Primary Care Behavioral Health Introduction

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Supporting the Climb Toward PC Behavioral Health Care in Oregon

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Winner of the 2009 APA Practice Innovation Award
Objectives for Today

• Be able to describe the PCBH model and the evidence that supports it
• Understand the components of a brief visit
• Review and discuss as a team important steps for implementation
• Hear from a leader in Oregon who has experience integrating behavioral health into primary care
• Self-assess competencies related to working in the PCBH model
• Learn the components of the PCBH Toolkit

Who is in the room?

• Single clinic or part of clinic system
• Small (2 or less), Medium (2-10), Large (11+)
• Rural or urban
• Family practice, focus on a subgroup (e.g., pediatric practices)
• Behaviorist on staff
• Looking to hire someone else’s behavioral health provider by the end of today?
Primary Care Behavioral Health Model

• An approach to population-based mental health clinical care
• That is simultaneously
  – Co-located
  – Collaborative
  – Integrated within the primary care clinic
• It is a consultant model; not a psychotherapy model
• Will meet the needs of 90% of the people in PC

What is the “population health perspective”

. . . encompasses the ability to assess the health needs of a specific population; implement and evaluate interventions to improve the health of that population; and provide care for individual patients in the context of the culture, health status, and health needs of the populations of which that patient is a member.

*American Association of Medical Colleges (AAMC)*
The Goal of PCBH

To improve and promote overall health within the general population

Focus is broad: Preventive, Acute and Chronic

Big Mission!

Behavior Improvement Group

Do you want to decrease your child's behavioral problems?  
Do you want to improve your parenting skills?  
Do you want a better relationship with your child?

If you answered “Yes!” to any of these questions, this group is for you and your child (age six and under).
PCPCH and PCBH Alignment

<table>
<thead>
<tr>
<th>Oregon’s PCPCH Core Attributes</th>
<th>PCBH Goals</th>
<th>Measurement Ideas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Care</td>
<td>Improve Access to BH &amp; Medical Care</td>
<td>Cost offset, particularly for high users of medical care</td>
</tr>
<tr>
<td>Accountability</td>
<td>Measures QOL at all visits, helpfulness, fidelity</td>
<td>Duke Health Profile</td>
</tr>
<tr>
<td>Comprehensive Whole Person Care</td>
<td>All visits are biopsychosocial</td>
<td>Mental Health, Physical Health, Social Health (0-100)</td>
</tr>
<tr>
<td>Continuity</td>
<td>BHC is available throughout the life span</td>
<td>Repeat episodes of care</td>
</tr>
<tr>
<td>Coordination and Integration</td>
<td>BHC links with community resources</td>
<td>Reduction in ER visits; unnecessary hospitalizations</td>
</tr>
<tr>
<td>Person and Family Centered Care</td>
<td>BHC provides services to individuals, couples and families</td>
<td>Count of visit types</td>
</tr>
</tbody>
</table>

What’s the Urgency?

- Half of PC patients present with psychiatric comorbidities
- 60% of psychiatric illness is treated in PC
- Many patients have medical and mental problems
- PCCs trained medical model; solutions to problems involve meds, procedures, advice
  - RX 70% of all psychotropic meds
  - RX 80% of antidepressants
Affordable Care Act

- Obama signed 3-23-2010
- Comprehensive health insurance reform
  - Enhance prevention efforts
  - Improve care for chronic conditions
  - Reducing disparities
- PCC payment based on value (quality of care)
- Millions of previously uninsured will be insured
- Shortage of PCCs

Now . . .
Time for CHANGE

Whoops!

Who, What, When, How

BHCs
BHC-Fs, BHC-CNAs
Trained PCCs, RNs
New Services Require New Skills

I am Mary Virginia
I am the clinic’s BHC and my job is . . .

• We will come up with a plan and I’ll share that with your PCC
• Some people come back to see me to learn more skills and address other concerns; some only see me one time
• Okay, let’s start with this brief survey; it will give us some numbers about your overall quality of life over the past week
What is Mary Virginia Thinking?

• Her Assumptions about Behavior Change
  – Maladaptive behaviors are learned and maintained by various external and internal factors
  – Many maladaptive behaviors occur as a result of skill deficits
  – Direct behavior change is the most powerful form of human learning

Mary Virginia’s Services

• Brief Interventions
  – Directive 15-30 minute visits
  – Most same day of medical visit
  – Usually complete episode in 4 or less visits
  – Continuity visits for more at risk patients (1:1, T/C)
  – Workshops, classes (10-20%)

• Pathway Services
  – Assess and intervene with members of high impact group
Mary Virginia’s Helpers

• BHC Facilitator, DM
  – Uses roster to organize contact with members of an identified group
  – Primarily phone-based work
  – Addresses med adherence and supports behavior change
  – Staffs patients with BHC weekly
  – May assist with workshops, classes, group medical visits

Mary Virginia’s Helpers

• BHC Assistant (CNA)
  – Enhances BHC productivity
  – Manages BHC patient flow
  – Obtains outcome information
  – Schedules
  – Stocks patient education materials
  – Maintains current list of community resources
  – T/C checks to patients
  – May be cultural and language broker
Initial Consult; Follow-up As Needed

- **Physician** refers to BHC for specific problem / question
- **Patient** implements behavior change plan, returns for follow-up as needed
- **Clinician** review recommendations; retains full responsibility for patient care decisions
- **Introduction**
  - 5 minutes
- **Snapshot**
  - 5 minutes
- **Functional Analysis**
  - 5 – 10 minutes
- **Problem Summary/Behavior Change Plan**
  - 5 – 10 minutes
- **Charting/Feedback to PCP**
  - 5 minutes

BHC Practice Habits Based on Evidence

- Provides “behavioral prescriptions” for skill practice and monitoring at follow-up (associated with improved outcomes)
- Uses empirically supported treatments that have been shown to contribute to improved clinical outcomes in fewer treatment sessions across a diverse outpatient population without exclusion
Example of RX Pad: Preventive and On-Going Management of Chronic Pain

Your Clinic
Your Phone Number

Love  Work  Play

Plan: ____________________________
____________________________________
____________________________________

PCBH Pathway Services

• **Targets a patient population** that has high impact (by numbers or by way of presentation)
• **Applies the evidence** for the care of the targeted population
• Respectful of **local resources**
• **Seeks to improve efficiencies**
• Measurement of **outcomes** planned
PCBH Pathway Services May Include...

- **Screening Processes**
  - Neurodevelopmental screening at 18- and 24-month well-child visits and exam room posters

- **One-on-One Interventions**
  - BHC consult at any 2-year old well-child where child is overweight

- **Classes or workshops . . . Or ultra-brief checks**
  - Sleep hygiene, smoking cessation
  - Visit check-in screen: Do You Want to Make A Lifestyle Change?

PCBH Pathway Services May Include...

- **Group medical visits**
  - Chronic pain

- **Coordination of BHC-F**
  - **Step Up**
    - e.g., detox, IOP, Sober Housing
  - **Step Down**
    - Return to PC with support of skills gained in specialty treatment
  - **Step In**
    - High use of ER and/or no primary care
Example: Pain & QOL Program Pathway

PCC: Enrolls patient in pathway  
Completes pain agreement  
Refers to BHC (same-day)  
Monitors & updates TX plan

BHC: Orientation to Class  
Opiod Risk Assessment  
Monthly Class  
Monthly charting of outcomes  
Three Strikes Program  
Coaching  
Program Evaluation

RN: Adds patient to Pain & QOL Registry, maintains registry  
Works with PCM re RX in week prior to monthly class

QOL Class Agenda

- Introductions
- Assessment (Healthy Days Questionnaire)
- Script Sign up sheet
- Brief discussion of workability of pain avoidance and introduction of Love-Work-Play Bull’s Eye Planning Tool, Crossroads
- BHC does 1:1 eyes-on check re: outcomes while pts work in pairs on Bulls-Eye Plan
- Group discussion of successes and barriers
- Targeted lecture / skill development exercise
PCC Top Ratings

Year 1: Able to access effective programs

Year 4: Have skills to work effectively

Year 5: I usually have a new idea about how to help my most difficult CP patients

The Other End of the Pain and QOL Pathway

PCC
- Risk assessment 4-8 weeks post-injury
- Uses L-W-P RX Pad to shift focus
- Refers to BHC as indicated

BHC
- Values Clarification
- Committed Action Plan
- Family Support

PCC
- Refers to QOL Program if indicated at 3 months post-injury
PCBH Evidence:
References in Tool Kit Tab 11

- Patient Symptoms and Functioning
  - Broad spectrum improvements among Family Practice patients seen two or more times
    - Symptoms
    - Functioning
    - Social Integration
  - Change was robust and stable during a two year follow up period
  - Rates of using evidence-based coping skills improved
  - Those with more severe impairment at pre-treatment improved faster than patients with less severe impairment
- High patient satisfaction

PCBH Evidence: Depression

Review of 12 RCTs (Schulbert 2002)
- Evidence-based psychotherapies adapted for PC are comparable to RX alone (supported by Psych) and superior to UC

Impact of embedded BHCs (Serano, 2011)
- Reduced referrals to MH (only 8% referred)
- Improved adherence to evidence-based guidelines
- Reduced RX for anti-depressants
PCBH Evidence

- Impact on PCC
  - More able to detect BH problems
  - More able to use BH interventions; less use of meds
  - Better patient retention
  - Reduced PCC workload (for patients with behavior change needs)
  - Stronger PCC-patient relationships
  - Better communication with BH
  - Improved satisfaction with BH

- Impact on system: Reduced health care costs

I am Mary Virginia
I am the clinic’s BHC and my job is . . .

- To help your PCC help you
- Your PCC calls me in to help when there’s a concern about mental, physical or social health
- My job as a consultant to you and your PCC is quite specific
- We will spend about a half hour today . . .
Example of Launch: Pediatric Clinic

Month 1: Leadership Consensus
Month 1: Manual Ratification
Month 2: Launch (didactic) training: 2 BH providers and their supervisor
Month 2: Start of service and on-the-job Core Competency Training

12 months

Example of Launch: Pediatric Clinic

Month 3-5: Start of pathways: Overweight/obesity; Parenting; Neurodevelopmental; Healthy Relationships; Return of Expelled Students to School
Example of Launch: Pediatric Clinic

Month **11**: Re-placement of one BHC; 1:1 Core Competency training for replacement, fidelity check, Referral Barrier’s Questionnaire to inform educational efforts and system refinements

Example Launch: Family Practice Clinics, Military Medical Treatment Facilities

**Year 1**: Pilot study, development of consensus

**Years 2-3**: First draft of manual; core competency training of original cohort; identification of 12 mentors; implementation of training in all residency training sites

**Years 4-6**: On-going training, one-clinic at a time; service mostly by part-time AD BHCs, burden of replacement of BHCs substantial due to deployments, separations
Example Launch:
Family Practice Clinics, Military Medical Treatment Facilities

Years 7-current: Expansion to all MTFs worldwide; move to FT contractor BHCs; DoD agreement on PCBH model for all branches

Year 14: Revised manual

Year 16: Focus on on-going expansion and sustainment (twice monthly webinars: one Q&A; one content focused; 1:1 phone conferences with mentor available; distribution of monthly outcomes to clinics)

Implementing PCBH Services

Assessment of Organizational Readiness to Succeed

I. Political and Organization
II. Core Program Philosophies
III. Financing Strategies
IV. Program Mission, Scope and Tactics
V. Administrative
VI. Staff Training
VII. Performance Indicators
PCBH Readiness Assessment Tool

1. Complete independently
2. Score
3. Discuss results with others on your team

Next Steps: See Worksheet

- Work in teams:
  - Write out 3 team agreements—Next steps to prepare a strong foundation for implementing PCBH strategies in your clinic

- For each agreement:
  1. Planned Action
  2. Who is responsible?
  3. Review date

Meet and greet your sister clinic colleagues.
Guest Presenter: Lessons Learned

Carrie Suiter, Health Services Coordinator
Center for Family Development

• Where we started
• How we “grew” our readiness for full integration of behavioral health services
• Where we are today

Questions from Lunch Discussions

1. Do you believe that implementation of this model will improve health in your community? How?
2. What are the barriers to implementing this model in your community at this time? Do you have ideas about how to address barriers?
3. What is unclear to you about this model at this point? What questions do you want our experts to address after lunch?
The PCBH Tool Kit

• The PCBH Manual (Tab 1)
  – Vision and Mission
  – Guidelines, Goals and Objectives
  – Roles and Responsibilities of the PCBH team
  – Training Program Overview
  – Clinical Activities
    • Brief Intervention Services, Pathways, Excluded Services
    • Practice Support Tools

Primary Care Behavioral Health Toolkit

The PCBH Tool Kit

• The PCBH Manual (continued)
  – Clinical Activities
    • Practice Support Tools
      – Scripts for RNs, PCCs, clinical guides for BHCs
    • Outcome Assessment Tools and Screeners
    • Clinical Policies and Procedures
      – Patient access, Informed consent, clinical assessment standards
    • Quality Assurance of Charting and Documentation
    • Providing Feedback to PCC
    • Medication Consultations, Psychiatric Consults
### The PCBH Tool Kit

**• The PCBH Manual (continued)**

- Administrative Procedures (BHC appointment template, revenue/billing, performance measures including staffing guidelines and productivity standards)
- Core Competencies

**• The PCBH Manual Appendices**

- Performance Measures (**A – Tab 2**)
- Core Competency Tools (**B – Tab 3**)
- Self Assessment Tools (**C – Tab 4**)
- Pathway Program Examples (**D & E – Tabs 5 & 6**)
- Practice Supports: Referral scripts, referral form, interview note form, chart not example, intervention quick guide, interventions for 7 common referrals, PCBH Introduction (**F – Tab 7**)
The PCBH Tool Kit

- The PCBH Manual Appendices (continued)
  - Assessment and Screeners: List, Outcome, As Indicated (G – Tab 8)
  - Patient Brochure Example (H – Tab 9)
  - Quality Management Chart Tool (I – Tab 10)
  - PCBH Model References (J – Tab 11)

Patient Education Protocols (Tab 12)

- ADHD
- Adherence Using Meds Successfully
- Alcohol & Low Risk Drinking
- Anxiety & Coping with Panic Attacks
- Anxiety
- Chronic Pain
- Depression – Postpartum
- Depression
- Exercise & Physical Activity
- Grief
- Headaches
- Hypertension
- Parenting Protocol
- Relationship Problems

- Relationship Sexual Problems
- Sleep & Insomnia
- Sleep Apnea
- Sleep Behavior Change & Diary
- Sleep Class Packet
- Stress
- Substance Misuse & Maintaining Behavior Change
- Weight Management
Self-Assessment

Individual Work
- BHCs complete the Core Competency Tool
- PCCs and RNs complete the Core Competency Tool
- Operations can review all tools and identify impact on clinic operations

Team Discussion
- What are your strengths and weaknesses?

Skills:
PCCs, Nurses, BHCs, Operations

- Demonstration & Skill Practice:
  - Who to refer (see Referral Form Example, Tab 7 / App F-2)
  - What to say (see Tips for Referring, Tab 7 / App F-1)
  - What to do when someone is ambivalent

- Discussion with team:
  - How to refer (system supports)
Skills Training on BHC Outcome Tools

- **Health-related Quality of Life (see Duke Health Profile, App G2)**
  - Age 18 plus, normed on PC patients
  - 17 items, 3 minutes to complete
  - Scores 0-100: Physical, Mental, Social, General Health
  - Scoring: Excel or by hand (see App G2)

- **Psychosocial distress (see Pediatric Symptom Checklist 17, App G2)**
  - Ages 4-17, designed for PC
  - 17 items, 2-3 minutes to complete
  - Scores: Total and 3 subscales (Internalizing, Inattention, Externalizing)

Skills Training on Chart Notes

- **BHC Chart Note (example form, App F-3, Tab 7)**
  - In Medical Record
  - SOAP format
  - Coding: Use of Health and Behavior Codes or Psychiatric Codes for Brief Visit
  - Plan: Recommendations to patient, recommendations to PCC, F-U

- **Chart Review (see Tool, App I, Tab 10)**
Health and Behavior Codes

All Medicare Carriers Cover Health and Behavior Code Services

These are the 2012 reimbursement amounts (per 15 minutes)

96150 Initial Assessment $20.42
96150 Reassessment $19.74
96152 Intervention Individual $18.38
96153 Intervention Group $4.42 per person
96154 Intervention Family with patient $18.38
96155 Intervention Family with out patient $0

http://flash1r.apa.org/apapractice/hbcodes/player.html?

Skill Training:
PCCs, Nurses, BHCs, Operations

- Large Group Discussion
  - PCP, RN, CNA: Patient that has seen the BHC returns for a medical visit, what do you do?
  - Team participation in PCBH pathway development and implementation
  - How and when to assess progress (see Referral Barriers Questionnaire)
And because we don’t know, if we don’t assess

PCBH Program Evaluation Matrix

- Health Status of Primary Care Patients
- Satisfaction
- Access to Service
- Detection of BH Problems
- Fidelity to PCBH model

PCBH Evaluation:
Health Status of PC Patients

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve the functional status of Primary Care patients who receive BHC services</td>
<td>Duke Health Profile General Health Score</td>
</tr>
<tr>
<td>Demonstrate improved health-related quality of life among adult patients who come for more than one BHC visit</td>
<td>Duke Scaled Scores: Physical, Mental, Social</td>
</tr>
<tr>
<td>Demonstrate decreased psychosocial distress among children who come for one or more BHC visits</td>
<td>Pediatric Symptom Checklist-17 Total Score</td>
</tr>
<tr>
<td>Support PCCs in their efforts to focus specifically on PC delivery</td>
<td>Preventive service delivery rates among PC patients for services (e.g., immunizations, pap smears and additional preventive measures of patients with chronic diseases</td>
</tr>
</tbody>
</table>
### PCBH Evaluation: Satisfaction with Care

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve PCC ability to care for patients with BH issues</td>
<td>PCC Survey pre and post implementation</td>
</tr>
<tr>
<td>Improve PCC satisfaction with system of care for PC patients with behavioral health problems</td>
<td>PCC Survey pre and post implementation</td>
</tr>
<tr>
<td>Establish level of satisfaction of BHCs with training on PCBH model</td>
<td>BHC survey 1 month after implementation</td>
</tr>
<tr>
<td>Establish level of satisfaction of BHCs with implement of PCBH model</td>
<td>BHC survey 6 months after implementation</td>
</tr>
<tr>
<td>Establish high satisfaction level of PC patients with BHC services</td>
<td>6 question survey for patients seeing BHC, 3 months post implementation</td>
</tr>
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### PBBH Evaluation: Access to BH Services

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase number of PC patients screened, referred and treated for BH conditions</td>
<td>The number and percentage of Primary Care patients newly screened, referred, and treated for behavioral health conditions compared over time</td>
</tr>
<tr>
<td>Decrease appointment and temporal wait times for patients to receive an initial behavioral health service in the PC setting</td>
<td>Appointment and Temporal Wait Times: The amount of time a patient waited to see the BHC following a referral to the BHC from a Primary Care Clinician</td>
</tr>
<tr>
<td>Decrease the “no connect” rate for specialty behavioral health services for patients who receive initial behavioral health treatment from the BHC in the PC setting</td>
<td>Number of patients who are referred by the BHC to specialty BH treatment and receive services relative to the number of individuals who are referred for additional Behavioral Health treatment but do not receive additional services.</td>
</tr>
</tbody>
</table>
**PBBH Evaluation: Detection and Fidelity to Model**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiate use of Primary Care screeners (e.g., PHQ-9, PTSD-4, GAD-7, Pain Dysfunction Questionnaire)</td>
<td>Based on the PCC survey, how many and what % of providers perform screening for Behavioral Health conditions in the Primary Care setting? (Pre and post?)</td>
</tr>
<tr>
<td>Establish BHC practice that has high fidelity to model</td>
<td>BHC contact sheet (on back of Duke or PSC) Ratios of new to follow-up and same-day to scheduled for each BHC on a monthly basis Encounters per day (Billing data may not be reliable)</td>
</tr>
<tr>
<td>Establish BHC optimal productivity</td>
<td>See above</td>
</tr>
<tr>
<td>Maintain 48 hour access for BHC visits</td>
<td>Periodic sampling of BHCs access (sample 5 days for 5 BHCs every month)</td>
</tr>
</tbody>
</table>

**With an eye toward the future**

**Spread and Sustain: Best Practice Sites**

- 2-4 practices will have the opportunity to receive additional training to become “best practice sites”
- Goal is to spread and sustain the impact of the weeklong training within regions, communities, groups or health systems
- January & February 2014
Questions, Evaluations

Thank you for your precious time!

Please complete a session evaluation.

Additional Resources & Closing

• Visit Institute website (www.pcpci.org)
  – Reference list and slides for today’s presentation
  – Additional resources related to primary care home transformation
  – Register for PCPCI email updates to learn about future webinars and other training opportunities

• Thank you!