Bringing balance to primary care behavioral health and specialty behavioral health

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Epidemiological researchers in 1993 dubbed primary care the "de facto U.S. mental and addictive disorders service system"[1] due to the sheer volume of mental healthcare it was delivering. An epiphany at the time to many, it is still essentially true 27 years later: More people receive mental health and substance use disorder treatment through primary care rather than through the official behavioral health systems of care.[2]

There are many drawbacks, however, to primary care providers (PCPs) attending to mental health and addiction-related concerns: Visits last almost twice as long as regular acute and chronic care visits,[3] and many PCPs would readily acknowledge that they are not sufficiently trained in behavioral health assessment and treatment.[4]

WHAT WAS THE PLAN TO IMPROVE THE PRIMARY CARE SYSTEM?

The idea to incorporate behavioral health providers onto primary care teams as "physician-extenders" emerged in the 1990s; however, many primary care clinics simply started colocating behavioral health providers. It didn't work; they were just on-site specialists.

According to Thatcher Felt, DO, Yakima Valley Farm Workers Clinic, Grandview, Wash., those days yielded very little integration between primary care and behavioral health. "All of a sudden we had a psychotherapist down the hall," he joked. "She was the one with the ferns and white noise maker whose door was always closed."

Imagine if epidemiological researchers dubbed primary care the "de facto U.S. dermatologic conditions treatment system," and the response from primary care organizations was to hire on-site dermatologists for better warm hand-offs. Co-location of specialty providers in and of itself is insufficient to solve the systemic problem at hand.

Co-location of behavioral health providers is a first-order change — an obvious adjustment within the existing structure, doing more or less of something. As Amir Levy wrote in 1986, first-order change "consists of minor improvements and adjustments that do not change the system's core, and that occur as the system naturally grows and develops."[5] Second-order change — offered by primary care behavioral health — requires new learning and involves systems reengineering.

Strategic integration of behavioral health providers onto primary care teams holds significant promise for streamlining care delivery, improving the way providers collaborate and treat, and reducing overall costs.

HOW DOES INTEGRATED, PRIMARY CARE BEHAVIORAL HEALTH WORK?

The goal for primary care behavioral health patients is functional restoration with a light touch. There is a focus on outcomes, not necessarily based on any behavioral health metric but instead on clinical judgment and intentional, constructive collaboration between the embedded behavioral health provider and the PCP.

> **The goal is to attempt to treat patients first through primary care, only referring to specialty care after consultation with the integrated behavioral health consultant (BHC). This balancing act ensures the specialty care system is reserved for patients who most need it.**

A significant element of the model involves a normalization of the experience for patients engaging with a behavioral health provider when they see their PCP.

Bridget Beachy, PsyD, director of behavioral health at Community Health of Central Washington, Yakima, Wash., clarified that their mode number (the number most often seen in the practice) of integrated behavioral health encounters is one. This can be tricky from a revenue perspective when you understand what those singular encounters often amount to 15 minutes or less of patient-facing time, which constitute nonbillable services for many primary care practices (depending on the state and/or provider credential).

Nonetheless, the goal is to attempt to treat patients first through primary care, only referring to specialty care after consultation with the integrated behavioral health consultant (BHC). This balancing act ensures the specialty care system is reserved for patients who most need it.

Behavioral medicine is one version of integrated behavioral health associated closely and overlapping considerably with primary care behavioral health but tending to focus more on treatment of comorbid physical and mental health conditions.

At Columbia Valley Community Health's largest clinic, one of the psychologists and BMED consultants, Misha Whitfield, PsyD, provides regular treatment groups for patients being prescribed chronic pain medication to promote development of the use of effective, non-pharmaceutical pain management skills.

At another clinic, Christine Wineberg, PsyD, a BMED consultant, co-facilitates (with a registered nurse) a pain management group incorporating yoga. Both groups have a high attendance rate — Dr. Whitfield and Dr. Wineberg's groups have an average no-show rate of just under 6% — and a very high level of constructive engagement by patients.

Issues that arise in primary care prompting an integrated visit could include anxiety, depression, parenting issues, child behavior issues, domestic violence, addiction or other mental health or substance use issues. Integrated visits also include providing a whole person care approach to addressing issues such as obesity, hypertension, diabetes, tobacco cessation, insomnia, asthma, and coping with chronic pain and other forms of chronic illness. This is generally a brief, integrated biopsychosocial intervention, resulting in collaboration with the primary care team and/or referral to specialty behavioral health care when appropriate.

LESSONS ON HOW BEST TO BALANCE

In Washington State, we have learned three basic lessons about implementing primary care behavioral health.

1. **Integrated behavioral health providers must remain consultants and generalists if the integrated model is to retain its integrity or at least serve its originally intended, primary purpose — as a PCP extender and primary care team member**. Providers are less available for integrated access when they serve a dual role as integrated behavioral health consultant and co-located behavioral health therapist. As advanced practice providers (APPs, such as nurse practitioners and physician assistants) primarily were used as generalist physician-extenders, integrated behavioral health providers are best utilized as a type of primary care-based behavioral health generalist. Nonetheless, there is tension between prioritization of BHCs as PCP extenders versus prioritization of maximizing behavioral health treatment capacity.

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2. **BHCs must be treated as members of the primary care team**. If BHCs do not maintain physical proximity to the other primary care team members in the course of daily flow, they will not be treated as members of the primary care team. If BHCs do not participate in team huddles and some regular medical provider meetings, or if they are not regularly accessible in the team's pod, they will not be treated as members of the primary care team. If BHCs are not treated as team members, the service delivery is no longer in alignment with a primary care behavioral health model. Consequently, "[w]hen patients present to primary care for mental health concerns, visits last almost twice as long as regular acute and chronic care visits."[6]
3. **BHCs must be sufficiently available to PCPs**. If there is not sufficient BHC capacity to serve the PCP team and patient population, there will be angst. PCPs will be left to put forth best efforts to act as the de facto mental and addictive disorder treatment provider, primary care encounter levels will be reduced, and patients will not be best served. An ideal ratio for BHCs per PCPs in primary care behavioral health is 1-to-4, or 1-to-3 in pediatrics.

Part of maximizing utilization requires a paradigm shift from PCPs acting as the "quarterback," a commonly used football analogy that does not align with principles established for Patient-Centered Medical Homes (PCMH). According to core principles jointly established by six professional societies of family medicine, the PCMH model is marked by a team-based approach rather than a physician-centric approach.[7] Consider this baseball analogy: I view the PCP as a pitcher and the BHC as a catcher. Given a host of nuanced factors, the catcher may call the pitch to throw. The pitcher may veto the call, but even then there's collaboration. Most important, pitches from pitcher to catcher are routine.

SUCCESSES AND CHALLENGES IN INTEGRATING CARE

One of our biggest challenges is providing integrated services in rural areas, where there are limited specialty mental health services. The integrated care delivery model opens the door for us to serve many more patients. While some of those patients improve rapidly with brief integrated services, other patients will experience modest improvements early on but then require specialty behavioral health services to address more serious or several mental health and/or substance use disorder issues.

We blend integrated and specialty mental health services in our model, which makes it not quite fully available to either at times. If we focus on brief services only, we might reach more patients, but there might not be enough specialty mental health providers for patient referrals. On the other hand, if we provide more specialty services to some patients, we might not be able to reach more new patients. It's a constant balance, especially because many of our patients need longer-term services.

The integrated model requires complex care coordination and a lot of collaboration. While there are tools to meet diverse patient needs in the course of a visit, care coordination tasks can add up quickly as patient visits increase — tasks that result in time not billed for and/or not paid for by health plans. Nor is time for such tasks built into our providers' schedules — they simply complete them whenever and however they can. That's

stressful at times, trying to meet diverse needs with limited time between patients.

Innovation requires living in the tension. Through continual, strategic planning and process improvement, we must go beyond simply reacting or providing first-order solutions to meet community demand.

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NOTES

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