

MONTANA PRIMARY CARE ASSOCIATION

*COMING OUT OF THE SILOS*

***Companion Reader***

**For**

**The Integrated Behavioral Health (IBH)  
Implementation Guide**

## Reading Series 1: Primary Care Behavioral Health Services

***Behavioral Consultation and Primary Care: A Guide to Integrating Services. NY: Springer. Robinson, P. J. & Reiter, J. (2016).***

### Chapter 1

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#### Behavioral Consultation and Primary Care: The “Why Now?” and “How?”\*

“There are those who look at things the way they are, and ask why . . . I dream of things that never were and ask why not.”

Robert Kennedy

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Before beginning our careers in primary care (PC), both of us authors worked in traditional specialty mental health (MH) settings. Like most MH providers, we worked hard, kept up on clinical innovations and had the best interests of our clients at heart. Of course, we had clients who progressed and many who appreciated our assistance. However, we could not help but wonder what happened to clients who failed to show. On a typical day, we might have seven clients scheduled, of which two or three would not show. What happened to them? Why didn’t our follow-ups return? If first time clients failed to show, we rationalized that the client was not ready for change; but was that really the case? Further, we felt frustrated that, by the end of the day, we might have only seen a handful of clients, many of whom were weekly regulars. This begged the question: How many people were we really helping?

As we have since learned, our experiences and questions were not unique. Further, we have learned that our PC colleagues also had some nagging questions: Why do so few patients referred to MH care follow through on the referral? Why are so many “psych” patients coming here when a system already exists to tend to their needs? How can we get patients with chronic conditions like diabetes to manage their condition better? How can a primary care provider (PCP) be expected to meet the needs of every patient with a 15-minute visit?

What we have learned is that the MH system in this country simply does not meet the needs of the population, and the PC system has been left to pick up the slack. Unfortunately, though, PC historically has not been the best place for treating behavioral issues. Overwhelmed by the demand for care, underprepared for many of the problems seen, and often unable to access timely specialty help, PC is a busy and stressed system. All of this has led to the question: Is there a better way?

This book aims to help provide a better way. The chapters that follow are a guide for reinventing PC, by improving the quality and accessibility of care for patients whose health is compromised by behavioral issues. We hope to reshape ideas about how to help patients change problem behaviors by restructuring the way that care services are delivered. The *Primary Care Behavioral Health (PCBH)* model, as outlined here, provides a framework for integrating MH providers into PC settings. It changes how MH providers Practice in that setting, how PCPs Practice, and how they work together for the health of the population. As noted by

Strosahl (1998), an early developer and proponent of PCBH care, this model is best considered a form of *health care* rather than *mental health care*.

The general rationale for integrating PC and MH has been discussed thoroughly in other texts (e.g., Belar & Deardorff, 2009; Blount, 1998; DiTomasso, Golden, & Morris, 2009; Frank, McDaniel, Bray, & Heldring, 2004; James & Folen, 2005; James & O’Donohue, 2009; Patterson, Peek, Heinrich, Bischoff, & Scherger, 2002). Rather than rehashing those writings, this book will focus on *how* to implement, evaluate and sustain integration. Specifically, this book explains how to integrate using the PCBH model. This is first and foremost a pragmatic book. We begin by outlining the problems that our health care system faces in both the PC and specialty care sectors. Understanding the problems with the current system is essential when considering the importance of taking a fundamentally different approach. One by one, these problems help us not only understand the need for integration, but also the need for the particular type of integration the PCBH model provides. We then introduce the PCBH model.

### **Primary Care and The Epidemic of Behavioral Health Problems**

At the time of this writing, the population of the U.S. is 313.9 million. Remarkably, around 30% of these Americans have a diagnosable psychiatric disorder at a given point in time (Kessler et al., 2005). Around 50% will experience a diagnosable disorder at some point in life (Kessler et al., 2005). Reflect for a moment on this point - That is a lot of people! So what happens to all of these people? Figure 1.1 offers some clues.

As shown in Figure 1.1, only about 20% of those with a diagnosable problem receive care from a specialty MH or substance abuse clinic, while 21% are treated in PC. The majority, around 59%, receive no care at all (Wang et al., 2005). These basic statistics upend the notion many have about where and how MH problems are treated in this country. Most people with problems seek no care, and many who do seek care simply go to the family doctor; few will ever see a therapist’s couch.

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Figure 1 Here

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Primary care providers see the full spectrum of psychiatric disorders, from depression to substance abuse to psychosis. They prescribe around 60% of psychotropic medications (Mark, Levit, & Buck, 2009; Mojtabai, 2008). They regularly handle chronic psychiatric problems as well as acute flare-ups (e.g., a suicidal patient). Because they provide care across the lifespan, PCPs also treat child behavior problems (e.g., ADHD) in addition to the problems of adults and older adults. Of course, they must do all of this while also tending to the medical needs of their patients. A PCP must truly be a generalist! For all of these reasons, PC has earned the label of the country’s “de facto mental health care system” (Regier et al., 1993).

Thus, one reason to integrate MH services into PC is to help meet the demand for care there. Another reason lies with the 59% of people who seek no care. An interesting point is that approximately 80% of adult Americans will visit PC in the course of a year (National Center for Health Statistics, 2012a). Among American children, the number is about 93% (National Center for Health Statistics, 2012b). Thus, many if not most of these undiagnosed people will most certainly enter the PC system. They might only seek help for a sore throat or a work physical, rather than for psychiatric or substance abuse problems. However, the point is that they do enter PC.

Most of the time, these patients pass in and out of the clinic without the psychiatric problem being detected. For example, patients with alcohol dependence receive appropriate assessment and referral in PC only about 10% of the time (McGlynn et al., 2003); and depression goes undetected 30 to 50% of the time

(Simon & VonKorff, 1995). However, a PC clinic with good screening protocols, behaviorally savvy clinicians, and a robust behavioral health staff might be able to detect and treat problems that may otherwise go unnoticed. Thus, a second reason to integrate is to increase a clinic’s ability to identify and provide MH care to patients who would otherwise slip through the cracks of a broken system.

**Takeaway: Integration must improve identification of undiagnosed problems.**

Yet, improving care for psychiatric problems is not the only reason to integrate a clinic. Behavior interferes with health in many ways, and the consequences show up in PC patients in many ways. To illustrate this, we often have new behavioral health consultant (BHC; we explain this term later in the chapter) trainees review the daily patient schedule of a PCP, with the goal of finding possible behavioral components to the problems patients are presenting with that day. For example, the patient seeing the PCP for headaches might be stressed or skipping meals; the patient presenting with stomach pain might be drinking alcohol to excess; the patient complaining of dizziness might be having panic attacks. There is even a behavioral component to the common cold, in that frequent hand washing helps prevent it! The point is that health and behavior are so intertwined that it can be difficult to find any medical problem that does not involve behavior in some way. A behavioral influence is most notable in four types of patient concerns: 1) lifestyle-based somatic complaints, 2) sub-threshold syndromes, 3) preventive care, and 4) chronic disease management. We describe these concerns in detail below.

Irritable bowel syndrome, tension headaches, insomnia, and chronic pain are a few examples of *lifestyle-based somatic complaints*. In a classic study of these complaints, researchers demonstrated that, of the 14 most common complaints in a PC clinic, 84% had no clear organic etiology over a 3-year follow-up period (Kroenke & Mangelsdorff, 1989). In other words, these symptoms were likely the result of stress and/or lifestyle. Because these conditions are experienced as physical symptoms, patients often view them as medical problems and thus seek help from a PCP rather than a MH provider (Bray et al., 2004; Patterson et al., 2002). Obesity is another lifestyle-based somatic issue that PCPs confront almost hourly. On rare occasions patients seek help specifically for obesity, but much of the time it is a problem that never even gets discussed (Greiner, Born, Hall, Hou, Kimminau, et al., 2008)

The second category of *sub-threshold syndromes* includes marital conflict, domestic violence, bereavement and other life stressors. These are problems that do not meet the “threshold” of a DSM diagnosis, but are nonetheless problems that may take a significant expenditure of PCP time and energy. For example, conservative estimates indicate 12 to 23% of patients in family medicine have experienced intimate partner violence in the last year (Cronholm, Fogarty, Ambuel, & Harrison, 2011), and such patients utilize 1.3 to 2.6 times as much health care (Ulrich et al., 2003).

*Preventive care* is another area where PCPs spend a lot of time and energy, and mostly this involves counseling patients on healthy behavior change. Risk factors for heart disease, cancer, stroke, diabetes, and respiratory diseases go far beyond genetics and social inequalities. To prevent these problems, patients must modify tobacco use, unhealthy diets, sedentary lifestyles, and problematic alcohol and drug use, and PCPs help them with this. They also teach patients to use seat belts, bike helmets and contraceptives and help them avoid high-risk sexual behavior. Most MH providers in a traditional MH setting would be surprised and

perplexed if asked to help a client with one of these behavioral issues. However, PCPs counsel patients regarding these issues every day.

Behavioral issues also arise in patients with *chronic diseases*, the major causes of morbidity and mortality in the world in both developed and developing countries (Heron, 2010). Primary care systems have historically focused mostly on treating acute problems, but chronic conditions are the fastest growing part of PC (Patterson, Peek, Heinrich, Bischoff, & Scherger, 2002). More than 75% of health care costs are now attributable to chronic conditions (see Web Link 1). This rise is due to several factors, including an aging population, an increase in conditions such as diabetes, lipid disorders, and obesity, and medical advances that allow people to live longer with diseases that would have been fatal in earlier years. The trend toward more chronic disease means that PCPs must more often help patients learn to manage them. They must counsel patients on how to cope with a chronic condition, educate family members, motivate patients to make changes and teach them skills for managing it. Unfortunately, estimates suggest that up to 60% of patients with chronic disorders adhere poorly to treatment (Dunbar-Jacob & Mortimer-Stephens, 2001).

**Takeaway: Integration must help with ALL behaviorally influenced conditions.**

The challenge of responding to all of these behavioral issues in PC may be reason enough to integrate services. Yet, there is another reason why integration is so crucial: PCPs simply cannot go it alone. Primary care is a very busy place, and a very stressed system.

### **Primary Care: Overworked and Underpaid**

Imagine you are a PCP seeing a patient who is brand new to your clinic. The patient reports having diabetes, hypertension, high cholesterol, depression, sleep apnea, and chronic pain. The patient also tells you he has been off all of his medications for a few months, and can't recall the names of most, nor the dosages. He is coming in now because he has not been feeling "right" and thinks his blood sugar is "off." You call an endocrinologist the patient recently saw (the patient recalled the name, but you had to find the phone number), but after 20 minutes, the endocrinologist still has not called you back. You were 45 minutes behind at the start of the visit, and need to see four more patients in the next hour before lunchtime.

If this scenario sounds unrealistic, it is not; if it sounds unworkable, it very nearly is. The reality is that scenarios like this play out every day on the schedule of most any PCP. The typical PCP sees 20 to 25 patients in a day, many with complex problems. The average length of a PCP visit is 16 to 18 minutes, during which time the average patient will bring up three health concerns (*more* than three concerns in 37% of visits; Mechanic, McAlpine, & Rosenthal, 2001; Beasley et al., 2004). Obviously, this means PCPs have little time to treat behavioral and medical issues that may be complex.

In addition to patient visits, a recent study in *The New England Journal of Medicine* documented that in a typical day, a PCP has over 36 urgent but unpaid tasks to tend to. Such tasks include reviewing labs, refilling medications, returning phone calls to patients or other providers, reading consult reports, and many others (Baron, 2010). Similarly, a PCP would need 7.3 hours per day, in addition to patient visits, to implement all of the preventive screening and counseling that is recommended (Yarnall et al., 2003), as well as ten additional hours a day to implement all of the clinical guidelines for chronic problems like diabetes (Yarnall et

al., 2005). Primary care is a very busy place, and all too often there is little time for anything but acute concerns.

The entire PC team often experiences the same high stress level of the PCP. Medical assistants (MAs), RNs and lab technicians also operate under a time crunch, and are likely no more prepared to deal with behavioral problems than PCPs. In some cases, they bear the brunt of complaints from disgruntled patients who may be reluctant to complain to the PCP. Similarly, receptionists and other administrative staff must often interact with psychotic, depressed or otherwise challenging patients, and referral coordinators must try, often in vain, to locate accessible specialty services. When training a new BHC, we often have her spend 30 minutes in the waiting room of the clinic, observing the patients and patient interactions with staff. Almost inevitably, there will be a disagreement over a bill, frustration with a lengthy wait, and questions beyond the realm of what front desk staff are able to answer. Observing the waiting room can provide valuable insight into the challenges faced by staff, all of which place additional strain on a PC system that is already taking on more than it can handle.

If patients with complicated problems reliably accessed the specialty care system, perhaps the situation would be improved. PC is supposed to be the entry point for treatment of any non-urgent problem, with the specialty care system standing by to accept those who fail to improve in PC. This is the case for all manner of health issues, including MH problems. Unfortunately, PCPs in the U.S. report being “unable” to access specialty MH services for two-thirds of their patients (Cunningham, 2009)! Thus, in the majority of cases where PCPs need specialty help, they simply cannot get it.

Adding insult to injury, PCPs have also not been compensated as well as their specialist colleagues. They are consistently the lowest paid of all physicians. In 2012, the median salary for a PCP was \$220,000, whereas the median for the other physician specialties was \$396,000 (Bureau of Labor Statistics, 2014). In comparison to their peers, PCPs are a classic example of “overworked and underpaid.” Perhaps not surprisingly, all of this has resulted in a shortage of PCPs nationwide. Medical students have been shunning PC, and seasoned PCPs are retraining or retiring early. Health care reform, with its emphasis on strengthening PC, may help PCP salaries some. However, it is also expected to bring about 30 million newly insured people into the already stressed PC system.

The important point from this discussion is that any attempt at integration must aim to reduce the burden on the PC system. Integration efforts that add more work to the overflowing plates of PCPs and other team members are doomed to fail. Behavioral health providers who Practice in PC without understanding the system’s stresses, or who choose to ignore them, risk being viewed as irrelevant at best and a nuisance at worst. Integration must help not only patients, but also the PC system, to function better.

**Takeaway: Integration must subtract from, not add to, the workload of PCPs.**

In addition to a lack of time, PCPs also report feeling underprepared for managing many behaviorally influenced problems. In a typical 3-year family medicine residency, the “psychiatry” rotation lasts just one month (and it is during this month that, as Kirk Strosahl (2013) likes to joke, most residents take a vacation). Indeed, many residents assume they will rarely need to manage complex behavioral issues and that they will be able to reliably refer to psychiatrists and psychologists, only to learn after residency that much of what they must help patients with involves behavior.

Not only is the quantity of training insufficient, the quality often is as well. Residency programs are rather notorious for not equipping PCPs with the behavioral tools they really need. In the real world of 15-minute visits, treating patients with multiple behavioral issues can be quite a jolt for new clinicians. Almost every PCP has at some point uttered, “My training never prepared me for *this!*” While diagnosing and prescribing are often a heavy focus of residency training, much less attention is typically given to teaching basic behavior change strategies, especially strategies for very brief encounters. Surveys of physicians and residents show that only around 25% feel effective when counseling patients on smoking cessation, diet, exercise, and weight management (Foster et al., 2003). And while the majority of PCPs say they feel comfortable treating anxiety and depression, many struggle with treating other types of psychiatric and substance abuse issues.

**Takeaway: Integration must help PCPs improve behavior change skills.**

### **The Effects on Patients**

At the risk of stating the obvious, we must note that patients also suffer under the current system. As indicated earlier, many if not most psychiatric problems go undetected in PC. When one is detected, the treatment is likely to be medication focused, and the outcome is likely to be subpar. This is true not only for psychiatric problems, but for a host of behaviorally influenced problems including obesity, diabetes and other chronic conditions. Numerous studies have shown that care for psychiatric disorders in PC is inadequate. Common problems include poor follow-up and tracking of care, inappropriate prescribing, over reliance on medication treatment, and a lack of communication with outside providers. Outcomes for chronic diseases such as diabetes and hypertension are subpar and access to care for well patients is limited due to the care that ill patients require. Treatment in PC needs to do better.

**Takeaway: Integration must improve care outcomes in PC.**

One aspect of PC that must change for this trend to be reversed is its ability to provide behavior change support to patients. Care for psychiatric problems in PC is heavily medication focused, including dramatic increases in prescribing over the last few decades, yet all of those prescriptions have not led to any clear improvements in population health. The case of antidepressants provides a good example. Antidepressant use has skyrocketed since the early 1990’s, such that they are now the most commonly prescribed medication in the U.S. for females, and the third most commonly prescribed medication overall (NCHS, 2013). The vast majority of this increase is attributable to increases in prescribing by PCPs that started with the introduction of SSRIs in the 1980’s (Wang et al., 2005). The lower side-effect profile of the SSRI’s allowed them to be more easily marketed to PCPs, a point that the pharmaceutical companies were quick to exploit. An almost four-fold increase occurred in the percentage of promotional spending dedicated to direct-to-consumer advertising of antidepressants (Donohue, Cevasco, & Rosenthal, 2007), with the result that patients now commonly request specific medications from their PCP.

All of this, and other factors, led to the explosion of antidepressant prescriptions; yet this vast expansion of antidepressant use hasn’t gotten us very far. National surveys from Great Britain show no

decline in the overall prevalence of depressive episodes, mixed anxiety and depression cases, or in the duration of depressive episodes, despite the dramatic increases in antidepressant use there (Brugha et al., 2011). Similar surveys in the U.S. have produced similar findings (Kessler et al., 2005; Mojtabai, 2011), with one study even showing an increase in depressive episodes in the population (Compton, Conway, Stinson, & Grant, 2006). As antidepressant use has climbed, so has the use of antipsychotics (Olfson & Marcus, 2009). When a patient doesn't improve on an antidepressant, an antipsychotic is often added.

A reasonable alternative to all of these medications would be a strong dose of behavioral interventions, but that rarely happens (Robinson, Geske, Prest, & Barnacle, 2005). As noted earlier, most PCPs have neither the time nor the training to provide detailed behavioral guidance, and specialty MH providers are hard to come by. As we will describe later on, the use of psychotherapy has even plummeted in the specialty MH world (Olfson & Marcus, 2009; Gray, Brody, & Johnson, 2005). Thus, even in rare circumstances where a PCP successfully refers a patient to specialty MH care, little attention is usually given to non-medication approaches.

This heavy reliance on medications is often more than just ineffective; it may also make some problems worse. For example, when a PCP, desperate to help and desperate for time, is faced with a patient with chronic anxiety, the end result may be chronic use of a habit-forming anxiolytic (PCPs prescribe two-thirds of the country's anxiolytics; Mark, Levit, & Buck, 2009). The patient and PCP may then end up with two problems: 1) continuing anxiety, and 2) dependence on the anxiolytic. Actually, they may end up with three or four problems, because the anxiety will likely continue and the frustrated patient may become depressed or begin to self-medicate with substances. This is a scenario that plays out daily in most PC clinics.

**Takeaway: Integration must help decrease the medication culture of PC.**

Even patients with no significant behavioral problems suffer under the current state of affairs. A lengthy visit with a patient with multiple behavioral issues often leads a PCP to recapture time from subsequent patient visits to stay on schedule. In addition to more lengthy visits, patients with psychosocial problems utilize medical services more frequently (Simon & VonKorff, 1995), which makes accessing services harder for other patients. One study of *high-utilizers* (patients who utilize medical services the most), found that about half had significant problems with depression and anxiety (Katon et al., 1990). The inference from all of this is that without sufficient care for behavioral problems we all are paying the price.

### **The Failings of the Specialty Mental Health System**

It is tempting to reason that one way of lessening the burden on PC and improving care outcomes, at least with respect to treating psychiatric problems, is to bolster the specialty MH system. In its *Interim Report to the President*, Since the President's New Freedom Commission declared in its Interim Report that, "... the mental health delivery system is fragmented and in disarray ... lead to unnecessary and costly disability, homelessness, school failure and incarceration", many efforts have been made to do just that (President's New Freedom Commission, 2003). Of course, the Holy Grail would be a system in which psychiatric and substance abuse disorders are first tended to in PC, with seamless and rapid transition to the specialty care system for those who do not improve. Presumably, the most severely impaired patients would end up in the specialty care system, where they would access therapy and perhaps medication care until their problems

have resolved. This certainly seems like a reasonable goal. Yet, this is not the system we have now and, for a variety of reasons, it almost certainly never will be.

Perhaps the biggest reason for this shortcoming is that patients simply do not always do what their health care providers recommend. As trainers of new BHCs in PC, we both frequently encounter trainees (and PCPs) whose main treatment plan for complex patients is to refer them to specialty MH. This plan might seem perfectly reasonable, and the patient might even agree with it; yet, more often than not, the patient simply ends up back in the BHC/PCP’s office, never having made it to specialty MH. As we noted earlier, two-thirds of PCPs report being unable to access specialty MH for their patients.

Why don’t more patients utilize the specialty MH system? For starters, recall from the earlier pie chart that most patients with diagnosable problems seek no care *anywhere*. Research shows that those with less serious problems often do not see a need for MH care, or perceive a stigma to MH care, or believe that treatment will not help (sometimes based on past experience). They also often expect that problems will improve without care. More severely impaired patients are often deterred by structural barriers; they anticipate difficulty obtaining appointments, trouble getting to appointments, uncertainty about where to go for care, problems paying for care, or a belief that treatment will take too long and be inconvenient (Mojtabai et al., 2011; Cunningham, 2009).

**Takeaway: Integrated care must be accessible.**

In cases where a patient does seek care for MH problems, as noted earlier, half the time such care is sought in PC. Many patients are reluctant to trust anyone other than their PCP, and as such will resist any referrals to specialty MH (Von Korff & Myers, 1987). Sometimes referrals even cause problems in the relationship between the PCP and patient, because the patient interprets it as a sign the PCP has given up or does not want to deal with the patient’s emotional health (Patterson et al., 2002; Strosahl, 1998). Older patients (i.e., over age 60) are particularly unlikely to accept a referral to specialty MH (Wang et al., 2005). Other patients who seek care in PC do so not for the MH problem per se. Instead, they seek relief from the physical manifestations of stress, such as headaches, fatigue or insomnia, but not the stress itself (Bray et al., 2004; Patterson et al., 2002). Such patients may simply not see any reason for a MH referral.

**Takeaway: Patients must perceive integrated care as routine health care.**

Much of the resistance patients have to specialty MH and substance abuse care is generated by the failings of these systems. They are notoriously inefficient systems that present numerous obstacles to care. A recent case from the clinic of one of us (JR) provides a typical example. The PCP of a 13-year-old patient referred the patient to specialty MH for psychiatric help with ADHD and other behavioral issues. A month later, the patient and his mother returned, with no MH appointment planned. The mother complained that no appointments were available for three weeks, and that five weekly therapy visits were required before they would be allowed to see the psychiatrist. As a working single mother, she did not feel able to make weekly

appointments, and felt her son was actually improving with just the stimulants from the monthly PCP visits. She had no interest going elsewhere for additional care.

Such stories are all too familiar to anyone working in PC. Wait time for an initial appointment with specialty MH care is commonly measured in weeks rather than days. The one-size-fits-all approach taken by most MH clinics (wherein hour-long appointments are utilized for all patients), and treatment plans that last for months or even years, results in rapidly booked schedules with long waits for new patients. Such long waits mean that patients are usually not able to get help when they feel they need it most. In many systems, initial appointments – once they do arrive – often involve merely an intake assessment, perhaps conducted by a technician who then schedules yet another appointment a few weeks off with a therapist or prescriber, if needed. In contrast, patients can typically obtain an appointment with a PCP in a day or two, if not on the same day.

This lack of timely access to MH care ironically flies in the face of what most MH providers know about the process of change; namely, that readiness to change can occur quickly and unpredictably. When faced with a problem health behavior, many people linger for months or years in a contemplative or pre-contemplative stage of change before something rather suddenly boosts them to preparation and/or action (Rollnick, Miller, & Butler, 2007). Providers in PC witness this regularly, such as when a longtime smoker suddenly expresses a desire to quit cigarettes after developing bronchitis. Patients are most likely to seek help during a crisis or when anxiety about a problem is heightened and are less likely to return for care when distress lessens (Brown & Jones, 2005). A system that forces them to wait weeks for an initial appointment will often miss opportunities to help.

**Takeaway: Long visits and frequent follow-ups must be avoided to enable access.**

Of course, some patients do manage to access the specialty MH system. Yet, they often don't last long in it. Many times, the care provided is not what the patient hoped for. Almost 60% of the patients seen in specialty MH care are treated with medications alone and just 10% receive psychotherapy alone, while 32% receive therapy and medications (Olfson & Marcus, 2010). Medication-only treatment has steadily replaced therapy. Thus, many patients hoping to receive in-depth psychotherapy from a specialty MH clinic end up disappointed by how unavailable or limited that care actually is. If treatment is going to be medication focused, so the patient's reasoning goes, why not simply go to PC?

When patients do access therapy in specialty MH, they usually do not use it for long. The modal number of therapy visits is merely one (Brown & Jones, 2005). Relatedly, the mean number of therapy visits per patient has decreased by about 20%, from 9.7 in 1998 to 7.9 in 2007 (Olfson & Marcus, 2010). Often patients complain of poor rapport with the MH clinician, or difficulty scheduling follow-up appointments that are convenient; worse yet, some patients are terminated from care for missing too many appointments or failing to follow through on the recommendations from the MH clinician. While the specialty MH care sector has the luxury of picking and choosing which patients to follow, the PC sector does not. This is particularly true for community health clinics, which are the safety net for the population. Thus, most patients spurned by the specialty MH system eventually end up back in PC.

**Takeaway: Integrated care must avoid rigid rules that make care less accessible.**

Of course, MH clinics vary, and not all operate with so many inefficiencies and barriers. There are certainly patients who access the system and benefit from it. But ironically, many times it is the most functional patients, those who can overcome the barriers, who end up utilizing the MH system the most. Patients who have generous insurance (or can pay out-of-pocket for care), reliable transportation, and better support such as childcare or flexible work hours, are often the ones who are most able to utilize the specialty MH system. Illustrating this point, one-third of patients treated in the specialty MH/substance abuse sector have no diagnosable disorder (Wang et al., 2005)! Thus, rather than serving those with the most need, the specialty MH system often serves those with the least need, while those with the most need often end up in PC.

The bottom line is that the specialty MH system, whether it reforms or not, is never going to meet all the MH needs of society. Even if it were functioning optimally, the reality is that a mere 6% of the U.S. population receives care from the specialty MH sector during a given year, whereas, in that same year, over 80% will visit PC (Regier et al., 1993; Kessler et al., 1996; National Center for Health Statistics, 2012a). As the frontline of our health care system, PC is and will always be where most behaviorally influenced health conditions, psychiatric and otherwise, are treated. Clearly, if we want to improve how care is provided for behavioral health issues, we must stop looking to the specialty MH system to save us. Instead, we must begin to reform PC. But *how* to reform PC is the important question. Any attempt to improve care for behavioral conditions will need to avoid the mistakes of the specialty MH system. We believe the PCBH model does just that.

### **The Primary Care Behavioral Health Model**

Early descriptions of the PCBH model come mostly from the work of Kirk Strosahl and Patricia Robinson, based on work they spearheaded at Group Health Cooperative and the University of Washington (Robinson, Wischman, & Del Vento, 1996; Strosahl, 1998; 1997; 1996a; 1996b; Strosahl, Baker, Braddick, Stuart, & Handley, 1997). Subsequent writings detailed the clinical applications of the model (Gatchel & Oordt, 2003; Hunter, Goodie, Oordt, & Dobmeyer, 2009; O’Donohue, Byrd, Cummings, & Henderson, 2005; Robinson, Gould, & Strosahl, 2010) and efforts to implement it in large health care systems (Runyan, Fonseca, & Hunter, 2003; Freeman, 2011; Department of Defense, 2013). This book provides a highly detailed description of the model, implementation and training materials, strategies for expanding and evaluating it and guidance on how to address challenges as the model continues to evolve. In the remainder of this chapter, we offer an overview of the PCBH model.

### **A Consultant Approach**

The hallmark of the PCBH model, and what sets it apart from other models of integration, is its foundation in a *consultant approach*. Behavioral health providers in this model are called *behavioral health consultants (BHC)*. Table 1.1 outlines key differences between a consultant approach and a more traditional *therapist approach*. As the table shows, a consultant approach is quite different from a therapist approach. While the therapist approach is, by definition, a method of specialty MH care, some PC clinics have behavioral health providers who also utilize this approach. In integrated care nomenclature, a therapist approach that is

housed in PC is referred to as a *co-located* or *collaborative care model*. The problem with practicing as a therapist in PC is that it often brings into PC the same problems that occur in the specialty MH system (e.g., problems with access, a narrow scope of care, etc.). It’s a bit like trying to fit a square peg into a round hole, as the goals of specialty MH care are different from the goals of PC. In contrast, the consultant approach characteristic of the PCBH model helps the BHC avoid the pitfalls of the specialty MH system. It brings a new approach to PC, one that fits its goals and culture. In the next few pages we explain how the various dimensions of a consultant approach, shown in Table 1.1, are applied in the PCBH model.

Table 1.1.

*Differing Dimensions of the Consultant and Therapist Approach*

<i>Dimension</i>	<i>Consultant</i>	<i>Therapist</i>
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 toward goals	Patient has met goals

In the consultant approach, the *primary consumer* is the referral source, and most often, this is the PCP. Hence, the BHC’s goal is to help the PCP manage the behavioral needs of patients. This carries many implications about how a BHC must operate within PC. The BHC must understand what the PCP needs, and be willing to help in many ways to facilitate improved care by the PCP. It also means a great deal of communication and collaboration must occur between the PCP and BHC in order for the former to understand and reinforce the plan of the latter. Through this process, one goal of the PCBH model is to eventually change the care milieu in PC by reducing the medication over-use/misuse problem and helping PCPs feel better equipped to manage behavioral issues.

By contrast, the therapist approach directs the behavioral health provider to assume primary responsibility for the patient’s MH needs. With this approach, communication between the therapist and PCP is often minimized. Thus, the therapist approach also minimizes opportunities to effect any change in the PC system, even if the therapist is a part of the PC system.

Relatedly, the *care context* in a consultant approach is team-based, whereas in a therapist approach, it is more autonomous. In most specialty MH clinics, a therapist can easily go an entire day without interacting substantively with co-workers. In fact, many therapists operate private Practices where co-workers do not even exist! While this may work in the specialty MH system, utilizing this approach in PC proves unhelpful. Primary care is a team-based atmosphere. Throughout the day, PCPs confer with each other and interact with other members of their team to ensure coordinated care. As a consultant, a BHC must mimic this behavior. The BHC must be transparent regarding patient care activities and constantly coordinate with the PCP. Typically the BHC is located in the PCP pod or work area to facilitate communication throughout the day. The BHC also maintains a fluid schedule, helping out as needed by working in patients for visits,

consulting on care plans, and sharing the workload for relevant tasks (e.g., returning a phone call to a patient in crisis, reviewing outside psychiatric records on a new patient, etc.).

Another key aspect of a consultant approach is *accessibility*. To be an effective consultant, one must be available to the referral source when needed. In the fast-paced, high-pressure world of PC, accessibility is key. Whereas therapists have a more predictable, defined schedule, a consultant’s schedule is more dynamic, changing all day long as needs arise. The therapist approach, as discussed earlier, is notorious for access problems. In taking a consultant approach, the PCBH model allows for help to PCPs and patients when needed.

A variety of strategies are useful in the model to promote accessibility. For example, visits are brief (the standard is 30 minutes, but visits are often much shorter), and BHCs encourage PCPs to interrupt them as needed, even during a patient visit. The goal is always to see patients on the same day a need is identified; sometimes this happens after the PCP visit, sometimes during, and other times even before the PCP visit. No formal referral process is required, other than a quick hallway discussion about the patient and a brief introduction to the patient. Note that being accessible also means that patients are much more able to access care when they need it or feel ready for it.

*Ownership of care* in the PCBH model belongs to the PCP. That is, the PCP remains in charge of the patient’s MH care; the BHC’s role is to join forces with the PCP to help when needed. This often helps avoid the problem of the patient feeling abandoned by the PCP, and the wariness and stigma some patients may feel when referred to a specialty MH provider. The PCP often introduces the BHC to the patient as a “team member who will help me help you.” By contrast, in a therapist approach the MH provider functions as a separate entity from the PCP and may feel little need to coordinate care with a PCP, even if co-located in the same clinic. The PCP’s ownership also means that notes from both BHC and PCP visits are kept within the same medical record.

*Referral generation* also differs in a consultant versus therapist approach, and this has implications for how a BHC must operate. The work of a consultant is scrutinized more than that of a therapist because of the close collaboration between the consultant and referral source. For better or worse, a therapist will often continue to receive occasional referrals from a PCP regardless of outcome, because the PCP knows so little about what the therapist is doing with his patients. Because therapists see a smaller number of patients, just an occasional referral may be adequate for the therapist’s business. By contrast, an ineffective consultant will see referrals drop off rather precipitously because PCPs are the consultant’s primary consumer; they experience the consultant’s work and outcomes firsthand. Thus, in the PCBH model, the BHC must be effective with patients and PCPs alike. The BHC must provide concise and relevant recommendations to the PCP, so as not to slow her down, and look for ways to share some of the PCP’s workload. The BHC must also always develop a clear *patient change plan* (i.e., a printed or written plan concerning one or more specific behavior changes to improve patient functioning), based on empirically supported interventions for both the patient and PCP to follow.

Another point of difference between a consultant and therapist approach concerns *productivity*. A consultant usually achieves a higher patient volume because he is not following patients as long as a therapist does. In addition, visits with therapists typically last an hour, whereas in the PCBH model visits are much shorter. In the PCBH model, a BHC’s schedule can typically accommodate 14 patients per day (a 7-hour clinic day, using 30-minute visits), and the pool of patients being followed is constantly refreshed because of more limited follow-up, which we will discuss in more detail below. In the therapist approach, a typical schedule only allows for seven patients (a 7-hour clinic day, using 60-minute visits), many of them being the

same patients seen over and over. Thus, the PCBH model has the ability to accommodate the tremendous needs of PC. Note that working as a regular PC team member alongside the PCP often allows a BHC to inherit the PCP’s “halo,” which allows for building rapport in much less time.

Owing to its place as the gatekeeper for the health care system, PC also treats a wide variety of problems, among all ages. Whereas the role of a specialist is to “know a lot about a little,” the PCP must be a generalist who “knows a little about a lot.” In other words, a PCP must have a *wide problem scope*. Therapists typically have a narrow problem scope. As specialists, they may have detailed knowledge of the problems they treat, but little understanding of how to treat other problems. This makes for a poor fit with PC. Instead, in the PCBH model, the BHC utilizes a consultant approach in which he sees any behavioral problem the PCP sees. The BHC will help with all ages, all manner of psychiatric and substance abuse problems, behavioral medicine conditions, preventive care, and any other problem that is behaviorally driven. Thus, a BHC must have a broad knowledge base and solid generalist skills that enable him to take all comers.

Finally, *termination of care* is conceptualized differently in a therapist versus a consultant approach. Because a therapist owns the patient’s MH care, the therapy plan is usually to follow the patient until she is no longer symptomatic. In PC, taking this approach is problematic because the therapist’s schedule will quickly fill as she sees the same patients over and over. Given the sheer volume of patients with behavioral needs in PC, a therapist who focuses on only a few patients risks becoming irrelevant.

Instead, the PCBH model utilizes a consultant approach in which patients are followed only until they begin to improve. Once a patient begins to improve and a clear plan is in place that both the patient and PCP understand, the BHC ceases planned follow-ups and the patient continues with the PCP. There is no limit per se on the number of visits a patient may have with a BHC. Rather, the number of visits depends on the patient’s progress. Many patients show sufficient improvement after just two or three (or even one) visits, and so only see the BHC very briefly. Others may follow-up numerous times before finally showing enough improvement for the BHC to end their involvement. Of course, PCPs may always refer patients back to the BHC if problems worsen or new problems arise.

### **Population Health and the Primary Care Behavioral Health Model**

The use of a consultant approach as we have just described it reflects the PCBH model’s roots in *population health management*, which is also the foundation of PC in general. Whereas the specialty system is supposed to direct high-intensity interventions to those with the most need, the role of PC is to intervene at the general population level. As described by the American Medical Association, community or population interventions succeed by making small changes in a large number of people rather than large changes in a small number of people. As an example, a decrease in fat consumption in the general population is more effective for decreasing the incidence of heart disease than providing cholesterol-lowering medications to all people who have high cholesterol (Young, 2005).

Using similar thinking, the PCBH model aims to make general behavior change services more accessible, with the goal of improving the health of the general population. Being located in PC, where care is provided across the lifespan, the BHC is offered numerous opportunities to encourage small lifestyle changes or coping Practices over time; the BHC is also able to help with prevention, as well as treatment of acute and chronic conditions. Certainly, improved care outcomes for individuals are also a goal of the model. But more broadly than the individual patient, a BHC asks, “How can we reach more people with this problem?” or “How can I teach PCPs to be more effective with behavior change?” or “How can we better educate our population

about this problem?” These are questions that, if answered, can bring better health outcomes even for patients who are never seen by the BHC.

### **Empirical Support for the Primary Care Behavioral Health Model**

The PCBH model evolved from early randomized control trials demonstrating improved clinical, cost and satisfaction outcomes for integrated care relative to the usual Practice of PCPs referring patients to specialty MH (e.g., Katon, et al., 1996; Cummings & Follette, 1968). Early studies also demonstrated that integrating care helped PCPs feel more confident in treating behavioral health conditions, increased the use of behavioral interventions by PCPs, and improved patient satisfaction (Mynors-Wallace, 1998; Robinson et al., 1995). Thus, the groundwork was laid for building a model that could change how care is delivered in PC.

Subsequent findings from disparate sources fueled the evolution of the model to its current form. First, numerous studies have shown that adding a more robust behavioral component to PC improves outcomes for a variety of problems. These studies have been conducted within a number of health disciplines (e.g., dietitians, physicians, psychologists, etc.) using a variety of models. For example, many studies indicate that adding screening and brief interventions for problematic alcohol use in PC improves outcomes for that problem (Jonas et al., 2012). The same is true for depression (U.S. Preventive Services Task Force, 2009a). Even a 3-minute counseling intervention by a PCP has been shown to improve the likelihood that a patient will quit smoking (U.S. Preventive Services Task Force, 2009b)! There are other examples like these, many of which can be found on the website of the U.S. Preventive Services Task Force (USPSTF; see Web Link 2).

Along similar lines, numerous studies, specifically on models for integrating behavioral health into PC, have shown integration, whatever the form, also improves clinical outcomes for psychiatric problems. In 2008, a comprehensive review by the Agency for Healthcare Research and Quality (AHRQ) summarized evidence for a variety of integration models. The review included studies of care management models, algorithm-based efforts to improve PCP care, and various other methods of augmenting behavioral support in PC. Reviewers concluded that integrated care generally improved outcomes, but no evidence for a “clearly superior model” of integration was found (Butler, et al., 2008).

Taken as a whole, these studies show that most efforts to increase support for the treatment of behaviorally influenced problems in PC do succeed in improving clinical outcomes. This should come as no surprise to anyone familiar with the environment of PC. Improvement should not be difficult in a system that provides care for complicated patients in 15-minute visits, using providers who have limited training and minimal specialist support. The more interesting, important and challenging goal is getting that improved care to the most people possible; that is the impetus for the PCBH model.

Like most other models, individual patients do improve with PCBH care. Research has found that the PCBH model does improve clinical outcomes. Various studies show improved symptoms; better quality of life and higher life satisfaction for most patients; that most patients benefit from an average of four or fewer visits; that gains made by patients are maintained for several years; and that patients and PCPs prefer this model to usual care (Bryan et al., 2012; Bryan, Morrow, & Appolonio, 2008; Cigrang, Dobmeyer, Becknell, Roa-Navarrete, & Yerian, 2006; Corso et al., 2009; Ray-Sannerud et al., 2012; Katon, et al., 1996; Smith, Rost, & Kashner, 1995). However, the goal of the PCBH model is not only to improve clinical outcomes for individual patients. Rather, it is uniquely created to ensure that as many patients as possible will be able to access that improved care.

### **Other Approaches to Integration**

As noted above, a wide variety of other strategies and models have been developed for integrating PC and behavioral health. Broadly, these other approaches can be labeled as *co-located* and *care management models*, though there is not yet an agreed-upon classification system (see Peek (2013) for an effort to rectify this issue). The co-located model typically places a MH provider in the PC clinic, where he Practices more or less as a specialist, depending on the clinic. In some clinics, a co-located service very much resembles a specialty service, with hour-long visits, frequent and prolonged follow-ups, separate records from the medical chart, and perhaps even separate support staff. In other clinics, co-located care may look a bit different. Records may be shared between MH providers and PCPs, some visits may be shorter in duration, and staff may be the same used by PCPs. In cases where there is greater interaction between PCPs and MH providers, the label *collaborative care* is often used (Butler et al., 2008). Regardless, what all such services share is the use of the therapist approach rather than the consultant approach.

Care management models are a bit different from both PCBH and co-located/collaborative care. Based largely on the *chronic care model* (Wagner, Austin, & Von Korff, 1996), this type of service is used primarily for specific chronic conditions. Typically, a *care manager* or *facilitator* (RN, social worker or other MH provider) is housed in PC and becomes involved with patients who are diagnosed with the condition(s) of concern. Most commonly, care managers are used for depression or post-traumatic stress disorder, but this model has also been used for other chronic conditions such as diabetes (Williams et al., 2004).

Care managers or facilitators typically track patients in a database, which helps them to contact patients who fail to follow-up for visits. They also provide basic behavioral support, often via phone, and, in some instances, act as a go-between for the PCP and a psychiatrist who offers medication advice. Some clinics have both a BHC and a facilitator as team members, the BHC being the initial point of contact for all patients and providing the bulk of the behavioral help in the clinic, and the facilitator being involved with a smaller number of patients who desire and need more prolonged tracking and support. In this book, we refer to staff providing care management services as facilitators. We discuss the interface of BHCs and facilitators more in the next chapter.

Much has been made of how to quantify models and systems in terms of degree of integration. A tool to help measure “degree of integration” was developed by SAMHSA (Heath, Romero, & Reynolds, 2013) and can be found on their website (see Web Link 3). Depending on how a service is structured in terms of the location of the MH provider, along with other factors, degree of integration is measured using a scale of 1 to 6. To be clear, we do not attempt to evaluate here how “integrated” the PCBH model is. We leave that task to others. If implemented effectively, it should fit very well into SAMHSA’s definition of “Full Collaboration” (Level 6). However, comparing the degree of integration of services in a consultant model to other models is really like comparing apples and oranges when considering the fundamental differences in goals and Practices. In the end, the PCBH model simply is what it is; a model designed to improve population health by promoting more effective and efficient management of behavioral issues by PCPs.

We recognize that many of the concepts of the PCBH model may leave the reader with a host of questions. Hopefully, the subsequent chapters will answer them. We find that most people new to this model grow to embrace it as their understanding of it grows. This is especially true for PCPs, who typically welcome a BHC service with arms wide open. In the chapters that follow, we will cover all aspects of developing and operating a BHC service, including the clinical, administrative, interpersonal and ethical challenges one may encounter. We recognize that PCBH care is now being delivered in a wide variety of settings, by a wide variety

of BHCs. Our goal is for all readers, regardless of their familiarity with PCBH care and the system they work in, to find inspiration and education within the pages that follow.

### Summary

1. PC is known as the de facto MH system. Patients have psychiatric conditions, behaviorally influenced somatic complaints, preventive needs, sub-threshold syndromes, and chronic diseases that a PCP must help with.
1. PCPs lack the time and training to address the large volume of patients who seek help for behaviorally influenced conditions.
2. While PCPs may refer to specialty MH, there are many barriers to patients accessing that system.
3. PCPs often respond to patients with behavioral problems by prescribing medications, which is often inadequate and may create new problems for some patients.
4. PCPs report job dissatisfaction, and recruitment is difficult, particularly to community health centers and in rural areas. There is a shortage of PCPs.
5. Integration must address each of the above problems to be effective at the population level.
6. This book is about the PCBH model, which introduces a new member to the PC team, the BHC. The BHC works as a consultant, rather than a therapist, which is what distinguishes the PCBH model from other integration models.
7. The PCBH model differs in many respects from traditional MH care. It is designed to mimic the goals and culture of PC. It changes the delivery of PC services, and aims to improve both individual and population health outcomes.

This book is available as Kindle book: [https://www.amazon.com/Behavioral-Consultation-PrimaryCareIntegratingebook/dp/B016XVMXFY/ref=sr\\_1\\_1?keywords=Robison+%26+Reiter+Behavioral+Consultation+and+Primary&qid=1621874532&sr=8-1-spell](https://www.amazon.com/Behavioral-Consultation-PrimaryCareIntegratingebook/dp/B016XVMXFY/ref=sr_1_1?keywords=Robison+%26+Reiter+Behavioral+Consultation+and+Primary&qid=1621874532&sr=8-1-spell)

### Web Links

Web Link 1 [www.cdc.gov/chronicdisease/resources/publications/aag/chronic.htm](http://www.cdc.gov/chronicdisease/resources/publications/aag/chronic.htm)

Web Link 2 [www.uspreventiveservicestaskforce.org](http://www.uspreventiveservicestaskforce.org)

Web Link 3 [www.integration.samhsa.gov](http://www.integration.samhsa.gov)

## Reading Series 2. Primary Care Workforce

### Creating a Primary Care Workforce: Strategies for Leaders, Clinicians, and Nurses

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CONFLICT OF INTERESTS: All authors declare that they have no conflicts of interest.

#### **DISCLAIMER**

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### **Abstract:**

Many primary care clinics struggle with rapid implementation and systematic expansion of Primary Care Behavioral Health (PCBH) model services. Often, an uneven course of program development is due to lack of attention to preparing clinic leadership, addressing operational factors, and training primary care providers (PCPs) and nurses. This article offers competency tools for clinic leaders, PCPs and nurses to use in assessing their status and setting change targets. These tools were developed by researchers working to disseminate evidence-based interventions in primary care clinics that included fully integrated behavioral health consultants (BHCs) and were then used by early adaptors of the PCBH model. By deploying these strategies, both practicing and teaching clinics will take a big step forward in developing the primary care workforce needed for primary care teams, where the behavioral health needs of a patient of any age can be addressed at the time of need.

### **Creating a Primary Care Workforce:**

#### **Strategies for Leaders, Clinicians, and Nurses**

A sea change for the Practice of primary care is occurring. On the horizon is a primary care system that includes behavioral health services as a part of routine good health care. In the Primary Care Behavioral Health (PCBH) model (Robinson & Reiter, 2007; 2015), the behavioral health consultant (BHC) is a fully integrated member of today’s health care team. The BHC is optimally positioned within the healthcare landscape to deliver evidence-based behavioral health interventions to address the biological, psychological and social needs of primary care patients of any age. The waves of this change have been rolling in for decades, first with the work of pioneers (Katon, Robinson, Von Korff, Lin, Bush, et al., 1996; Robinson, 1998; Strosahl, 1996a; 1996b) and then later with the widespread implementation of the patient-centered medical home (PCMH) concept (Agency for Healthcare Research and Quality, 2014). Because of both the demonstrated and expected benefits of PCMH team inclusion of BHCs, healthcare funders are beginning to offer rich incentives to PCMH sites that offer BHC services (e.g., Health IT Analytics, 2016). Even as healthcare system waters become favorable for BHC services, many primary care clinic leaders find the initiation and expansion of PCBH model services challenging. Clinic leaders may be confused about models of integration and may lack information about the impact of full behavioral health integration on patient outcomes. Developing a new business model is, of course, an on-going concern for leaders. Perhaps one of the greatest barriers to optimal integration is the lack of primary care providers (PCPs) and nursing staff who are trained to partner with a BHC.

The purpose of this article is to offer guidance to clinic leaders who are working to create a PCBH model-prepared workforce and to medical providers who want to develop their competencies for integrated care. Serrano, Cordes, Cubic and Daub (2017) addressed behavioral health workforce development recently; therefore, we do not address this area in this article. We provide tools that define the new competencies that clinic leaders, PCPs, and nurses need to learn to Practice effectively in a clinic implementing the PCBH model. Additionally, we suggest strategies for making operational changes and providing training necessary to build competence. We conclude with two brief reports from multi-site primary care systems that highlight lessons learned about workforce development.

The tools and strategies grow from our collective research, clinical work, management, leadership, consultation and teaching experiences over the past thirty years. Throughout this article, we integrate the best scientific evidence with our combined practical clinical experience to ensure clinic leaders, PCPs and nurses have the knowledge and skills needed to push the wave of behavioral health

integration forward. This wave can lead to primary care health services that routinely deliver evidence-based biopsychosocial interventions to primary care patients at the moment a need is identified. One of the best ways to ensure that those needs are met immediately is with the PCBH model of behavioral health integration.

### **The PCBH Model**

The PCBH model defines the BHC as a fully integrated member of the primary care team. The model has been described by various clinicians and researchers over the years (Freeman, 2011; Gatchel & Oordt, 2003; Hunter, Goodie, Oordt, & Dobmeyer, 2017; Serrano, 2015; Strosahl, 1998; Strosahl, 2005), including particularly detailed descriptions in Robinson & Reiter (2007, 2016). In this special edition of the *Journal of Clinical Psychology in Medical Settings*, Reiter, Dobmeyer and Hunter (2017) created a concise operationalized definition of the model that pulls from multiple published resources and consultation with nationally recognized PCBH experts. A recent review of 29 studies on the PCBH model found that it shows promise as an effective population health approach to behavioral health service delivery and that it is associated with positive patient and implementation outcomes (Hunter et al., 2017). At the same time, Hunter and colleagues also note the PCBH model literature has multiple scientific limitations that will need to be addressed in future research.

The BHC brings new services to primary care patients, PCPs, and nurses. In a variety of ways, BHC work mirrors that of the PCP's and nurse's, including accessibility, continuity, and coordination. BHC chart notes are considered primary care notes and entered into the medical record. PCPs and nursing staff can easily see, support and eventually implement the basic interventions started in BHC visits. Evidence-based behavioral, cognitive, and motivational interventions figure prominently in BHC services. The design and delivery of BHC services are influenced by two over-arching goals. The first goal is to help patients learn to be more effective in managing and/or improving their biological, psychological, and social health. The second goal is to help PCPs and nurses learn to implement effective biopsychosocial assessments and interventions in primary care.

### **Improving Patient Functioning**

Patients learn new skills from the BHC in individual or group visits. The BHC offers workshops, educational class series, and/or group medical services (e.g., group appointments led by the BHC alone or in co-leadership with another team member). BHCs may also initiate development of PCBH model pathways (i.e., standard integrated team-based workflows) that help make BHC services a routine part of primary care. The purpose of a PCBH model pathway is to improve outcomes for patients who are members of a specific group (e.g., patients experiencing chronic pain) by making delivery of evidence-based interventions more accessible for members of that group. Simple and complex pathway services are assessed and revised according to results achieved. An example of a simple pathway is automatic referral of a patient diagnosed with diabetes for a consult with the BHC on the same day of diagnosis. In that consultation appointment, the BHC engages in a focused biopsychosocial assessment to determine the patient's emotional response to receiving a diabetes diagnosis and identify what health behavior changes the patient might make for optimal diabetes management, given psychosocial resources and level of motivation. More complex clinical pathways may involve use of a patient tracking registry and delivery of group medical services in addition to individual BHC visits. This type of clinical pathway is useful for high-risk patients challenged with multiple chronic conditions. Complex pathways, such as those addressing chronic pain, increase opportunities for more efficient delivery of medical and behavioral services and improved social support.

### **Improving PCP and Nursing Staff Functioning**

Perhaps the most significant opportunities for BHCs to help PCPs and nursing staff enhance their skills for delivering effective biopsychosocial assessments and interventions occur while delivering daily services. In the PCBH model, the burden of biopsychosocial care is lessened on PCPs, as it is shifted to the BHC. Additionally, as PCPs and nurses see the effectiveness of biopsychosocial interventions implemented by the BHC, they may begin to implement those interventions with their patients without referral to the BHC. There are many opportunities for BHCs to reduce work-related stress on PCPs and nurses, as they are credentialed members of the team that can review records, initiate phone contacts, and assist with document production for PCPs and nurses.

### **Challenges for Clinic Leaders and Providers**

To achieve the benefits of integrated behavioral health care, many clinics begin by identifying a behavioral health provider to work as a BHC. While they will likely seek training for BHCs hired without prior experience in the PCBH model, preparation of clinic leaders, PCPs and nursing staff may be an after-thought. Without properly trained clinic leaders and providers, the pace of implementation will be slower and proceed unevenly. When clinic leaders are unable to anticipate necessary changes to clinic infrastructure, the newly hired and minimally trained BHC will lack the operational foundation for integrating fully. Similarly, PCPs and nursing staff who do not know how to interface with their new colleague may be hesitant to engage for concern about imposing or “doing the wrong thing.” They may rely on old habits established in interactions with traditional mental health and substance abuse providers and reserve use of the new BHC for patients in crisis and those with more severe problems. Implementation of the PCBH model proceeds more optimally when attention is paid to preparing clinic leaders, PCPs, and nursing staff.

### **The Role of Clinic Leadership in PCBH Model Implementation**

“Clinic leaders” include all members of the leadership team charged with oversight of implementing the PCBH model. The exact membership will vary depending on the size and structure of a healthcare clinic or system of clinics. The Chief Executive Officer (CEO), the Chief Officer of Operations, the Director of Primary Care Services, the Medical Director for a larger system, the Director of Nursing, the Chief of Information Technology, the Director of Human Resources, a designated Clinic Manager, and a designated Clinic PCP and/or nurse are all possible members of a PCBH model leadership group tasked with facilitating the substantial transformation occasioned by initiation of PCBH services. Most often, recruited leaders have little or no expertise in the PCBH model and so begin their learning by attending workshops or webinars on the PCBH model, along with other models of integration.

At some point, most implementation teams visit a clinic with PCBH services and request assistance from a consultant with expertise in the PCBH model. Often, a large system will begin with a pilot program to inform system-wide change at a future point in time. Smaller systems may start with implementation in one clinic and move quickly toward implementation in all clinics. From the beginning, leadership will need to ask the consultant to define a work plan that assures attainment of PCBH model sustainability by resources within the system in a short time period. The consultant will use standard implementation materials to assure model fidelity (see PCBH Tool Kit at [Mtnviewconsulting.com](http://Mtnviewconsulting.com)). Initially, the consultant will likely assist with selection and hiring of BHCs while simultaneously educating the leadership team about the PCBH model and assisting with development of a feasible program evaluation plan, a business plan, and specific implementation

strategies. Once several BHCs are hired, the consultant will assist with core competency training for the BHCs, as well as nurses and PCPs. The consultant can usually implement a train-the-trainer strategy within 6-12 months of initiation of BHC services, wherein the most successful BHCs are trained to train future BHCs and take lead roles in development of PCBH model pathways and other innovations.

Because clinic leaders will be charged with making key decisions about implementation, it is important that they be the first "on board" with adoption of the PCBH model. Once briefed, a central project lead or a pair of co-leaders may focus on implementation in pilot sites. Clinic leaders need to attend clinic-specific all-staff meetings where the PCBH model is introduced to PCPs, nursing, management, and support staff. Such meetings provide a great venue for further understanding the questions and preferences of end-users. In our experience, making sure all staff members know what changes are taking place, why those changes are important, and how those changes are likely to improve workflow, patient experience, and provider satisfaction with services are critical components of start-up of BHC services. As implementation proceeds, clinic leaders need to generate clinic-specific reports on PCBH model quality metrics (see Chapter 8, Robinson & Reiter, 2015). In our experience, regular feedback to providers and other team members encourages efforts to meet expected metrics, timely identification of barriers and creative efforts to effectively address identified barriers.

### **Competencies for Clinic Leaders**

The PCBH Clinic Leadership Competency Assessment Tool (CL CAT; Table 1) is a pragmatic tool based on our experience of what clinic leaders need to do to create a solid foundation for PCBH model services. It has 31 competencies, and they are organized into the same six domains that organize the competency tools for PCPs and nurses (see Table 2) and for BHCs (see Chapter 5 in Robinson & Reiter, 2015). The CL CAT is not a formal measure with psychometric validation; however, research on its properties and contribution to efficient implementation should be a research priority. Below we provide a focused review of each competency domain with recommendations for efficient competency attainment.

**Support of new clinical Practices.** The competencies in this area include fluency in describing PCBH model services and anticipating their impact on existing workflows. This area also includes adjusting electronic health records to support PCP, BHC, and nursing documentation related to BHC services. Finally, this area includes defining the details concerning the interface between clinical staff and support staff related to the delivery of BHC services. For example, PCPs and nursing staff need workflows on referral to the BHC, for both same-day and future appointments. Front desk staff and appointment line staff need to be prepared to schedule return appointments for patients seeking BHC follow-up and for patients intending to participate in BHC-led group services. BHCs will require access to scheduling and charting systems, and all clinical staff will need to be able to access the BHC's schedule and chart notes. It is incumbent on clinic leaders to make sure this access is available.

Preparation of BHC schedules will involve building a BHC patient appointment template and assuring it supports the core features of BHC Practice. Specifically, the template will need to include 10 to 14 30-minute appointments throughout the Practice day. To assure same-day access, every other appointment slot will need to be designated as "same-day only." Leaders should identify optimal strategies for communicating the need for a same-day BHC visit, such as use of text messaging, pagers, or person-to-person interactions and offer teams options for completion of necessary tasks (e.g., creating an appointment, checking patient in, transporting patient, etc.). Highly innovative BHC services, such as the PCP preparation visit suggested by Robinson and Reiter (2016), will require more

thought. This visit type involves the BHC completing part of the PCP visit prior to the start of the PCP visit (e.g., interviewing a new patient with a mental health history about their mental health history prior to the start of the PCP visit). This type of service can add quality and efficiency (i.e., save PCP time, particularly on a busy day); however, this option will be used only by the team that has worked out communication and workflow strategies.

To attain full population health impact of the PCBH model, it is important for BHCs to have access to demographic information about patients enrolled at the clinic. For example, it might be important to have information about a team’s or PCP’s panel, including the size, payer mix, age/race/ethnicity/language breakdowns and most frequent patient problem presentations or top ten diagnoses. It might also be useful for the BHC to have the relative standing of each panel on primary care quality metrics, such as diabetic control, colorectal screening, completion of adolescent Well Child visits, etc.). Access to such information will assist the BHC in thinking through population-based care strategies for delivery of BHC services and in anticipating what evidence-based interventions they can add into the clinic’s current efforts to attain primary care quality metrics. This type of information is also helpful to development of PCBH model pathways targeting the group of patients with greater complexity.

**Support of BHC Practice management.** One of the PCBH model goals includes shifting some of the burden of biopsychosocial healthcare from PCPs to the BHC to increase efficiency in primary care service delivery. For example, PCPs often spend more time with depressed patients, so having a BHC assess and intervene prior to the PCP visit with patients presenting with depression can shorten the amount of time the PCP needs to spend. When BHCs are included in daily team huddles, PCPs can anticipate patient visits that might “run long” due to the complexity of the patient and request that the BHC handle part of the visit so that the PCP can remain on-time. To optimize Practice management for PCPs and BHCs, each BHC in a clinic should work in the physical area of the clinic where their assigned teams work. This provides a visual reminder of BHC availability, promotes efficiency in team communication and coordination of care, and reinforces the perception of the BHC as an essential part of good healthcare.

Unlike most other members of the team, our experience suggests that up to 20% of BHC time may be spent in the delivery of group-based services. Group-based care allows for efficient delivery of services to large numbers of patients who could benefit from learning the same healthcare intervention or skill set. Clinic leaders can assist in determining group service location, supporting the creation of workflows for scheduling and multiple patient check in, and developing documentation templates that minimize length of time needed for BHC charting of group visits.

**Support of BHC consultation role.** The BHC is often one of the first members of the team to work in a consultant role; therefore, clinic leaders need to consider work processes designed to support this new role. Leaders may assist PCPs and nursing staff in using BHC services more broadly by identifying specific patients that might typically be sent to the BHC for a visit. For example, PCPs are typically good at referring patients with anxiety or depression but may not think to refer patients with other problems for which a BHC consultation could improve the treatment plan and/or treatment results (e.g., diabetes, hypertension, tobacco cessation, obesity, chronic pain). In our experience, reminding the primary care team to refer patients with these problem presentations or establishing a clinical pathway that identifies and makes referral a routine standard operating procedure can dramatically increase the referral rate.

Another aspect of the BHC consultation role is that of researching questions that PCPs and nurses may have about patients that they may or may not refer to the BHC for a direct service. For example, a PCP may have a question about the evidence for behavioral interventions for temporomandibular joint disorder or want an opinion on initiating an exercise program with an overweight adolescent with asthma. Sometimes the BHC will have the answer to questions like these, but other times, the BHC will need to access clinical decision support tools used by PCPs (e.g., Dynamed, Up-To-Date). Given the broad range of problems seen by the BHC and the rapid expansion of new scientific findings, the BHC needs to stay current with evidence-based assessments and treatments for behavioral health concerns.

One of the challenges for many BHCs new to the PCBH model is working as a consultant rather than a psychotherapist. Adherence to the consultation role may be estimated by the ratio of the BHC initial visits to the BHC follow-up visits. Generally, that will be in the range of 1:2 or 1:3. When ratios are as high as 1:5, this usually signals a problem with the BHC’s adherence to the PCBH model and more training may be necessary. Clinic leaders can assist with timely corrections in BHC Practice patterns and encourage Practice in a consultant role by making certain that monthly reports are available to the BHC and to the clinic manager for the BHC. Another important metric is the percentage of same-day visits the BHC completes on a daily basis. In our experience, optimal functioning occurs when about half of the BHC patients are seen in same-day, “warm hand off” encounters (i.e., a patient is seen by the BHC immediately after or before the medical visit and may be introduced to the BHC by the PCP). A same-day appointment also occurs when a patient calls the clinic requesting a same-day visit and is then seen by the BHC that day. Availability of BHC monthly metrics related to the ratio of initial and follow-up visits, and same day appointment frequency, provides the BHC and clinic leaders with actionable information to assist a new BHC in practicing with fidelity to the role of the BHC as a consultant.

**Support of BHC documentation.** Although a challenge, efforts to improve the match between available electronic health record (EHR) templates for mental health and substance abuse and the charting needed to support BHC work can pay dividends, both immediate and long-term. An EHR template with prompts and data fields that align with the typical BHC-focused assessment, interventions, and recommendations can support timely and accurate completion of visit documentation. Additionally, a well-developed BHC template highlights recommendations for PCPs and nurses concerning the possible focus for future visits with the PCP and nurse. It is important that BHC notes resemble PCP notes including a similar charting format (i.e., SOAP, DAP) completed in the primary care visit section of the EHR. In our experience, most EHR mental health note templates are designed for specialty mental health providers and offer mostly unnecessary and unhelpful structural components for BHC work. Therefore, it may be easier to create a BHC visit template rather than attempt to craft a BHC note from an existing template created to support a substantially different service.

Table 3 provides a listing of topics typically included in a chart note of an initial BHC visit. The note includes a brief contextual interview designed to provide an understanding of the referral problem in the context of the patient’s life and a functional analysis of the referral problem. Both help to inform development of a behavioral or cognitive intervention. For new BHCs, it may be helpful to have questions that support timely assessment of life context and completion of functional analysis included within the EHR. This may be accomplished by creating .dot phrases for the question lists.

Other .dot phrases may be used to assure that the BHC is using evidenced-based interviewing processes for risk situations, such as risk of suicidal behavior.

Assessments typically used by the BHC can be built into the EHR for easy access and, if possible, included in lab sections in a graph format to show change over time. It is also important for EHR/BHC templates to include clinical measures of health-related quality of life and links to quality patient education handouts for printing as a part of the “after-visit” summary (i.e., the summary and instruction sheet provided patients after a visit). Clinic leaders may encourage PCPs and nursing staff to consistently use BHC assessments and patient education handouts by making them accessible in the EHR. This can enhance patient experience of continuity and increase the likelihood of patient success in behavior change over time. There may also be adjustments that can be made to the after-visit summary sheet that increase its’ usefulness to patients. For example, automated text may be added concerning the availability of the BHC for same-day follow-ups in the future (as this has the potential to reduce no-show and cancellation rates associated with scheduled follow-ups).

Clinic leaders need to also consider billing strategies and assure that EHR documentation supports billing. This may require that PCP chart notes include documentation of a referral problem for a BHC consult, as well as specification of the referral problem. It is helpful to have the flow of the BHC note mirror the flow of the PCP note, so that readers know where to find information quickly. Table 4 provides an example of a chart review tool. Clinic leaders can use this tool as a checklist to assure that essential elements of a BHC chart note are included in the EHR template.

A final detail concerning BHC documentation involves trying to build key metrics of program evaluation in the chart note, to support development of monthly reports. Such elements might include documentation of referring PCP and referral problem, as this supports oversight of the number and breadth of referrals by individual PCPs. Other elements include whether the BHC visit is an initial or follow-up visit and whether it is a same-day visit or a future scheduled visit. Inclusion of outcome scores (e.g., quality of life scores) support creation of reports that provide feedback about the effectiveness of individual BHCs with all patients and, if a “target problem” list is included in the EHR, an estimate of BHC effectiveness with specific problems. Some systems may build in rating scale questions (using a 1-10 scale), such as problem severity, patient confidence in behavioral experiment resulting from the visit, and patient evaluation of the helpfulness of the BHC visit (for more information see Robinson, Gould, & Strosahl, 2010). Robinson and Reiter (2015) provide more general information about PCBH model program evaluation, and clinic leaders will also need to think through possible additional metrics that support value-based payment calculations.

BHCs will need access to patient registries created by other team members and the ability to create their own registries as well. Regardless of who creates the registry, all team members should have access to registries involving delivery of BHC services. Registries may include lists of patients with recent emergency department visits, patients recently discharged from the hospital, patients at high risk for suicide, patients with medication agreements, or patients who are receiving BHC care management while initiating psychotropic medication treatment. Additionally, registries may track other at-risk groups, such as those with multiple chronic conditions. Registries may also be helpful in tracking the impact of BHC efforts to support patient referral to specialty mental health and substance misuse services and to promote continuity in primary care after specialty treatment is initiated or completed.

**Supporting BHC integration with the team.** As a new member of the team, the BHC will benefit from clinic leadership efforts to formally integrate the BHC as a team member. This may be accomplished in

a variety of ways, including development of a poster with a picture of the BHC to introduce newly hired BHCs to staff and patients and developing a brochure and exam room poster that describes the role of the BHC and services provided by the BHC. Clinic leaders may also help by developing clear workflows and posting them in optimal locations in the clinic. Clinic leaders may also support BHC attendance at provider meetings and encourage the BHC to have and use a brief speaking time at every provider meeting. When there is more than one BHC in a clinic, clinic leadership may assign each BHC to certain teams so the BHC is responsible for providing care to a specific group of patients. Implementation of clinical pathways, in addition to improving population health impact as previously discussed, can also serve as a concrete way to involve the BHC in team-based care. In our experience, thoughtful efforts to make BHC services “routine” improve the frequency of team member use of BHCs. Increased team engagement creates the opportunity for team members to get to know the BHCs better, see the impact they can have, and more quickly view them as an important team asset.

**Administrative support.** Finally, while we have discussed aspects of administrative support in several of the preceding sections, it is important to emphasize the importance of clinic leaders’ on-going attention to administrative details, including developing appropriate policies and procedures. Table 5 offers a listing of PCBH model service delivery performance goals and objectives to support development of useful dashboards and program evaluation reports. Clinic leaders need to clarify responsibility regarding development of a manual to guide PCBH model implementation and operations and a plan for updating annually as the program evolves. With PCBH model expansion, there may be a need to revise the roles and responsibilities of various team members and to add information on new PCBH model team members, such as Behavioral Health Assistants (see Robinson & Reiter, 2015, Chapter 3).

### **PCBH Model Competencies for PCPs and Nurses**

The Primary Care Provider and Nurse Core Competency Tool (PCP & Nurse CC Tool) (Table 2) lists 35 competencies in six domains for PCPs and nurses working in the PCBH model (Robinson & Reiter, 2015). More details about the meaning of each competency and examples of these competencies are described by Robinson and Reiter (2015, Chapter 6). This tool was developed based on observations of PCP and nurse clinical behaviors that seem to work effectively in a PCBH model of service delivery. It has not yet been formally assessed for psychometric properties or predictive outcomes. The PCP and nurse CC Tool provides a structure for self-assessment and Practice improvement planning for PCPs and nurses preparing to work successfully in the PCBH model. Increasingly, PCPs and nurses will be able to attend workshops to learn fundamental skills for working in PCBH model clinics. Arizona State University (2016) is currently developing a series of webinars for PCPs focused on working with BHCs (see <https://go.asuonline.asu.edu>); however, many competencies are best mastered in the Practice context while providing services with a BHC. In the following section, we provide a brief review of competencies listed in the 6 domains of the PCP and Nurse CC Tool.

**Domain 1: Clinical Practice.** Competencies in this domain focus on PCPs and nurses further developing their skill in talking with patients about a biopsychosocial approach to health and in delivery of brief evidence-based behavioral interventions. This area also includes the PCP and nurse pattern of routinely using the BHC to enhance care for patients with broad range of presenting problems. This requires a shift from referring to the BHC as “specialist,” “psychotherapist,” or “counselor” to thinking of the BHC as a team member with expertise in biopsychosocial assessment

and intervention. PCPs and nurses may also improve their skill in working with a patient to identify a specific problem for the focus of the BHC consult. This is an important aspect of making successful referrals, as patients are often more likely to agree to involve the BHC when the problem agreed upon with the PCP is of fundamental importance to the patient. Training in this area encourages the PCP and nurse to look at the functional impact of symptoms and the use the BHC to help a patient improve their functioning in key roles, such as parenting or being a loving partner. Other aspects of this domain focus on learning the most common interventions used by the BHC so that they can support these in medical visits, promoting patient experience of continuity in care. Finally, this competency involves partnering with the BHC in delivery of group medical services and encouraging patients to participate in workshops and class series offered by the BHC.

**Domain 2: Practice management.** Competencies in this domain focus on use of the BHC to improve PCP and nurse efficiency in Practice and, as a result, may improve patient access to both medical and behavioral health services. For example, PCPs learn to use BHC referrals to reduce the length of a medical visit and nurses learn to offer a BHC visit when it better meets the needs of a patient than a medical visit (e.g., when a patient calls indicating psychological distress over a stressful life circumstance). Another skill in this domain is using on-going BHC services to improve outcomes for patients with multiple medical and psychological problems. With continuous availability to BHC services, patients may learn skills to reduce stress, make gains in motivation for health behavior change, and more consistently engage in approach-oriented skills for managing chronic disease and emotional problems that often accompany illness. Finally, this area includes learning to use the BHC to help with tasks other than patient visits, such as reviewing records and making phone calls. Flexible use of the BHC in accomplishing the multiple tasks of serving the planned and unplanned needs of patients may reduce stress and time pressure for the entire team and enhance their overall experience of job control and job satisfaction.

**Domain 3: Consultation.** This domain focuses on fine-tuning skills for using the BHC as a consultant. A consultant provides a variety of services, all to enhance the team's ability to conceptualize and implement behaviorally informed treatment plans for patients. PCP and nurse mastery in this area involves routinely using the BHC to research needed information about evidence-based behavioral interventions and to assist with treatment planning for patients the PCP may manage without referring the patient for a face-to-face visit with the BHC. It is also learning to consistently access the BHC at the time of consultation need in an efficient manner. This may involve interrupting a BHC during a visit, which is perfectly acceptable and expected in a PCBH model clinic. As PCPs and nurses gain fluidity in this area, their conversations about the BHC with patients come to more clearly reflect the importance of behavioral consultation to outcomes valued by the patient. Strong skills in using the BHC as a consultant also pave the way for PCP and nurses to make continuous gains in development of a broad repertoire of assessment, conceptualization, and interventions for patients with behavioral challenges.

**Domain 4: Documentation.** Although there are few skills in this area, they are important ones as they support inter-professional communication, billing procedures, and continuity for the patient. First, PCPs and nurses need to document their referral and specify the referral problem agreed upon with the patient. Most clinics will have specific workflows designed to support BHC billing, such as specification of a medical problem in the referral for patients with chronic diseases who are experiencing biopsychosocial barriers to self-management. When PCPs and nurses follow-up with a patient after a

BHC consult, they will need to review the BHC note and support the behavior change plan as a part of their medical visit. This will include the PCP or nurse charting patient status relative to the referral problem for the BHC consult and the patient’s experience with implementing the plan resulting from the BHC consult, as well as the behavioral plan resulting from the medical follow-up visit. While BHCs will typically complete progress notes on a same-day basis and notify PCPs of their availability in the EHR, most will want to make time to listen to brief verbal BHC feedback about a same-day consult (usually requiring less than a minute). Lastly, PCPs and nurses share the responsibility for clarifying charting responsibility associated with curbside conversations about a patient. Curbside conversations are those inter-professional interactions that occur separate from a patient visit and result in any type of modification to the treatment plan.

**Domain 5: Team performance.** In this domain, the PCP is encouraged to consider what standing orders they might support for automatic BHC referrals. For example, many PCPs routinely refer any patient that uses tobacco products for a same-day BHC visit. This area also concerns PCP and nurse collaboration in developing, implementing and evaluating PCBH model pathways. Such may develop out of mutual interests or be associated with participation in the clinic’s quality improvement committee work. This domain highlights the importance of competency regarding knowledge and consistent adherence to workflows established for accessing BHC services, both for same-day and scheduled appointments. Finally, this area concerns PCP and nurse responsibility in identifying barriers to use of the BHC and to working toward resolution of identified barriers.

**Domain 6: Administrative.** PCPs and nurses need to review the PCBH model manual and be supported in discussing questions and ideas concerning the program and related policies. The manual describes the roles and responsibilities of PCPs and nurses, as well as Practice management tools and risk management procedures. The manual also includes a listing of the services that BHCs do not provide, such as court-ordered services, and PCPs and nurses need to be aware of these. PCPs and nurses need access to the manual on a common drive so they can access it as needed. They also may contribute new ideas and suggest changes in annual updates to the manual.

**Challenges to PCP and Nurse Competency Development** It has been our experience that most PCPs and nursing staff can easily master the competencies of working in a PCBH model clinic and will quickly experience the positive reinforcement for changes they make to Practice habits. Unfortunately, there are a few, somewhat common barriers that may inhibit PCPs and nurses from acquiring some of the skills related to competent Practice in the PCBH model. Barriers may include insufficient time for learning new skills, change fatigue, and strong habit strength for old patterns of working with behavioral health providers. In addition, a lack of confidence in the quality of BHC services or a concern about overwhelming the BHC may suppress demonstration of behaviors consistent with the PCBH model. Finally, lack of understanding of the benefit of BHC services to PCP and nursing Practice and sense of job control may be a barrier.

**Lack of time and change fatigue or burnout.** Medical information grows daily, and PCPs are required to track new information about diagnosis and treatment in dozens of areas. As generalists, they need to stay abreast of findings related to preventive activities and treatment of acute and chronic conditions for infants, children, adolescents, adults and elders. Additionally, they work with EHRs that are imperfect, time consuming, do not necessarily support quality medicine, and are frequently

changing. With such high demands for acquiring and generating information, some PCPs and nurses may come late for trainings on PCBH model skills and/or multi-task while in training. Strategies for addressing these challenges include shortening PCBH model trainings and assuring that they are highly interactive and even playful, and therefore engaging for busy PCPs and nurses. PCPs and nurses are also likely to be more involved when trainings are anchored to a case example or a quality issue and involve small group skill Practices and discussions. In addition to group trainings, it is helpful to provide academic detailing to PCPs and nurses, often focusing on a competency area suggested to be problematic for a significant number of PCPs or nurses. Detail training can be supported by a half-page handout with three key points written to facilitate retention or by short video clips.

Additionally, the BHC may address the change fatigue or burnout directly by offering trainings that help PCPs and nurses identify sources of stress and develop plans to address stress effectively. In a recent study from the United States, 45.8% of physicians reported having at least one symptom of burnout (Shanafelt et al., 2012). Because physicians and nurses are not likely to seek help and about a quarter of doctors attempt to hide their symptoms of anxiety or stress from their colleagues (Rosvold & Bjertness, 2002), BHC services in the clinic may provide a new and needed support for improved attention to resiliency in the primary care team.

To address stress and burnout, the BHC may draw from empirically supported programs designed to improve the health and well-being of workers (Flaxman, Bond, Livheim, & Hayes, 2013), as well as adaptations of the Acceptance and Commitment Therapy (ACT) model designed to address provider resiliency (Robinson, Gould, & Strosahl, 2010). There are studies in progress assessing the impact of such programs on the health and well-being of health care workers (see for example, Baker, Beachy, & Bauman, 2017; Lee-Baggley, 2017). Lee-Baggley and colleagues in Halifax, Nova Scotia have discovered barriers to use of the program and experimented with offering different formats. Specifically, they report a tendency to under-report need for such programs and time constraints as barriers to participation. This research team has tried various delivery formats, including (1) a one day workshop with a half day follow-up; (2) 4weekly 1-hour sessions conducted during academic rounds, (3) 3 weekly 1.5-hour sessions, and (4) a single 1.5-hour awareness session. Currently, they are conducting a randomized trial using a 10-session telephone-coaching program, as this format provides greater flexibility as well as anonymity. Initial data from the various formats suggests that the ability to foster Practice of ACT skills is important to program effectiveness. Researchers working in this area will hopefully look at program impact on PCP development of PCBH model competencies and their related benefit to efficient and effective Practice, job satisfaction and continuation in the field of primary care.

**Strong habit strength.** Some aspects of working with BHCs may conflict with previous PCP and nurse habits, including those developed in Practice and those trained directly in traditional family Practice residents. For example, some PCPs and nurses were trained to never interrupt a "therapist" and it seems wrong for them to do so, even after encouragement. They worry about having a negative impact on the patient and offending the BHC. Another example involves the ways that PCPs and nurses have learned to interact with patients about mental health and substance abuse services. Strong training produces robust patterns, and some PCPs and nurses may resort to referring to the BHC as a counselor, or in some other way imply a specialist role, even after skill-based training in the PCBH model. Practice patterns and beliefs that run counter to PCBH model Practices can be addressed over time through re-education, encouragement, and persistence. Also, using physicians or nurses that are PCBH champions to share strategies in provider meetings may have a significant impact in modifying

strong Practice habits among their colleagues. Furthermore, PCPs and nurses learn from their experience and that experience includes what they see other staff do in day-to-day Practice and what patients report in the way of benefit from focused, consultative interventions with a BHC.

**Factors related to the BHC services.** Barriers related to competent team-based Practice with a BHC may also relate specifically to PCP and nurse beliefs about the BHC. For example, some believe that short-term work with patients with mental health problems is not helpful to patients. Other PCPs may have developed their own set of behavioral and medication interventions to use with patients with behavioral problems because they could not access specialty services for their patients. Among this group, some will be reluctant to change because they do experience success with their approach, although this may come at the cost of struggling with managing their schedule. For these barriers, the BHC will need to work to develop strong relationships and to continuously provide 5-minute updates on the literature supporting the use of brief interventions at provider meetings. A final barrier to competency development related to BHC services is a PCP or nurse's perception that the BHC is not competent in some ways. Early in the BHC's Practice, a patient receiving a consult may have provided negative feedback to the referring PCP or nurse. As discussed earlier, there is a shortage of behavioral health providers trained to work in the PCBH model. Even if a BHC has a good clinical repertoire, they may not be effective in teaching or influencing the PCPs and nurses.

Clinic leaders may be able to assist if this appears to be an issue in PCBH model implementation by working to obtain further training for the new BHC, both as a competent provider of clinical services to a wide range of patients and as an educator for PCPs and nurses. If a BHC appears to be ineffective and not inspiring the confidence of his new colleagues, clinic leaders may need to look for a replacement and to attend closely to strategies used in recruiting and selecting the replacement. In general, a strong BHC candidate is one who wants to change from traditional mental health to primary care, likes the idea of being part of a team, voices confidence in being able to help a patient in a short visit, knows cognitive behavioral interventions, and likes a fast pace. A BHC with these qualities may be better able to embrace the role of teaching PCPs and nurses over time, including barriers that are sure to arise.

**Lack of perception of benefit of BHC services to PCP and nurse Practice.** PCPs and nurses may see BHC services as an additional cost in a tight budget and not clearly understand the potential for the BHC to support their billing and reimbursement. In medicine, as in other fields, professional behavior is shaped by a business plan and the business plan in medicine revolves around using codes that will be paid and paid well. Historically, clinics have experienced barriers to billing BHC services at a level that would allow their service to break-even. This is changing now, state-by-state, and the current move to explore combined fee-for-service and value-based payment models is creating the financial culture needed for PCBH model services to take hold in clinics with differing population risk levels and payer mixes.

**Identifying Barriers** Of fundamental importance in addressing barriers to PCP and nurse development of competence in working in a PCBH model is identifying the specific barriers that appear to be influencing their Practice at any given time. There are many potential barriers, some subtle and some obvious, and they may be effectively addressed and then re-appear in the context of provider turn-over and system changes in a clinic. From our clinical experience, we have found two brief questionnaires useful in "testing the waters" to identify emergence of barriers to optimal

implementation, with PCP and nurse competence being only a subset of potential barriers. The PCBH Barriers to Use of BHC (BUB) (Robinson & Reiter, 2015) may prove useful in the first four to six weeks of starting a BHC service. The Barriers to Same Day Use of BHC (BUS) (Robinson & Reiter, 2015) is indicated after the program has been up and running for a few months, particularly when the BHC has not started to receive five or more same-day referrals daily. Most PCPs can complete the BUB or BUS in three to four minutes, and results can suggest problems with barriers related to operational factors, as well as PCP and nurse knowledge and Practice habits. Both questionnaires are readily available (see [www.behavioralconsultationandprimarycare.com](http://www.behavioralconsultationandprimarycare.com)). Although neither have been psychometrically validated, clinic leaders and providers have found them useful in a large variety of primary care systems.

### Case Studies

The final section of this article offers two case studies demonstrating how two very different healthcare systems addressed workforce development in PCBH model implementation and expansion. Multnomah County Health Department (MCHD) is an urban, safety net public health system, with many primary care sites that are designated as federally qualified health centers (FQHCs). In 2016, MCHD deployed BHCs in all primary care clinics and began a major initiative to transform to the PCBH model. The Department of Defense (DoD), a pioneer in integrated care, now mandates delivery of PCBH model services worldwide in all military adult primary care clinics with at least 3000 enrollees. These include services in both small and large clinics and in sites that train social work, psychology, physician assistant, internal medicine, and family medicine residents. This section describes the implementation strategies used in these system-wide initiatives. In addition, we address the “lessons learned” by each of these systems, with a specific focus on addressing the barriers to workforce development and preparation.

**Multnomah County Health Department** Multnomah County Health Department (MCHD) in Portland, Oregon is comprised of three divisions: Mental Health and Addictions, Public Health, and Integrated Clinical Services (ICS). ICS provides medical, behavioral, pharmacy, laboratory, and dental care services to over 70,000 patients in primary care Practices, a specialty HIV clinic, school-based health centers, dental clinics, and jails. MCHD's seven primary care Practices, specialty HIV clinic, and 13 school-based health centers adopted a team-based primary care model that included co-located mental health services in 2007.

As a part of continuous quality improvement, the PCBH model was fully implemented in all MCHD primary care clinics in 2016. While the PCBH model was implemented in 2016, organizational preparation for this Practice transformation began in 2012. At that time, due to MCHD's desire to enhance behavioral health integration, an expert in the PCBH model (with strong connections to the local mental health and addiction community) was hired as the PCBH program manager. The PCBH program manager's role was to advise senior leadership, be a member of the primary care leadership team, and serve as an ambassador creating a strategic link between MCHD primary care clinics and the local mental health and addiction provider community. MCHD senior primary care leadership and the PCBH program manager convened and supported a multi-session work-group in early 2012 to develop a strategic integration plan. This collaborative work-group included leadership from the health department's Mental Health and Addiction's division and MCHD primary care Practice representation. The goal of this multi-session work-group was to conceptualize an “ideal” system of care for MCHD primary care patients who have behavioral health concerns. Because of this collaborative effort, a

visual-model was created that depicted a BHC assigned to every primary care team (and therefore patient) and strategic connections between MCHDs integrated primary care teams and the secondary and tertiary mental health and addictions services in the local community. In 2016 (after successive and exhaustive internal clinical and operational efforts), this once "ideal" system of care was achieved in full with the PCBH model initiative. The PCBH model initiative focused on hiring, core competency training, and strategically assigning BHCs to every primary care team. Additionally, culturally-responsive community health workers were paired with each BHC to support each primary care team.

Currently, all MCHD primary care patients can receive an equitable biopsychosocial primary care service. Each full-time BHC works with the team in caring for between 3,000 to 5,000 patients. The number of patients assigned to BHCs depends on the complexity of patients in the Practices they support. For example, as is typically the case for PCP Practice, BHCs have fewer patient assignments working in an HIV clinic as compared to working in a pediatric clinic.

It is worth mentioning that when the PCBH model was initially implemented MCHD used the title "behavioral health consultant" to describe the licensed clinical social worker or psychologist primary care team member. This title was soon changed to "behavioral health provider." This new title supported PCBH model implementation in several ways. It promoted (1) the concept of "shared biopsychosocial care" between the PCP and assigned behavioral health provider; (2) an equitable relationship between the primary care provider and the behavioral health provider; (3) an understanding that the behavioral health provider was a clinician like the PCP; and (4) the important longitudinal and relational care aspects of the behavioral health provider's Practice. Regarding the last point, our experiences suggest that the longitudinal and relational care aspects of the PCBH model are important and may unfortunately be overlooked or underappreciated. MCHD primary care found that changing from "consultant" to "provider" ensured that the longitudinal and relational care aspect was better understood. One of the most rewarding aspects of BHC work is the opportunity to be a life-long, consistent, and ever-ready support to team-assigned patients. The goal of primary care is to provide a continuity relationship to patients; as such, this is also the goal of the BHC. BHCs, like PCPs, at MCHD can see a patient in childhood for school avoidance then again in adolescence for depression and then again in adulthood for chronic disease and, eventually, perhaps for end-of-life care. In close collaboration with PCPs, BHCs at MCHD can support the identification of severe mental illness early in life, ensure coordination of the patient to comprehensive care, keep abreast of treatment progress, and support the patient throughout their life in a bio-psycho-social way.

To support this new and sizeable BHC workforce, and to develop a PCP and nurse workforce to partner with them, MCHD initiated a core competency training program in clinics for BHCs and a structured PCBH model orientation program for PCPs and nurses. To prepare the clinics for PCBH model Practice transformation, leadership and primary care teams received extensive training on the skill sets of BHCs (who were licensed clinical social workers and psychologists) and the impact of these skills on PCP and nurse Practices, team effectiveness and patient outcomes. Leadership, PCPs, and nurses learned about the extensive training received by BHCs and the level of comparability between BHCs and PCPs regarding educational attainment and clinical preparation. Primary care teams also received training in a variety of behavioral interventions for common primary care problems. The overall training approach validated the use of psychiatric medications as a treatment option, but encouraged widespread use of focused cognitive-behavioral interventions for many problems. Teams came to understand that these interventions would be widely available to MCHD patients because of BHC staffing. They also learned that focused cognitive-behavioral interventions can be clinically and cost-effective treatments for many problems. Lastly, teams learned that focused cognitive-behavioral

interventions provide the additional benefit of having few or no side effects and, because these interventions help patients learn new skills, their benefits can be more durable than medications which are eventually discontinued placing the patient at risk for relapse.

MCHD also developed a three-phase competency-based training program to support BHCs in their clinical Practices. This training included (1) didactic training both in live and video formats, (2) shadowing of BHCs on-the-job by an expert trainer and expert trainer coaching for BHCs using the PCBH model core competency tool, and (3) a focus in clinic on retooling the primary care team for integrated team-based care. The purpose of this training program was to promote integrated team-based competencies for all clinic staff, with a focus on clinic leadership, PCPs, nurses, and BHCs.

To sustain integrated team-based training goals over time, an additional eight-hour didactic training was created by MCHD BHCs and was reviewed and approved by MCHD senior leadership. This training is now an ongoing regular training for all MCHD primary care providers and nurses. It is a respected training that is attaining interest from various divisions within this health department and from external organizations. The training reviews the following: integrated team-based care concepts and workflows; how to access and engage with the local mental health and addiction system of care; how to effectively use psychiatric consultation and psychiatric care management; basic motivational interviewing skills; basic suicide prevention skills; biopsychosocial care for patients who have chronic pain; the impact of adverse childhood experiences on health outcomes; the nature of posttraumatic stress disorder, trauma-informed and trauma-specific care; biopsychosocial care for patients who have depression and/or anxiety, and MCHD’s standard team-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) workflow for substance use concerns.

Additionally, MCHD continues to develop standard integrated team-based workflows with cross-functional work-groups (similar to PCBH model pathways described earlier in this article). An integrated team-based workflow was implemented as part of a suicide prevention initiative and another for the detection and management of depression and anxiety in primary care. Workflows are being developed to improve supports for patients with chronic pain and to improve early detection and treatment of behavioral concerns in children. These new integrated care team workflows typically include standardized screening and then referral to the patient’s BHC for focused clinical assessment and cognitive and behavioral interventions. The referring PCP and BHC then develop a team-based care plan for management of the patient’s concerns over time. The healthcare reimbursement system is a significant barrier to integrated primary care in Oregon, as it is across the United States. To address this external barrier, MCHD primary care and other local integrated care advocates educated local medical plans about the population health benefits of integrated primary care teams. MCHD explained that current fee-for-service payment did not incentivize BHC Practice and suggested that medical plans consider alternative payment methods (APM) to promote widespread adoption of integrated primary care teams. MCHD also made it clear that earlier initiatives to co-locate traditional mental health providers in primary care clinics were not able to address the extensive demand for behavioral services of all kinds, and only a population-focused, high-capacity, immediate access-driven approach like the PCBH model could dramatically improve the psychosocial health of the MCHD population. Because of these communications and other factors, a large local payer developed a unique per member per month payment rate for local primary care clinics who adopted the PCBH model. This new payment strategy, in concert with an overall blended payment structure for primary care, is ensuring the fiscal sustainability of the PCBH model at MCHD. The MCHD blended primary care payment structure that sustains integrated primary care includes: (1) a unique BHC per member per month rate from a local payer; (2) fee-for-service billing by BHCs; (3) primary care APM that pays per member per month for

most comprehensive biopsychosocial primary care service; and (4) team-based workflows that capitalize on the BHC to help teams meet local payer quality incentive metrics, such as metrics that incentivize SBIRT and universal depression screening and follow-up.

**Lessons learned.** Throughout the evolution of integrated services, attention was paid to empowering PCPs and nurses to function competently in the new model of care. The strategies that proved most useful included: (1) initial introduction of the PCBH model; (2) facilitated discussions among discipline specific groups (PCPs, nurses) focused on the benefits and challenges of implementation; (3) development of well-documented workflows related to BHC services; (4) team meetings including BHCs and all other members focused on optimizing workflows; (5) BHC shadowing of PCPs and nurses; (6) BHC presentations on evidence for behavioral interventions at provider meetings; (7) information boards in clinics maintained by BHCs; (8) patient education handouts addressing the 10 most common behaviorally-influenced problems stocked in accessible areas of the clinics; (9) initiation of a system-wide training for new employees that included instruction in PCBH model competencies; and (10) pursuit of a collective effort to reform payment for biopsychosocial primary care.

**Plans for the future.** Next steps for integrated primary care teams at MCHD include continued re-development of all workflows that could benefit from routine BHC support. Now that BHC services are rapidly available to patients, there is an opportunity to shift work previously done by PCPs that may be more effectively addressed by a BHC. For example, MCHD primary care clinics have the capacity to offer a visit with the patient's BHC instead of the PCP for common issues within the BHC's areas of competence (depression, anxiety, weight loss, smoking cessation, behavioral problems in children, etc.). In this way, MCHD primary care plans to use the BHC as a PCP extender. Losing providers because of professional burnout is a concern for MCHD primary care and for primary care Practices across the country. MCHD BHCs are focused on supporting efforts that have promise to decrease MCHD provider burnout. It is hoped that as PCPs are supported with a BHC that this in and of itself will help to reduce provider burn-out. In our experience, many PCPs report that patients with complex behavioral health concerns tend to bring challenge to their Practices. PCP access to a BHC (who is extensively trained to assess and treat behavioral concerns) could potentially mitigate some factors associated with PCP burnout. As an example, a team-based workflow is being created at MCHD primary care that would ensure a shared BHC and PCP approach to the care of patients who have chronic pain. It is hoped that this new approach could result in the PCP feeling more supported when caring for these patients whose concerns often persist and continue to be presented by the patient well after the PCP has exhausted viable medical options. Another current initiative intended to reduce provider burnout is a current pilot of BHC- and PCP-facilitated Balint groups. Balint groups are usually closed-groups of providers that meet regularly to review challenging patient cases for the purpose of exploring patient-provider relational dynamics. MCHD primary care has hopes that this offering will provide unique support to providers and help them leverage the patient-provider relationship to promote provider professional resilience as well as healing in the patient. In preparation for implementing this service, MCHD primary care determined that BHCs tend to have unique knowledge, skills, and abilities that often make them particularly strong Balint group facilitators. As such, BHCs have been paired with PCP leaders to facilitate these groups.

**The United States Department of Defense** A history of the implementation of the PCBH model in the DoD is described elsewhere (Hunter & Goodie, 2012; Hunter, Goodie, Dobbmeyer, & Dorrance, 2014). A

2013 DoD policy (DoD Instruction 6490.15) established policy, staffing requirements, behavioral health models of service delivery for primary care, and procedures for attainment of DoD required core competency standards for developing, initiating, and maintaining adult behavioral health services in primary care (U.S. Department of Defense, 2013). This instruction also described the training standards for BHCs and care facilitators in primary care (nursing staff members working with registries of patients, such as those with depression), but did not specifically address training standards for PCPs and nurses that would now work with integrated BHCs.

A working group which included representatives from each branch of the military developed a PCBH model competency-based, phased training and evaluation approach for BHCs in 2012 (Dobmeyer et al., 2016). This training was significantly expanded in 2016-17. Currently, newly hired BHCs complete a 3-week distance learning orientation phase of training consisting of self-guided learning activities as well as online webinars. BHCs then attend a 5-day Phase 1 centralized classroom training and skills evaluation. Phase 1 classroom training consists of didactics, demonstrations and role-plays of patient encounters, and a requirement for BHCs to demonstrate a set of core competencies in simulations of events likely to occur in real world Practice settings. After Phase 1 training, BHCs begin seeing patients in their primary care clinics. For the first three months of their new Practice, they receive bi-weekly phone mentoring from an IBHC trainer. Three to six months after Phase 1 training, BHCs participate in Phase 2 training, where they are observed during live patient appointments and real-time consultation with PCPs. During this phase of training, the BHCs are again required to demonstrate core competencies, but in a context of delivering services in primary care.

Although comprehensive training for new BHCs yielded positive outcomes, an equivalent training approach for PCPs and nurses was not available. As a result, the responsibility for training PCPs, nurses, and other staff became the responsibility of the clinic's BHCs and care facilitator. BHCs have a standardized clinical Practice manual and other specific instructional materials that they can use to assist staff in developing new clinical, Practice management, and team-based care skills. The DoD has continued to evolve trainings and Practice skills for the primary care team. For example, in 2014, they provided informational documents for teams to use in developing clinical pathways for eight specific, common conditions (i.e., depression, anxiety, diabetes, obesity, alcohol use, tobacco use, chronic pain, and insomnia). The pathways included methods for identifying patients and connecting them with primary care services, BHC interventions, and outcome monitoring strategies. In 2015, the DoD developed a one-day training for clinic leaders to prepare them to function as subject matter experts (SMEs) on the PCBH and collaborative care models of service delivery. Participants learned to identify and address PCBH model implementation challenges; design a PCBH model evaluation plan for their clinic and monitor results; facilitate effective multi-disciplinary teamwork, and provide effective training on PCBH model competencies for PCPs in the clinic.

**Lessons learned.** Over the past five years, DoD experts on the PCBH model have developed a better appreciation of the difficulties that many BHCs experience in mastering the skills required to succeed in the fast-paced, multi-disciplinary team setting and to function as effective teachers for PCP and nurse colleagues. To develop a strong BHC workforce, the DoD revised the Core Competency Tools for BHCs, as well as BHC mentors/trainers. Additionally, there have been efforts to make the BHC training more robust (e.g., increasing active learning, using standardized patients in role plays with BHCs). On-going mentoring has helped BHCs be more effective in assisting PCP and nurse colleagues with learning new competencies for delivering services consistent with the PCBH model.

**Plans for future.** Plans for integrated primary care teams in the DoD continue to emphasize knowledge translation, evidence-based Practices, and fidelity to the PCBH model. Implementation of clinical pathways continues to be refined to support the use of BHCs for primary care patients with specified conditions. As an example, the Army along with Center for Deployment Psychology recently completed a pilot in which approximately 50 IBHCs were trained in a Brief Behavioral Treatment of Insomnia (BBTI) protocol. Initial anecdotal feedback from trained BHCs has been positive, and a more formal evaluation of the pilot and plans to train additional BHCs are underway. Additional knowledge translation and implementation projects are planned for conditions such as chronic pain as well as the development of telemedicine protocols for BHCs. The Air Force is testing the use of psychology technicians to assist with conducting the assessment prior to the patient being seen by the BHC. Use of technicians further expands the primary care workforce involved in behavioral health care delivery

Training for BHCs within the DoD also continues to be refined. Toward that end, a comprehensive evaluation of the current BHC phased training program is underway to identify the most important aspects of the training that support the development of individual BHC and team competencies and behaviors. One part of this evaluation includes a PCBH patient "tracer," which allows for a robust chart-based evaluation that follows a patient's multi-disciplinary experience during their treatment course.

### Summary

There is a well-worn saying that states, "Be careful of what you wish for; you just might get it." This saying sums up the conundrum of workforce development, as PCBH model integration becomes the "new normal." PCPs and nurses have advocated for their patients to have better access to behavioral health services, and now this is increasingly possible. The PCBH model provides a needed structure to guide delivery of highly integrated behavioral health services, as well as new strategies for the new team to work together to improve outcomes. The initial concerns for most healthcare systems are with finding and training competent behavioral health providers to deliver BHC services. However, it is increasingly clear to systems transforming to the PCBH model that preparation of clinic leaders, PCPs and nursing staff are of equal importance to both short-term and long-term success. When prepared, clinic leaders can build a strong foundation for evaluation of the PCBH model, prepare for efficient implementation, and promote expansion and evolution of services over time. Clinic leaders can also promote competent PCBH model Practice among members of the primary care team by supporting training. This article offers tools to help clinic leaders, PCPs, and nurses be fastidious and effective in transforming to the PCBH model. Use of recommended tools and strategies in Practice and training venues is of paramount importance to the goal of creating a workforce for today and tomorrow, one with PCPs and nurses ready to partner with BHCs and address the behavioral health needs of patients of any age at the time a need is identified.

**Table 1**

*PCBH Clinic Leadership Competency Assessment Tool (PCBH CL CAT)*

Competency	Rating 1 = low, 5 = high
<b>Domain 1: Support of New Clinical Practices</b>	
1. Accurately defines the role of BHC.	
2. Develops and maintains schedule template of 30-minute visits for BHCs, with at least half designated as same-day.	
3. Demonstrates understanding of a population-based care approach to BH problems and anticipates impact on clinic operations.	
4. Supports BHC access to information needed to understand population served at clinic.	
5. Works effectively to address scheduling and charting needs related to delivery of group medical visit services.	
6. Works effectively to address scheduling and charting related to classes and workshops provided by BHC.	
7. Promotes use of BHC clinical measures in Practice evaluation reports.	
<b>Domain 2: Practice Management Skills</b>	
8. Assures optimal location of BHC in clinic (i.e., preferably in the team room with the BHC us exam rooms or consult rooms for patient visits).	
9. Advocates for optimal staffing of BHCs.	
10. Supports huddles that involve all team members, including BHCs.	
11. Identifies and addresses barriers to PCP and nurse use of BHC on a same-day basis.	
12. Identifies and addresses barriers to patient scheduling of future BHC appointments.	
<b>Domain 3: Consultation Skills</b>	
13. Develops Electronic Health Record flags for routine delivery of BHC services to targeted patient groups.	
14. Assures BHC has the resources to research questions about evidenced-based treatment and training to use resources well.	
15. Promotes collection and dissemination of data to team concerning BHC fidelity to consultation role.	
<b>Domain 4: Documentation Skills</b>	
16. Adjusts EHR to support BHC documentation of screening tool and assessment results.	
17. Adjusts EHR format for after visit summary to accommodate behavior change plan provided to patients by BHC.	
18. Changes EHR to support referral of patients to groups, classes, and workshops led by BHC.	
19. Works with EHR to facilitate development of registries supportive of BHC work.	

20. Works with EHR to enhance team linkage with Emergency Departments and hospitals.
21. Works with EHR and staff to enhance communication between BHC and external specialty providers, supporting continuity in stepping up/down.

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**Domain 5: Team Performance Skills**

22. Assists with BHC assignment to one or more PCP patient panels.
23. Encourages PCPS to provide standing orders for delivery of BHC services to targeted patient groups.
24. Adjusts EHR to support PCBH pathway design and implementation.

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**Domain 6: Administrative Skills**

25. Has read a copy of PCBH program manual and appendix.
26. Knows and supports staff training from the BHC to optimize clinic response to patients presenting with urgent threats to safety.

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**Table 2**

*PCBH Primary Care Provider and Nurse Core Competency Tool*

Competency	Rating 1 = low, 5 = high
<b>Domain 1: Clinical Practice Skills</b>	
1. Applies principles of population-based care to preventive and chronic care services.	
2. Applies principles of population-based care to MH problems.	
3. Defines role accurately.	
4. Shows understanding of relationship between medical and psychological systems.	
5. Refers a broad range of patients to BHC.	
6. Rapid problem identification for BHC referral.	
7. Uses appropriate assessment tools.	
8. Notes functional impact of problem.	
9. Supports self-management, home-based Practice.	
10. Supports interventions recommended by BHC.	
11. Demonstrates basic knowledge of best Practice guidelines for common behavioral health problems.	
12. Ready to work with BHC in group medical visits.	
13. Ready to work with BHC in providing PC lifestyle groups or classes.	
<b>Domain 2: Practice Management Skills</b>	
14. Uses BHC referral to reduce length of medical visit.	
15. Uses BHC visit to save a medical visit.	
16. Shows capacity to use BHC for continuity visits.	
17. Refers to BHC groups, classes and workshops.	
18. Uses BHC to link with ACO, CCO, hospital, school or other staff not co-located.	
19. Uses BHC to link patients with community resources.	
20. Uses BHC to make phone contacts with patients.	
21. Works effectively with PCBH registries.	
22. Uses BHC to assess and as appropriate to triage to MH and chemical dependency.	
<b>Domain 3: Consultation Skills</b>	
23. Understands consultative nature of BHC services.	
24. Expects BHC consultation to focus on one problem or answer a question.	
25. Seeks curbside consultations with BHC.	
26. Willing to interrupt BHC visit, when indicated.	
27. Asks BHC to research questions about patient care.	
<b>Domain 4: Documentation Skills</b>	
28. Documents referral to BHC and referral problem in chart note.	
29. Makes time for BHC to give 1-minute feedback when needed.	
30. Clarifies responsibilities for charting curbside conversation results.	
<b>Domain 5: Team Performance Skills</b>	
31. Provides/supports standing orders for BHC services.	

32. Supports PCBH pathway design and implementation.
33. Knows multiple ways to access BHC services, both same-day and scheduled.

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**Domain 6: Administrative Skills**

34. Has copy of PCBH program manual and appendix.
35. Knows what services BHC does not provide.

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*Note.* Robinson & Reiter, 2016. Used with permission.

**Table 3**

*BHC SOAP notes for Initial Visit*

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**Subjective**

Patient age and sex, referring provider and referral issue  
Patient's responses to life context questions  
Patient's responses to functional analysis questions

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**Objective**

Behavioral observations of the patient and any others present  
Pertinent mental status issues (e.g., affect, cognitive organization, suicidal ideation, etc.)  
Test results (e.g., screener or health related quality of life scores)

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**Assessment and Plan**

Conceptualization from functional analysis/life context questions  
Diagnosis (physical from the PCP; or other)  
Recommendations for the patient and the PCP  
Any further planned assessment or follow up

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*Note.* Robinson & Reiter, 2016. Used with permission.

**Table 4**

*The Primary Care Behavioral Health Chart Review Tool*

<b>Competency</b>	<b>Yes/No</b>
<b>Documentation in Patient Medical Record</b>	
1. Entries are brief, specific, and accurate.	
2. Each encounter contains written or electronic signature of BHC.	
3. All entries are completed and signed within 3 working days.	
<b>Behavioral Health Documentation Content</b>	
4. Includes name of referring provider and referral problem or question.	
5. Subjective includes life context assessment.	
6. Subjective includes functional analysis of target problem.	
7. Subjective includes suicidal/homicide risk assessment as indicated.	
8. Follow up notes assess change and patient experience with the initial consult plan.	
9. Objective includes description of patient behavior and/or outcomes instrument (e.g., DUKE for adults; PSC-17 for children).	
10. Assessment includes medical diagnosis by referring PCP (as applicable) and/or other diagnosis by PCP or BHC.	
11. Functional analysis problem conceptualization is in the note.	
12. Plan includes interventions for patient and follow up plan.	
13. Plan includes recommendations for PCP.	
Feedback to BHC from Reviewer (including any corrective action needed):	

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**Table 5**

*PCBH Model Performance Goals and Objectives*

<b>I. Patient Outcomes</b>	<b>Objectives</b>
Patients’ health-related quality of life indicators improve through provision of PCBH model of care.	A. Adult PC patients who receive services from a BHC show improvement in their health-related quality of life. B. Children/youth who receive services from a BHC show improvement in their psychosocial wellbeing. C. Patients participating in PCBH Pathways (self-care; self-management) show improvement in one or more areas of health. D. Patients who are identified as high risk/high cost patients who are only engaged in urgent/emergent services (e.g., high utilizers) are connected to a PCP and BHC.
<b>II. Access</b>	
Access to PCPs improves.	A. PCPs demonstrate an increase in the average number of patient encounters per clinical hour. B. Wait times for PCP appointments decrease. C. High users of PC visits who participate in Pathways demonstrate a reduction in PCP visits.
Access to behavioral health services for patients in the PC setting improves	A. Patients who have no histories in specialty BH / SA have their behavioral health issues detected and addressed in the PCBH model of care. B. Patients who have only urgent/emergent histories in specialty BH / SA have their behavioral health issues detected and addressed in the PCBH model of care. C. Patients in need of specialty behavioral health services are referred and connected.
<b>III. Experience and satisfaction</b>	
Patients experience the PCBH model of care as beneficial.	A. Patients (or their parents) express overall satisfaction with services provided in the PCBH program.
PCPs experience the PCBH model of care as beneficial.	A. Increasingly, PCPs report reduced barriers to use of PCBH services. B. Increasingly, PCPs indicate a stronger likelihood of working with the PCBH staff to develop and support a behavior change plans for their patients. C. Increasingly, PCPs indicate confidence in the PCBH program as beneficial to most of their patients. D. Increasingly, PCPs indicate belief that PCBH services help them provide better PC to their patients.
PCBH staff experience the PCBH model of care as beneficial	A. Increasingly, PCBH staff express satisfaction with providing PCBH services. B. Increasingly, PCBH staff indicate belief that PCBH services help them provide better PC to their patients.

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## Compliance with Ethical Standards

Human and Animal Rights and Informed Consent: This article does not contain any studies with human participants or animals performed by any of the authors.

## DISCLAIMER

The opinions and statements in this chapter are the responsibility of the authors, and such opinions and statements do not necessarily represent the policies of the Department of Health and Human Services

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## **Reading Series 3. Other New Primary Care Roles in Integrated Behavioral Health**

### **Reading A; The Teamlet Model of Primary Care**

Thomas Bodenheimer, MD and Brian Yoshio Laing, BS

#### *Abstract*

The 15-minute visit does not allow the physician sufficient time to provide the variety of services expected of primary care. A teamlet (little team) model of care is proposed to extend the 15-minute physician visit. The teamlet consists of 1 clinician and 2 health coaches. A clinical encounter includes 4 parts: a pre-visit by the coach, a visit by the clinician together with the coach, a post-visit by the coach, and between-visit care by the coach. Medical assistants or other practice personnel would require retraining to assume the health coach role. Some organizations have instituted aspects of the teamlet model. Primary care practices interested in trying out the teamlet concept need to train 2 health coaches for each full-time equivalent clinician to ensure smooth patient flow.

pdf of full article available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2000308/>

### **Reading B: Using the Teamlet Model to improve chronic care in an academic primary care practice**

Ellen H Chen 1, David H Thom, Danielle M Hessler, La Phengrasamy, Hali Hammer, George Saba, Thomas Bodenheimer

PMID: 20737236 PMCID: PMC2940441 DOI: 10.1007/s11606-010-1390-1

#### *Abstract*

**Background:** Team care can improve management of chronic conditions, but implementing a team approach in an academic primary care clinic presents unique challenges.

**Objectives:** To implement and evaluate the Teamlet Model, which uses health coaches working with primary care physicians to improve care for patients with diabetes and/or hypertension in an academic practice.

**Design:** Process and outcome measures were compared before and during the intervention in patients seen with the Teamlet Model and in a comparison patient group.

**Participants:** First year family medicine residents, medical assistants, health workers, and adult patients with either type 2 diabetes or hypertension in a large public health clinic.

**Intervention:** Health coaches, in coordination with resident primary care physicians, met with patients before and after clinic visits and called patients between visits.

**Measurements:** Measurement of body mass index, assessment of smoking status, and formulation of a self-management plan prior to and during the intervention period for patients in the Teamlet Model group. Testing for LDL and HbA1C and the proportion of patients at goal for blood pressure, LDL, and HbA1C in the Teamlet Model and comparison groups in the year prior to and during implementation.

**Results:** Teamlet patients showed improvement in all measures, though improvement was significant only for smoking, BMI, and self-management plan documentation and testing for LDL ( $p = 0.02$ ), with a trend towards significance for LDL at goal ( $p = 0.07$ ). Teamlet patients showed a greater, but non-significant, increase in the proportion of patients tested for HbA1C and proportion reaching goal for

blood pressure, HgbA1C, and LDL compared to the comparison group patients. The difference for blood pressure was marginally significant ( $p = 0.06$ ). In contrast, patients in the comparison group were significantly more likely to have had testing for LDL ( $P = 0.001$ ).

Conclusions: The Teamlet Model may improve chronic care in academic primary care Practices.

pdf of full article available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2940441/>

For more information, see Bennett, H. D., Coleman, E. A., Parry, C., Bodenheimer, T., & Chen, E. H. (2010). Family Practice Management, September/October, pp. 24-29. [www.aafp.org/fpm](http://www.aafp.org/fpm)

### **Reading C: Health Coaching for Patients with Chronic Illness**

Heather D. Bennett, MD, Eric A Coleman, MD, MPH, Carla Perry, PhD, MSW, Thomas Bodenheimer, MD, MPH and Ellan H. Chen, MD

#### *Abstract*

Primary care clinicians – struggling to fit multiple agenda items into a 15-minute visit – cannot meet every need of their patients with chronic conditions. Half of patients leave primary care visits not understanding what their doctor has told them. Through shared decision making is associated with improved outcomes, only 9% of patients participate in decisions. Average adherence rates for prescribed medications are about 50% and for lifestyle changes they are below 10%.

In the face of these discouraging statistics, primary care must take on a new task: working with patients to ensure that they understand, agree and participate in the management of chronic conditions. Health Coaching is one way to accomplish this function.

Article Web Address: <http://www.aafp.org/fpm/20100900/p24>