

## Behavioral Health in Primary Care

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## Disclosures

- No disclosures or conflicts of interest, financial or otherwise.

## About me

- I currently work at KU-Wichita School of Medicine, Pediatrics Department, in the Ambulatory Services and Newborn Divisions.
- I also serve on the Integrated Behavioral Health Workgroup at KU-Wichita Pediatrics and the regional Mental and Behavioral Health of Children in Wichita Group



- I trained and practiced in the USAF at the beginning of my career. Military families and especially military children go through unique stressors and it was not uncommon to see stress-related conditions or stress-related exacerbations of underlying mental health conditions. When I had a co-located, collaborative care type model of behavioral health available it made a huge difference for these patients and families. Since that time I have become very passionate about learning more how we can break down barriers to providing better mental health care and behavioral interventions to our patients.

- Together, with my wife, a Child and Adolescent Clinical Psychologist, we are on a mission of sorts to help educate and inform others regarding the potential benefits of some form of behavioral health integration in the primary care setting.

## Objectives

- Define Integrated Health
- Review evidence regarding benefits of Behavioral Health in Primary care
- Discuss some different models
- Highlight ongoing barriers and areas for future discussion
- Provide list of resources regarding BH (Behavioral Health) integration

## Integrated Health Care

- What?
  - Shared care with primary care and behavioral health providers in the same setting
- Why?
  - Access and family engagement
  - Comprehensiveness
  - Continuity
  - Quality and cost
  - Reduce stigma



## What the literature says:

- Higher rates of treatment initiation (access) and completion
- Improvement in . . .
  - behavior problems
  - parental stress
  - treatment response
  - consumer satisfaction
- PCPs reported greater perceived practice change, efficacy and skill use
- Many studies note advantages to on-site care over facilitated referral to mental health provider
- Sustainable ways to integrate with different models

## Case Discussion

- At the end of a well visit parents state that they are also concerned with their 4 year old acting out more since going to daycare. They describe it as a very difficult transition when they drop him off, sometimes they just bring him home and they are not quite sure what to do after 'trying everything.'

## Usual Plan

- In a busy day you may take just a few minutes (5-10) to find out what they have tried and how it has gone, you may share a couple of new ideas, if any, provide reassurance, perhaps offer a handout and have them call to schedule a follow up if still noting concerns in 3-4 weeks, then you move on to your next visit.

## Barriers

- Time: Is it adequate to address, or will it potentially put you even further behind on a likely regular busy day?
- Frustration: Parent and provider, feeling like inadequate time to address, less likely to understand and recommended interventions, feeling 'blown off,' compliance with handout review and recommended interventions may go down. Provider feels like they are now further behind which may affect the quality of the next patient encounter.
- Money for private practice: Taking time to provide comprehensive patient care is important, but may not yield much, if any, extra compensation, which makes it difficult to keep your lights on, especially during the uncertain times of COVID. As we all know, no money, no mission. If your clinic ceases to exist or if you have a drop in your capacity of how many you can see it directly affects patients in your community.

## Another common case

- You have a 12 year-old that screens positive for depression with a score of 12 on the PHQ-9 at a well visit where they need the paperwork for the school physical tomorrow.

## Usual Plan

- Normally you would take a moment to chat with the patient 1:1. Now you may need to take all the time relegated for a more comprehensive HEADSSS assessment to focus on this one specific concern, also discussing at least a brief safety plan if note any SI/HI. After doing so, you discuss possible plan of care with the family, have to place referral, perhaps personally contact therapy/psychiatry offices to identify available/appropriate therapist, who's taking new patients and their insurance, etc. Most likely will add at least 20-45 minutes to your day for this single encounter.

## Barriers

- Time may make it difficult to complete the well visit and this evaluation without putting you way behind on your day
- Provider and family feeling overwhelmed, perhaps like their concerns are not properly addressed, questions not fully answered leading to frustration
- Statistics indicate only 1/3 of kids referred to mental health attend their first appointment, your patient may not get the care they need in a timely manner, and the issue may not get addressed again until their next visit with you

## PCBH (Primary Care Behavioral Health) Model

- Fully integrative, collaborative and co-located. Provides BH services to all patients seen and allows for warm hand-offs between PCP and BHC (Behavioral Health Consultant). BHC is a consultant to PCPs, supporting patients in BH management of symptoms. The idea is for small interventions (15-20 minute encounters) and as necessary outpatient BH referrals and follow-up to be sure they made their appointment. It is not meant to substitute psychotherapy services.

## Barriers removed or reduced

- Increases collaboration and alters traditional team dynamics/facilitates a cultural shift to allow for more comprehensive care
- Stigma reduction, especially in populations less likely to seek MH care
- Concerns for transportation to another location are eliminated as it is completed same day. This will improve patient/family compliance and outcomes
- Parent/provider frustration is greatly reduced
- Time for provider is preserved to give toward other patients' needs
- More availability to cover more things with other patients may contribute to greater reimbursement potential, helping cover part of the extra cost of the BHC
- Some reimbursement, even if just partial by the BHC services can also help offset the cost of another full-time staff member

## Barriers that remain

- Unable to provide psychotherapy services or assessments if clinically warranted, which may reduce compliance for such recommended referrals
- Uncertainty regarding insurance ability to cover services may lead to less encounters, reimbursement and/or reduced patient satisfaction
- Covering costs of BHC (salary, reimbursement questions, space in facility), this includes reduced reimbursement for same-day interventions for the same diagnosis by different providers

## Case Discussions revisited

### ■ PCBH model

- 4yo: You express equal concern with the parents and inform them that the BHC on your team is uniquely prepared to assist them today. Let them know that you will step out and speak with them briefly and the BHC will be in to see them shortly. You update the BHC on the parent concerns and move on to your next steps in patient care.
- 12yo: You discuss PHQ-9 results with the family and express concern regarding the child's wellbeing. After which, you spend a few minutes reassuring the family that you have someone on your team (BHC) who is specially experienced to address this and help walk them through the next steps and that they will be coming in to chat with them shortly. The BHC can coordinate referral to psychotherapy, develop safety plan if necessary and discuss with you afterward if starting a medication is indicated/desirable and schedule follow up with you to address medication management if necessary.

## Collaborative Care Model

- BHC would be co-located and collaborative, but not fully integrated. It allows for warm handoffs if BHC is available, but they are not focused on providing small targeted interventions with most patients, but rather to provide co-located evaluation and psychotherapy services to patients in the practice. These may occur on the same or different days, but would likely require a separate appointment with the BHC.

## Barriers that are broken down

- Increases collaboration and alters traditional team dynamics/facilitates a cultural shift to allow for more comprehensive care
- Concerns for transportation to another location is eliminated as they have proven ability to get to the Drs' office. This will improve compliance for follow up
- Stigma about going to see a 'therapist' as they are going to 'Drs' office' is reduced, thus increasing chance for compliance
- Reduced financial concern about practice providing for BHC salary as patients are usually seen on different days by different providers. They provide more reimbursable services such as psychotherapy helping to offset more potential losses from taking them on

## Barriers that remain

- Possible reduced compliance as they have to return on a different day
- Space in the practice and support staff that may be required may go up and increase costs as they will need their own space for psychotherapy and support staff for scheduling/rooming patients

## Case discussions revisited

### ■ Collaborative Care Model

- 4yo: PCP may be able to provide warm hand-off with the BHC on the same day, perhaps introduce the BHC to the parents and family, but often this is not possible, so family and provider may be a little frustrated with inability to help them out that day with a small intervention. A separate appointment would have to be booked for later, sometimes the same day, but most likely another day as the BHC would likely have their own schedule already filled for the day.
- 12yo: same as above, except you will coordinate care yourself if medication management is necessary and take time to discuss safety plan if note any SI/HI.

## Co-located Model

- This would be a Behavioral Health office that is practicing independently but happen to be in the same building, on the same floor, same business center, etc. The physical proximity may increase opportunities for PCPs to be acquainted with those BHCs and facilitate more collaboration than with a non-co-located Behavioral Health office.

### Barriers that are reduced

- May increase collaboration allowing for more comprehensive care
- Transportation less of a concern as it's in the same general location as the Drs' office
- **Saving money by not having to pay a BHC, provide extra space or staffing to room patients**

### Barriers that remain

- Less collaborative because you are not under the same roof and part of the same team
- Having to schedule a separate appointment at another office may have multiple opportunities for breakdown in communication and they may not schedule or make the appointment
- They are still seeing a 'therapist' in a different location so some stigma may remain

### Case discussions revisited

- Co-located model:
  - 4yo: In this situation the PCP would tell the family that they have a BHC next door, etc, that is good with these types of interventions, that they can refer them over there, and that the family will wait for their call after the PCP places referral or speaks with the BHC.
  - 12yo: Same as above with addition of the medication management and safety plan discussion completed by you

### Medical Family Therapy (MedFT)

- Provides curb-side consultation to PCPs like PCBH, but also more intensive outpatient mental health care. Usually this is done by a MFT with additional training in integrated primary care. This includes a combination of some of the principles from the PCBH and Collaborative Care Models, but with a specially trained MFT. Family may be seen by the MFT same day like with PCBH, or perhaps on another day depending on their schedule.

### Barriers that are reduced

- Increases collaboration and alters traditional team dynamics/facilitates a cultural shift to allow for more comprehensive care
- Time for provider is preserved to give toward other patients' needs if BHC is available same day
- Stigma and transportation reduced due to co-location and compliance is much more likely
- Parent/provider frustration is greatly reduced
- More PCP availability to cover more things with other patients may contribute to greater reimbursement potential, and having some individual psychotherapy may be able to improve reimbursement, helping cover the likely partial extra cost of the BHC

### Barriers that remain

- Very specialized individual, may be difficult to find one to do the job if seeking for a specially trained MFT
- Availability of BHC may be reduced as they are also providing individual/family psychotherapy services outside of just the regular PCP visits
- Covering costs of BHC (salary, reimbursement questions, space in facility) may be difficult

## Case discussions revisited

- MedFT Model:
  - 4yo: In this situation the PCP would tell the family that they have a BHC in-house that is good with these situations. Depending on the shift they may be available to provide a small intervention that day, or perhaps at least meet the family. If they cannot meet them the provider at least can do a warm handoff with the MFT, and get them scheduled for another day to return for an intervention.
  - 12yo: Same as above, but depending on the day may require the addition of the medication management and safety plan discussion completed by you if the MFT is unavailable.

## Summary

- Integrated Health can come in many forms, not just those listed here
- Integrated/collaborative models in primary care have been shown to boost comprehensive care to patients and families and has improved patient and family outcomes, both in adults and pediatric settings
- There are different barriers as an organization to address when considering one of these types of models, but overall the findings are promising
- This seems to be the wave of the future as more and more Behavioral/Mental Health needs are being addressed in the primary care setting

## Resources

- Milbank Memorial Fund: Behavioral Health Integration in Pediatric Primary Care: Considerations and Opportunities for Policymakers, Planners, and Providers
- Milbank Memorial Fund: Evolving Models of Behavioral Health Integration in Primary Care
- <https://www.samhsa.gov/integrated-health-solutions>
- <https://www.thenationalcouncil.org/integrated-health-coe/>
- <https://www.thenationalcouncil.org/integrated-health-coe/request-assistance/>
- <https://www.thenationalcouncil.org/integrated-health-coe/training-events/>
- <https://www.thenationalcouncil.org/integrated-health-coe/resources/>
- Collaborative Care Outcomes for Pediatric Behavioral Health Problems: A Cluster Randomized Trial. David J. Kolko, PhD, John Campo, MD, [...], and Stephen Wansiewski, PhD
- The Integration of Behavioral Health Interventions in Children's Health Care: Services, Science, and Suggestions. David J. Kolko, PhD, ABPP and Ellen C. Perrin, M.D.
- Five-Year Outcomes of Behavioral Health Integration in Pediatric Primary Care: Heather J. Walter, Louis Vernacchio, Emily K. Trudell, Jonas Bromberg, Ellen Goodman, Jessica Barton, Gregory J. Young, David R. DeMaso and Glenn Focht, Pediatrics July 2019; 144(11):e20183243; DOI: <https://doi.org/10.1542/peds.2018-3243>

<https://www.samhsa.gov/integrated-health-solutions>

- <https://www.thenationalcouncil.org/integrated-health-coe/>
- <https://www.thenationalcouncil.org/integrated-health-coe/request-assistance/>

## Request assistance continued

Request Technical Assistance

Applicant must have an ICHS team request.

First name \*  Last name \*

Title \*  Organization/Company \*

City \*  State \*

Email \*  Phone \*

Are you a member of the National G.I. \* ☐ Yes ☐ No

Describe your specific TA request and the region you are interested in learning more about. \*

Briefly describe the population your organization serves. \*

Adults ☐ Children or Adolescents ☐ Rural ☐ Urban ☐ Other

Where is your organization in the process of integration? \*

Learning/Exploring ☐ Beginning implementation ☐ Advanced ☐ Ongoing quality improvement ☐

Are any of the following challenges in your organization? \*

Administration / Infrastructure ☐ Workforce development / training ☐ Policy and regulation ☐ Clinical workflow ☐ Billing and billing codes ☐ Other

- <https://www.thenationalcouncil.org/integrated-health-coe/training-events/>

## Training events continued

### Calendar of Events

Upcoming Events

Past Events

Filter Event Type  mm/dd/yyyy

SEP 23	Addressing Trauma, Racism, and Bias in Behavioral Health Service Delivery	+
SEP 30	CoE Office Hours: Addressing Trauma, Racism, and Bias in Behavioral Health Service Delivery	+
OCT 07	Reentry for Citizens Needing Substance Use Disorder Treatment	+
OCT 13	CoE Office Hours: Reentry for Citizens Needing Substance Use Disorder Treatment	+

<https://www.thenationalcouncil.org/integrated-health-coe/resources/>

CoE

Center of Excellence for Integrated Health Solutions  
Funded by Substance Abuse and Mental Health Services Administration  
Operated by The National Council for Behavioral Health

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## Resources continued

### Featured Resources by Focus Area

Assessing Organizational Readiness

- Wellness Organization Self-Assessment Tool
- Standard Framework for Levels of Integrated Care
- Quick Start Guide to Behavioral Health Integration
- Organizational Assessment Toolkit for Primary and Behavioral Health Care Integration
- GHF Framework Issue Brief
- Culture of Wellness Organizational Self-Assessment

Building the Business Case

- The Value of Integrated Behavioral Health
- Substance Use Disorders and the Patient Centered Medical Home
- Behavioral Health/Primary Care Integration and the Person-Centered Healthcare Home

## Resources continued

Workforce Development

- Medication-Assisted Treatment Provider Readiness and Implementation Checklist
- Medication-Assisted Treatment Community Implementation Checklist
- Improving Adolescent Health SBIRT Change Package
- Guiding Principles for Workforce Development
- Expanding the Use of Medications to Treat Individuals with Substance Use Disorders in Safety-Net settings
- Core Competencies for Integrated Behavioral Health and Primary Care
- Behavioral Health/Primary Care Integration and the Person-Centered Healthcare Home
- Adult SBIRT Change Package