

Part III
Primary Care Life

Chapter 8

The Primary Care Behavioral Health Model: Applications to Prevention, Acute Care and Chronic Condition Management

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Research findings consistently suggest that most people receive behavioral health (BH) services in the primary care setting.¹ The annual rate of onset of mental and addictive disorders hovers in the vicinity of 27%, and the vast majority of those afflicted by these problems seek care from primary care providers (PCPs).²⁻³ People present to primary care for assistance with a myriad of other BH problems, such as nicotine addiction, obesity, chronic pain, medical nonadherence, insomnia and learning problems. For most problems that challenge the quality of life for citizens of any age, primary care is the beginning and ending point of care. It is unfortunate that most PCPs need to see 20–35 patients a day to stay in business, as the time constraints alone make it nearly impossible for them to detect and treat the BH needs of the patients filling their waiting rooms. Limited training and a growing lack of access to BH providers for consultation further frustrate the typical PCP's efforts to address the BH needs. When not addressed effectively, BH problems contribute to higher medical costs, as well as poorer medical, functional and behavioral outcomes.⁴⁻⁷ Given this dire situation, primary care systems, both large and small, are exploring collaborative care options.

Currently, BH providers practice collaborative care in numerous medical settings, including hospital-based behavioral medicine programs, free standing multidisciplinary pain centers, family practice and internal medicine residencies, and publicly and commercially funded primary care clinics. Given the diversity in settings, the diversity in the models of collaborative care is no surprise. Next to the word “love,” the most frequently misunderstood terms in the English language may well be “collaborative” and “integrated” care. They often include an array of practice styles, ranging from collegial information sharing between a medical and a BH provider to active comanagement of patients by a multidisciplinary medical team. While the proliferation of models of collaboration and integration generates different strategies for providers in different practice settings, it contributes to conceptual problems, limits the design of needed research studies and obstructs implementation efforts with fidelity to a specific model. What are the hallmarks of an optimally integrated program in the primary care setting? As this is our area of clinical and consulting expertise, this is the question we address in this chapter. In doing so, we

will describe the primary care BH (PCBH) model⁸⁻⁹ and present three cases to illustrate its wide-ranging applications to the cause of improving health care.

Six Vectors in Three Worlds

Peek's Three Worlds model¹⁰ provides an interesting framework for approaching the question of integration. What is the ideal arrangement for clinical services? What is the best approach for allocating resources for administration and day-to-day operation? Implementation of the following six vectors enhances the likelihood of optimally positive returns for primary care integration efforts.

Mission Integration

Mission integration is difficult as it requires providers from a variety of disciplines to embrace a common mission. The mission of primary care is to achieve the best health status possible for the most members of the community. This population-focus is the sine qua non of contemporary primary medicine. To achieve improvements to the health of the population, PCPs work in a biopsychosocial model and adapt empirical findings to implementation at the clinic rather than the case level. The effort is to prevent illness and to maintain health while attending to both preventive and acute care needs. The BH provider trained in cognitive behavioral therapy and program evaluation can play a core role by providing preventive and acute care services and assisting primary care colleagues in developing population-based care programs powered by the most potent behavioral technology.

Clinical Integration

This vector describes the extent to which the clinical activities of primary care team members, including BH providers, are seamlessly connected. Optimal clinical integration involves the use of shared protocols that direct the activities of each team member, as well as active comanagement of patients supported by the same patient education and assessment materials. This is possible in behavioral integration models that emphasize same-day, brief visits with the BH provider and the use of clinical pathways by primary care and BH providers.

Physical Integration

While it is possible to practice collaboratively without being co-located, it is not possible to be fully integrated unless medical and behavioral health providers are working in the same immediate area. However, physical integration alone does not ensure that other

aspects of integration will materialize. In fact, the co-located specialist approach is a very common method of collaborative care, characterized mainly by having providers practice under the same roof. In this model, the BH provider provides traditional specialty therapy services to patients referred by PCPs. The co-located therapist is really on a completely different mission than his or her primary care colleagues. In contrast, optimizing the potential benefits of physical integration requires the BH provider to practice in the exam room area, providing PCPs with an ongoing visual reminder that they have immediate access to consultation, temporary co-management of patients and the opportunity to engage in shared practice protocols.

Operations Integration

This vector measures the extent to which the BH provider and the PCP practice within a shared infrastructure. One of the subtle ways that care is segregated involves separating infrastructure operations, such as developing separate billing sheets, having different waiting areas for patients, different entries and role restrictions on support staff. Thus, operations infrastructures that simultaneously support the functions of the BH provider and PCP are a very significant aspect of integration. Examples include using common, scheduling, service capture and billing programs, a common encounter form, common committed hours and productivity standards, as well as shared reception, check-in, nursing and support staff.

Information Integration

This vector describes the ability of the PCP and BH provider to share clinically relevant information in real time and without needless barriers to access. This includes such strategies as documentation in a common medical record, placement of the BH notes in the chronological record, an integrated problem list and an aggressive culture of “curbside consultation.” Information integration also includes shared, interactive patient care protocols such as patient registries, flow sheets and other care tracking devices. The advent of the electronic medical record (EMR) provides an unprecedented opportunity to achieve seamless and real time information sharing.

Financial and Resource Integration

This vector describes the ability of a clinic or system to finance integrated services using a blended pot of health care and mental health care resources. In the ideal world, integrated behavioral health is regarded as a core primary care service and is reimbursed on a par with medical services. Taking it one step further, integrated behavioral health services are funded out of the medical insurance dollar, rather than being viewed as a separate and distinct type of service to be managed in a

“carve out” model. This means adopting billing and reimbursement practices that emphasize parity in health care and mental health care benefits and compensation rates. An often overlooked aspect of financial integration involves compensating the BHC using the same strategies that are applicable to fellow medical team members. This might include pay for performance or productivity based compensation methods, in addition to the more traditional hourly and salary based approaches.

The Primary Care Behavioral Health Model

The PCBH model⁸ of integration is at the forefront of the integration movement in the USA. First described over a decade ago,¹¹⁻¹³ a variety of large delivery systems employ this approach, including the US Air Force and Navy, Veteran’s Administration, and Kaiser Permanente. In 1999, the Health Resources Services Administration and the Bureau of Primary Care began providing both financial funding and technical assistance training to implement this model in Federally Qualified Health Centers across the USA. Several works address various clinical applications of the PCBH model and similar integration approaches. However, Robinson and Reiter⁸ offered the first comprehensive text on the model, and it includes strategies for operations, financing, training and evaluating the model, as well as numerous clinical examples for individual and group interventions and training PCPs in common cognitive behavioral interventions.

The PCBH model requires BH providers to make significant adaptations in practice, some subtle and some obvious but any one of them can be difficult for the BH provider new to primary care life. First, the model describes the mission of primary care BH as that of improving the overall health of the population. Robinson and Reiter⁸ recommend that the BH provider pursue this lofty goal in two ways: (1) by augmenting the usual preventive and direct care for behaviorally based problems; (2) through educational interventions and changes to the system of care that improve the primary care system’s ability to provide such care. Achievement of this mission is possible through ongoing assessment of patient health-related quality of life. The PCBH model envisions the process of achieving good health as a social activity that occurs within a biopsychosocial context. Good health means freedom from premature disease and implies ongoing efforts to develop skills necessary to living a meaningful life. Immediate patient access allows distribution of limited BH resources across the largest possible number of patients in the clinic population. The BH consultant (BHC) consultant is co-located in the examination room area and functions as a core medical team member whose services are a part of routine daily practice. The modal patient referral is a warm hand-off, in which the PCP introduces BHC services as a routine part of care. Given this high level of integration, the BHC is likely to see 12 or more patients in a typical 8-h day.

The PCBH model involves a shift from a traditional mental health psychotherapy model to a consultation approach. The BHC functions as a consultant to the referring PCP and the patient, rather than as a therapist. The PCP is the primary

“customer” in this model, and the ideal outcome is to enhance the PCP’s ability to help the patient with whatever problem has surfaced. Because of this, consultation visits are typically shorter (15–30 min) than the traditional 50-min hour of psychotherapy. There are typically fewer consultative visits with any one patient (one to three on average), and the PCP continues to be in charge of the patient’s ongoing care. The high practice volume of the consultation approach allows the consultant to teach core behavioral intervention skills to PCPs in the context of real-time patient care. This increases the likelihood that PCPs will use optimally effective behavioral interventions with the majority of patients, most of whom will not see the BHC directly.

The goal of consultation and temporary co-management is not to cure the patient of all symptoms, but rather to improve the patient’s functional status over time and to empower the physician-patient relationship over the long haul. This means the focus of consultation is not on providing a full mental health evaluation and differential diagnosis, but rather on identifying valued directions and defining concrete, functional goals that the PCP and patient think are vital to improving the patient’s quality of life. This involves a greater emphasis on using strengths-based interventions, psychoeducational strategies and home-based practice to achieve mutually agreed upon goals. All of these intervention strategies are designed to fit the 5-min hour of the primary care visit. Since the BHC service is a part of routine care and is often immediately available in the PCBH model, most patients feel no stigma and readily accept the idea of coaching support for making changes important to health.

Applications to Preventative Care, Acute Care and Chronic Condition Management

The beauty of the PCBH model is that it empowers the PCP to better address any number of BH issues. The PCP has options, including consulting with the BHC about a patient, referring the patient for a direct contact with the BHC, or capitalizing on the BHC’s expertise to develop a clinical pathway program to address specific health conditions. Clinical pathways define a specific population of interest (e.g., patients with diabetes or ADHD) and suggest specific assessments and interventions that various members of the primary care team may provide to improve the health of the patient population of concern. Given the fact that chronic diseases—such as cardiovascular disease, cancer and diabetes—are among the most prevalent, costly and preventable of all health problems, BHCs need to present a power-packed approach for this large and growing group. Chronic, disabling conditions result in major limitations in activity for one of every ten Americans, and seven of every ten Americans who die each year die of a chronic disease. The PCBH model positions the BHC to help PCPs improve outcomes for patients with preventive, acute and chronic care patients.

Prevention in Action: A First Panic Attack

Lucy is a 32-year-old, married white female mother of two young children. After presenting to a local emergency room over the weekend, she comes to see her primary care doctor on Monday. She explains that she experienced chest pain, rapid heart beat and dizziness on Saturday evening and went to the emergency room because she feared that she was having a heart attack. Since her blood pressure and heart rate were clinically elevated, she underwent further testing. Cardiology examination findings were normal and she left the hospital with a prescription for benzodiazepines.

At the primary care clinic at which the BHC works, patients seen in the emergency room for symptoms of chest pain, dizziness and anxiety are referred by protocol for BHC services at their first clinic follow-up visit. The PCP brought Lucy to the BHC with a request for behavioral interventions and a recommendation concerning the usefulness of medications.

In the initial 25-min consultation, Lucy explained that she was high strung and prone to worry. She had never seen a counselor for anxiety or taken medications for emotional problems. She reported increased stress at home, which started 3 months earlier when her husband was laid off from his job. She worked full-time, but her income did not provide adequate resources for the entire family. She complained that her husband was not trying hard enough to get a job, that he did not help as much as he could at home and that he was more irritable. She was sad about having so little time with her children. Lucy indicated that she had walked her treadmill at least three times a week until a few months ago, when she simply did not have the time to do it. She had slipped back into smoking recently after having quit for a 2-year period. Smoking was about her only way to relax. The episode of chest pain and panic terrified her. She wanted to stop smoking but felt she could not. She had trouble concentrating on routine activities because she was trying to monitor her heart rate so she could prevent another attack. Lucy felt relieved about the test results from the hospital, but she worried that they might have missed something. The BHC provided the following interventions during the initial consultation with Lucy:

1. Information about the behavioral, physical and cognitive aspects of chest pain and other panic symptoms, supported by an interactive patient education pamphlet that included strategies for working with panic symptoms
2. Instruction in a simple mindfulness-based breathing strategy with the recommendation that she practice it twice daily
3. Encouragement to resume all normal activities and to use the mindfulness technique to offset urges to avoid activities that might trigger panic symptoms
4. Encouragement to gradually resume her previous exercise program

During the post-visit curbside consultation, the PCP was advised to reinforce these interventions in a planned follow-up with Lucy in 2 weeks. The BHC recommended against prescribing a medicine at this time and agreed to see her for follow-up in 1 month. This interaction between the PCP and the BHC took approximately 2 min.

The patient returned approximately 1 month later and reported no troubling symptoms of panic. She was exercising three to four times per week and felt more

relaxed. She also enjoyed her mini-mindfulness sessions and was noticing how much muscle tension she carried around on a daily basis. She had in fact noticed some physical symptoms that she associated with her initial panic attack but was not frightened by them. She had reduced her smoking to about a half pack a day and her goal was to stop smoking altogether in the next month. In response to this information, the BHC offered the following interventions:

1. Encouragement to incorporate exercise and mini-mindfulness sessions into her daily lifestyle
2. Continuation of all normal daily activities and mindfulness response to urges to avoid specific activities in an effort to control anxiety
3. Review of the specific plan concerning smoking cessation

The BHC talked briefly with the PCP at lunch that day and reviewed the interventions, giving particular attention to motivational interviewing and stages of change. Lucy planned to follow up with her PCP in 2 weeks. The BHC did not plan follow-up with Lucy, as her functioning seemed to have stabilized. Four months later, while discussing the relationship between smoking and symptoms of panic with the BHC, the PCP mentioned that he had seen Lucy recently and that she had stopped smoking.

Acute Care: Adolescent Rapid Weight Loss

Maria, a 13-year-old Hispanic female patient, was referred by her pediatrician for unexplained weight loss. He asked the BHC to assess for behavioral factors that might be contributing to the situation, while he awaited results from multiple tests conducted to rule out an organic basis. Marie had lost 27 kg over a 5-month period. Although her father was worried, she was not. She attributed her weight loss to a change in eating, which started when she had braces placed on her teeth. She was sensitive to the pain, particularly after periodic tightening, and she found the hygiene requirements cumbersome. Marie weighed 70.4 kg at the visit to the BHC and measured 68 in, in height, resulting in a body-mass index of 23.5. She appeared to be a happy, carefree youngster, and she related to her parents in a loving, respectful way. She was an above-average student, who planned to become a lawyer. Recreational activities included playing soccer and basketball and serving as the team manager on the school volleyball team. She denied any persistent worries and indicated that she felt she looked okay the way she had looked before her weight loss.

Since a few days had passed between the pediatrician's referral and the BHC visit, the results of the laboratory tests requested by the pediatrician were available to the BHC and all indicated good physical health. The functional analysis did not suggest an eating disorder, and, therefore, BHC interventions focused on reassurance and education, including the following:

1. Support of the family's relationship with the pediatrician and reassurance about his thoroughness
2. Education about the body-mass-index concept

3. Brief overview of guidelines for a healthy lifestyle supported by a patient education handout
4. Suggestion that Marie shop for groceries with her parents
5. Brief exploration of social and emotional meanings of eating and weight in the family and a suggestion

Since the father in particular saw Marie's decrease in appetite as a sign of unhappiness, it was decided that Marie would make more of an effort to express her love and happiness to her father and that the father would focus more on social aspects of Marie's day, and less on what she ate during conversations at the family's evening meal. Follow-up services included visits to the pediatrician in 1 week and the BHC in 2 weeks. Specifically, the BHC planned to evaluate the results of the planned interventions and to see if Marie's weight stabilized at the follow-up.

When Marie returned, she had gained 2kg and she explained that there had been some great food at several recent family celebrations. Her parents were adjusting to her new appearance and her independence in eating. She enjoyed shopping for groceries with her parents and planned to continue with this. The BHC provided a handout on label reading and briefly reviewed the results of several studies indicating the importance of breakfast to academic success in children and youth. Follow-up plans included Marie seeing her pediatrician in 6 weeks or sooner if Marie or her parents had concerns.

Chronic Care: An Opiate-Dependent Older Woman with Multiple Chronic Conditions

Sherry, a 61-year-old widow, was referred by her family practice physician for participation in the primary care clinic chronic pain program, the Pain and Quality of Life (P & QOL) program. Sherry had multiple health problems, including osteoarthritis of the lumbar spine, shoulders and knees; hyperlipidemia; hypertension; and mild congestive heart failure. She was obese and had become socially isolated since the death of her husband. Her physician had recently asked her to try methadone for pain control, but when she experienced central nervous system side effects, he continued her on low-dose, short acting opiod therapy. The use of pain medication seemed to improve her functioning, and he had not seen evidence of medication abuse.

The BHC saw Sherry for a P & QOL orientation visit and provided the following services:

1. Review of program contract, which included the requirement that she attend a monthly 1-h class in order to receive her opiod prescription
2. Explanation of acute versus chronic pain and the special challenges of learning to live with chronic pain
3. Importance of shifting focus from pain elimination to functioning and quality of life
4. Introduction to assessment approach used in the monthly class

5. Education about the difference between goals and values and the use of values to guide behavior change
6. Introduction to acceptance and commitment therapy (ACT)¹⁴ as the dominant approach used in P & QOL class activities

Sherry responded well to the initial consultation and stated that she looked forward to “going to school again.”

Over the following 27 months, Sherry attended the class faithfully. Her only misses were anticipated and planned and related to surgery or a special family occasion. Sherry enjoyed the social aspects of the class and developed a relationship with another woman in the class who was close to her in age. She told her physician that she was learning new approaches to protecting and maintaining her health and to working with pain. Even with further decline in her health, she did not become demoralized. She was diagnosed with diabetes during her first year in the class, and she took pride in being able to make necessary changes. She underwent surgery for a bladder problem, but only missed one class. She reduced her rate of smoking cigarettes and planted a small garden in her second year in the program. When she began to have problems with falling, she used physical therapy services to strengthen her gait and proprioception and learned to use a cane.

Her physician found BHC chart notes concerning her attendance helpful to his ongoing treatment planning. He consulted with the BHC several times in order to learn more about ACT interventions mentioned in brief class chart notes. Outcome measurements also helped him make ongoing decisions about treatment. During her first 14 months in the program, Sherry completed the Duke Health Profile¹⁵ at each class. The physical health and mental health scores from the Duke Health Profile are graphed in Fig 8.1. As can be seen, her mental health was relatively strong during this time period.

During the second year of participation in the P & QOL program, Sherry completed an adapted version of the Healthy Days Questionnaire.¹⁶ Figure 8.2 provides

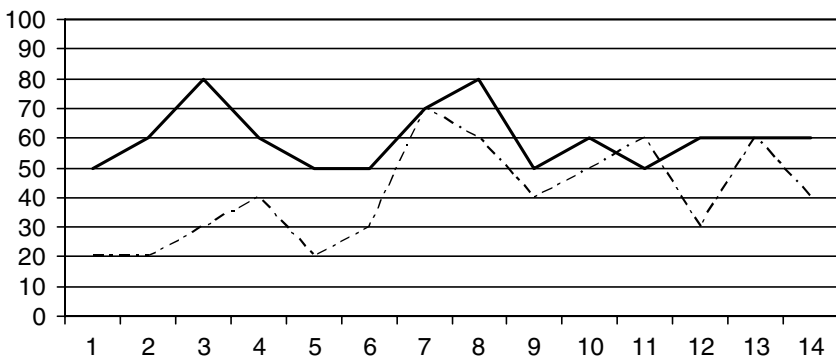


Fig. 8.1 Sherry’s Duke Health Profile physical health (*dotted line*) and mental health (*solid line*) monthly scores during her first 14 months in the Pain and Quality of Life program. The y-axis represents the Duke score, which can range from 0 for worst possible health to 100 for best possible health; the x-axis represents months 1–14

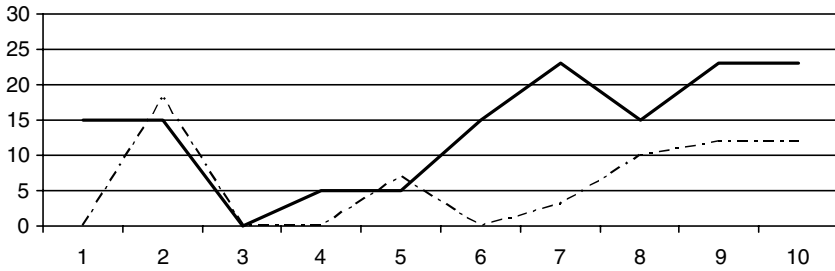


Fig. 8.2 Sherry’s healthy days (dotted line) and able days (solid line) scores during her second year in the program. The y-axis represents the number of days; the x-axis represents months 1–10

a graph of Sherri’s “healthy days” and “able days” (i.e., days when she was able to engage in valued activities, even with poor physical and/or mental health). Sherry’s health declined significantly during the beginning of her second year in the program. However, her able days scores rose consistently during the second 5-month period of the year, suggesting that she was consistently capable of engaging in valued activities at least half of the time, even with ongoing health problems.

Summary

The Three Worlds model provides a strong conceptual framework for evaluating possible approaches to collaboration and integration. The PCBH model rates as a highly integrated approach in the six vectors of integration: mission, physical, operational, informational, financial and resource. The PCBH model offers structure for those wanting to create, deliver, evaluate and further develop innovative BH services for the primary care setting. In this chapter, we provided an introduction to this model and examples of its use to (1) prevent onset of a relatively common mental disorder among adults, (2) address an acute medical concern in an adolescent and (3) create a program that plays an important role in helping an older adult with multiple chronic conditions maintain vitality. Use of a consistent model in integration efforts will support consistency among BH providers who work in primary care settings and allow large-scale evaluation of an effort to improve the health the majority of the members of society by providing effective BH care consistent with available health care resources.

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