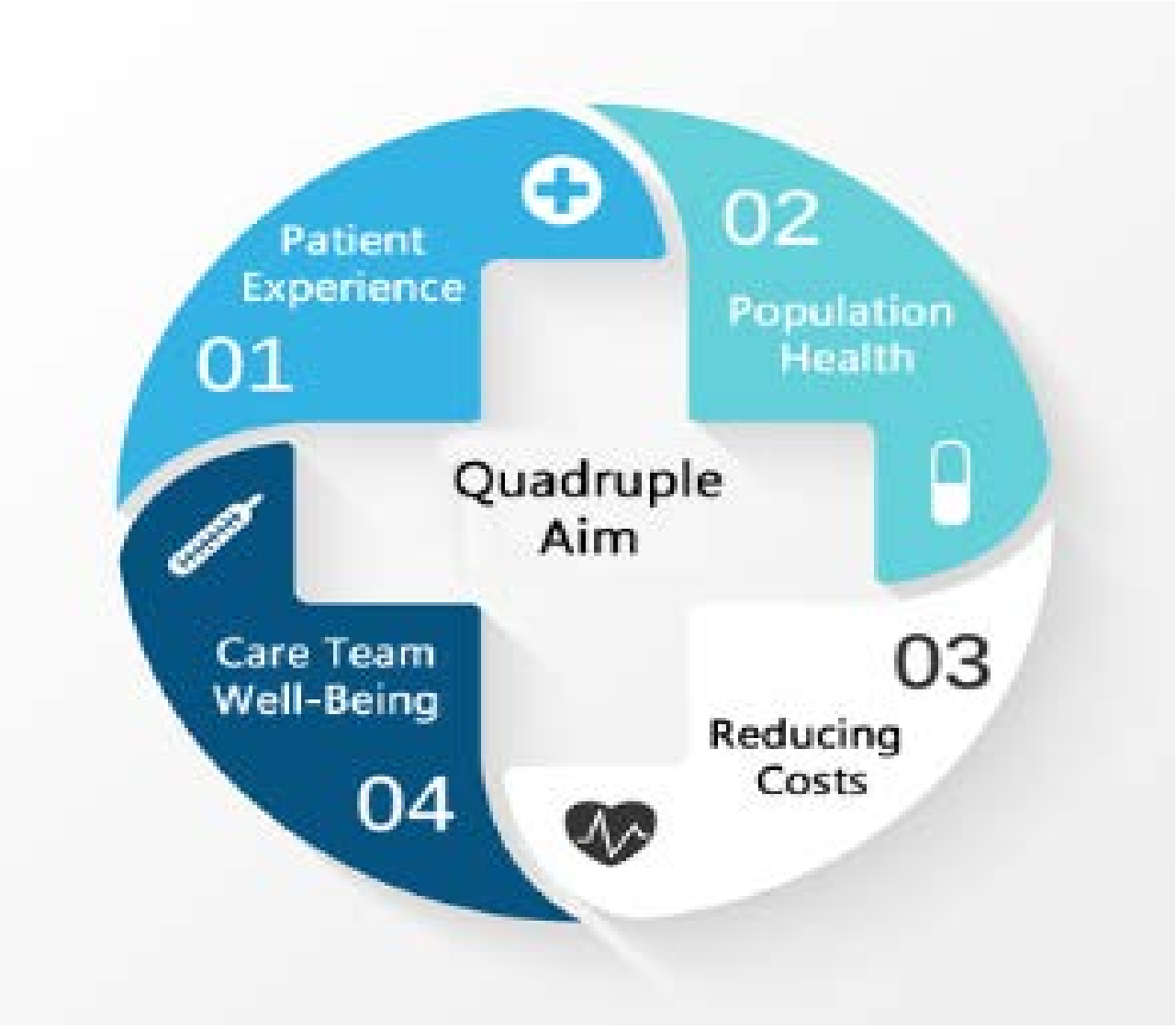
- G – Generalist
- A – Access
- T – Team based
- H – High productivity
- E – Educator
- R – Routine

PCBH: Trident Approach

Direct Clinical Services	• Provide brief, evidence-based interventions during patient visits
	  • ≤ 30 min, limited follow-up
	  • Flexible
	  • Improving quality of life vs. symptom reduction
	• Develop group interventions that utilize multiple professionals
	• Transdiagnostic approaches

BHC Presence/ Training	• Give presentations at meetings • Distribute educational flyers • Clinical pathways incorporating the BHC • Develop shared treatment plans containing straightforward behavioral interventions
Supporting PC System	• Follow-up with patients instead of PCPs • See patients before PCP to help • Take over care during a PCP visit so PCP can move to next patient • Phone visits for behavioral issues • Review outside mental health records and brief PCPs

PCBH Philosophy: *Research*



Summary of Patient Outcomes

- Patients receiving 2-4 visits show broad improvement in symptoms, functioning, well-being (3-7, 9-11, 13-18, 33)
- Improvements seen in both mild and severe presentations (7)
  - More severely impaired may improve faster
- Changes are stable at 2 years (16,17)
- Improved adherence to evidence-based depression guidelines (12)
- More appropriate antidepressant prescribing (12, 28)
- Improved completion of anticipatory guidance in well-child checks (8)
- Improved detection (and treatment) of suicidal ideation (19)

Summary of Costs

- PCPs saw more patients, spent less time in visits, and collected more revenue on days when BHC is present (20)
- Large reductions in specialty mental health referral rate (27-29)
- More appropriate antidepressant prescribing (27-28)
- Rates of preventable inpatient utilization decreased significantly (no change in control) (21)
- Pediatricians spend more time in behavioral visits and get reimbursed less (relative to medical visits) (26) (not PCBH)

Summary of Patient Experience

- Patients report strong therapeutic alliance to BHC
- High patient satisfaction (5, 28, 34, 38, 30, 31)

Summary of Provider Experience

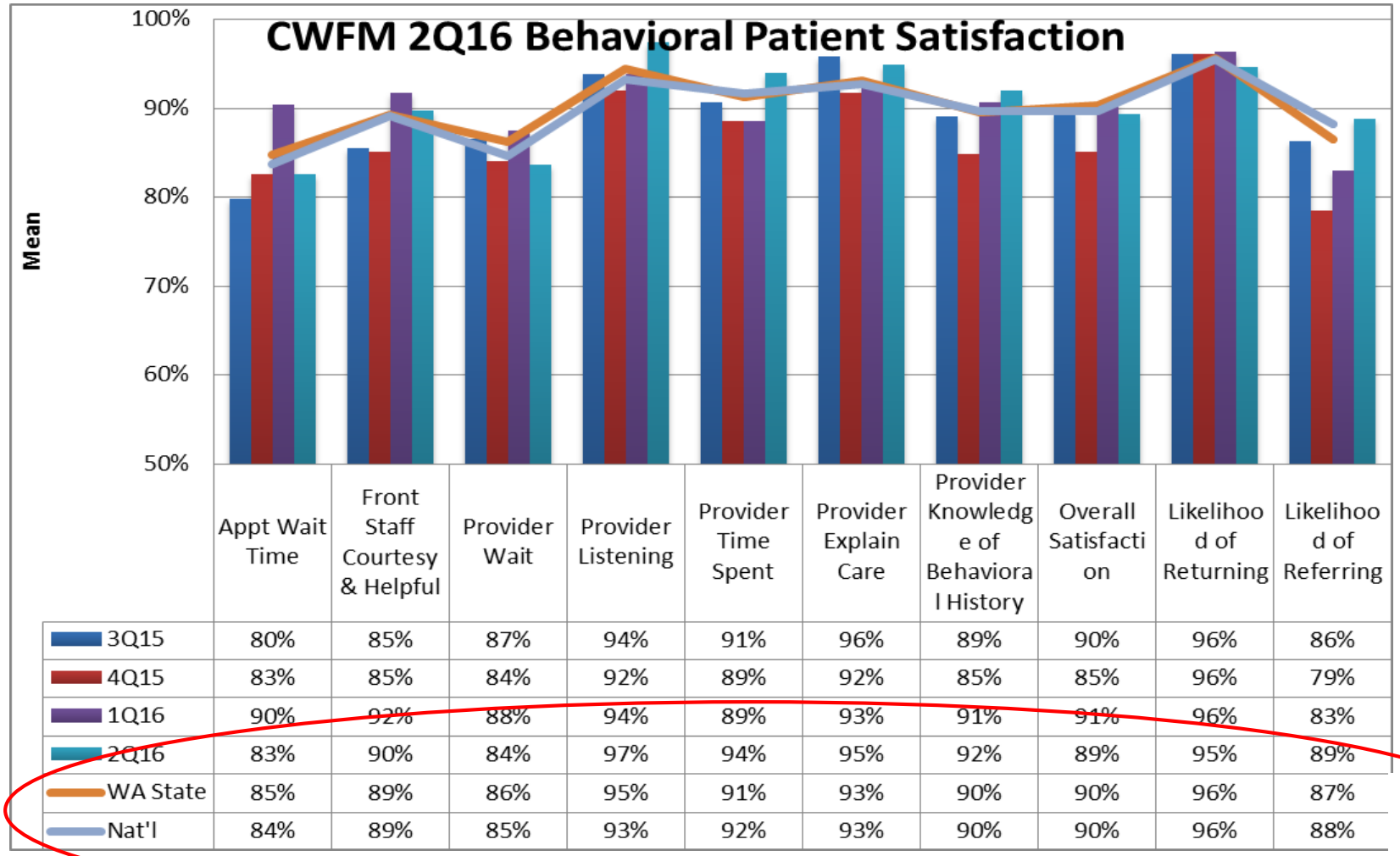
- Improved PCP identification of behavioral issues (27, 39)
- Improved PCP willingness to engage with behavioral issues (38)
- Improved PCP ability to provide care for physical and mental health needs (38, 39)
- High PCP satisfaction with service (27, 28, 30, 38)
- More inclined to apply for, or accept, a position if the clinic has BHC (37)
- Two fewer minutes spent in visits, and more patients seen, when BHC present (20)

PCBH in Action: Community Health of Central Washington

- CHCW
  - Serves 30,000 patients in Central Washington
  - Five primary care clinics
    - Eight full-time BHCs
    - Three trainees, two interns and a post-doc fellow*

Our data

- CHCW
  - 2017 data for 4.25 FTE BHC
    - *Patients/clinic = 4.1
    - *Initial visits = 45%
    - *Same day visits (WH or paired medical) = 51%
    - Penetration rate 15%
      - CWFM – 19%
    - *David's August visit/patient:
      - Average – 2.5
      - Mode – 1
      - Median – 1
      - 13% of visits greater than 6



	Appt Wait Time	Front Staff Courtesy & Helpful	Provider Wait	Provider Listening	Provider Time Spent	Provider Explain Care	Provider Knowledge of Behavioral History	Overall Satisfaction	Likelihood of Returning	Likelihood of Referring
3Q15	80%	85%	87%	94%	91%	96%	89%	90%	96%	86%
4Q15	83%	85%	84%	92%	89%	92%	85%	85%	96%	79%
1Q16	90%	92%	88%	94%	89%	93%	91%	91%	96%	83%
2Q16	83%	90%	84%	97%	94%	95%	92%	89%	95%	89%
WA State	85%	89%	86%	95%	91%	93%	90%	90%	96%	87%
Nat'l	84%	89%	85%	93%	92%	93%	90%	90%	96%	88%

Improved Clinician Experience: BHC Program Evaluation

- How often do you use a BHC:
  - Every or most days = 50%
- Overall Satisfaction w/BHC Services
  - **M=4.5**
    - Extremely/somewhat: 100%
- How helpful for your patients:
  - **M=4.6**
    - Extremely/somewhat: 100%

Improved Clinician Experience

- How helpful for you:
  - **M = 4.67**
    - Extremely or somewhat: 100%
- Patients are more compliant with medical recommendations:
  - **M = 3.54**
    - Stro. agree/agree: 58.34%

Improved Clinician Experience

- BHC makes job easier
  - **M = 4.5**
    - Stro. agree/agree: 92%

Break for lunch

Welcome back…

- How we doing?
  - Thoughts, comments, questions from the morning?
  - Anything that we should make sure we discuss this afternoon?

Overview of CHCW internship

Overview of CHCW internship

- Before they get here
  - How we advertise our internship
  - How we interview/recruit
- Onboarding process
- Clinical experiences
- Other experiences
- Supervision

Overview of CHCW internship

- Before they get here
  - How we advertise
    - Recruiting video: http://chcw.org/training-programs/
    - Integrated care list serves:
      - Collaborative Family Healthcare Association www.cfha.net
      - APA Division 38 (Health Psychology)
    - Schools that have integrated care tracks
  - How we interview
    - What we look for: http://chcw.org/training-programs/
    - Interview questions (Clinical questions, interpersonal questions, overall questions)

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

Overview of CHCW internship

- Onboarding process
  - Start with our family medicine residents - PAUSE
    - Complete majority of orientation month with them
    - Embedded and learn the medical culture
      - Lexicon:
        - Patient instead of client
        - Visit instead of session
        - Consultant/Provider/Team member instead of therapist/counselor
        - Consulting instead of staffing
        - Interventions instead of therapy
      - Shadow medical providers and entire team
        - Learn the culture and what it is like to work in primary c
          - Everyone should do this probably

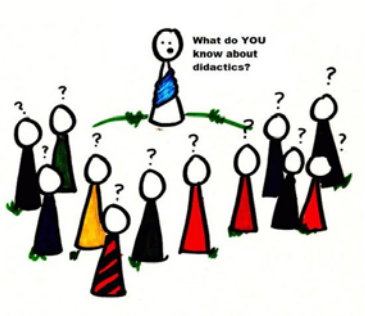
Overview of CHCW internship

- Onboarding process
  - Intentionally teach them:
    - How to introduce yourself to patients
    - How to consult with a medical provider
    - How to huddle and scrub provider's schedules
    - How to complete an initial brief visit
      - Intro →Contextual interview → Conceptualize → Intervention → Set goals
    - How to complete a follow up visit
      - Set agenda→ Assess previous goal completion → Topic(s) for discussion → Conceptualize→ Intervention → Set goals
    - How to concordant chart
    - …Every aspect

Overview of CHCW internship

- PCBH service delivery
  - Work as a BHC in primary care clinics
- Pairing with a medical provider
  - Act as provider own personal BHC
- Group activities
  - Chronic pain, wellness, teen group
- Teen health clinic

Overview of CHCW internship



- Other experiences
  - Scholarly project
    - QI project based on a clinical need →PDSA
  - Experiential didactics
    - Weekly:
      - Role-plays, didactic topics related to PCBH, philosophical discussions, mock supervision, group supervision, etc.
        - Often, portions with the FM residents

Supervision

- Amount based on APA requirements
  - Weekly supervision
    - Behaviorally focused
      - Set an agenda, first hour logistics, second hour cases
        - Discuss philosophy, **ethical and culture factors that arise**, etc.
  - Monthly shadowing
    - Not only with patients but working with providers
  - Precept
    - Encourage interns to call or text if unsure of what to do with a patient

Other suggested training

- Train entire PC team
  - PCPs, MAs, RNs, front desk staff, etc.
    - We have videos to help!
  - Need to train on:
    - Role of intern (not to be a social worker and connect resources)
      - What can they help with?
      - What can they not help with?
        - Shouldn't be a lot we can't help with, but, also shouldn't be receiving referrals for med management.
    - How to introduce
    - How to complete warm-handoff
    - Why they should be in the medical pods
    - Why they should see patients in an exam room or close by
- Have interns attend meetings/forums/parties/etc.
  - Reinforce positive behavior of the medical team!

Yeah… we probably need a break ☺

- 15 minutes

Break-out groups

- Topics to discuss:
  - How are you feeling?
    - What you are excited about?
    - What you are fearful about?
  - How have you changed your thoughts on how the interns could be utilized?
  - What seems doable?
    - Short-term goals
    - Long-term goals
  - What lingering questions are there still?
  - Who is calling Adam???

How we can help?

- Beachy Bauman Consulting, PLLC
  - Members of Mountainview Consulting, LLC
    - Multiple associates (world leaders, it's always nice to be able to name drop ☺)
  - Our goal is simple: Help health organizations, small and large, integrate behavioral health services in hopes of fortifying primary care
- What we do?
  - Help recruit/interview
  - Train up PCPs and staff
  - Train up newly hired BHC
  - Provide ongoing support
  - *Anything related to your integration efforts!*

Resources

- http://www.mtnviewconsulting.com/
- http://www.behavioralconsultationandprimarycare.com/
- http://www.cfha.net/?page=PCBHSIG
- https://www.youtube.com/channel/UCR_hf_LGVtUOoLa_KFvqvtQ
  - PCBH Corner
  - What medical providers enjoy about PCBH
  - Different aspects of clinical care

Questions/comments?

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Improved Patient Outcomes

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Improved Patient Outcomes (cont'd)

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Improved Patient Outcomes (cont'd)

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Improved Patient Outcomes

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