



IssueBrief

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No Longer a Novelty: Integrating primary care and behavioral health

“Primary care is inextricably linked to behavioral health.”

With that, Teri Treiger, RN, MA, CCM, CHCQM, FABQAURP, chair-elect, Commission for Case Manager Certification articulates both the problem and the solution.

Most outpatient mental health care takes place in the primary care setting. If you think about it, it makes sense: Primary care providers are often the first to observe and diagnose mental health issues, and they frequently write prescriptions for psychotropic medication.

Neftali Serrano, PsyD, CEO, of the nonprofit Collaborative Family Healthcare Association, agrees. PCPs regularly see patients with depression, anxiety, attentional issues and other mental health issues. “Primary care has been pretty much a de facto mental health system in the United States, because most people with mental health issues will come to their primary care provider at some point and ask for help,” he says. Others may not ask for help, but they, too, may have untreated behavioral health issues.

Then there are patients who don’t necessarily have a mental health concern. These are individuals who need to make complex behavioral changes, such as: changing their lifestyle, eating better, exercising more or starting a complex medication regimen, he adds. That, too, falls to the PCP.

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Referrals aren't the solution, he adds. A big challenge relates to insurance and the ability to pay. Another common barrier—especially in underserved areas—is a lack of mental health providers in the community. Stigma is an additional factor: Patients may be reluctant to visit a psychiatrist or other behavioral health specialist.

Even when PCPs make those referrals, many patients may never get the care. "The research shows that referral completion rates are very, very poor," Serrano says. "Oftentimes 50% of those folks who get referred out from primary care make their visit, or even are able to access care externally and make that first visit."

It makes sense that a primary care doctor is responsible for all these patients. At the same time, it may *not* make sense for an

already- overwhelmed primary care to take on this additional load. Even *if* a primary care provider has adequate training in pharmacology, they typically lack extensive understanding of how to use talk therapy or cognitive behavioral therapy techniques, Treiger points out. And most, simply lack the time.

The solution, Serrano says, is to integrate behavioral health care with primary care; drawing on professionals from both fields.

"So, if we can't get the specialty mental health system to solve these issues for us, what can we do? How do we care for folks in an integrated fashion here, within our four walls? Through primary care behavioral health integration," he says. He points to two models in particular: Primary Care Behavioral Health (PCBH) and the Collaborative Care Model (CoCM.)

PCBH: Providing resources for PCPs

PCPs often feel ill-equipped to address patients with behavioral health issues, and behavioral health professionals usually are not trained to provide care in the context of primary care. PCBH bridges the gap.

The PCBH model is a psychological approach to population-based clinical health care that is co-located, collaborative and integrated within the primary care clinic. Behavioral health consultants—primarily social workers and psychologists—serve as resources to the primary care

team, he explains. Serrano, who describes himself as a primary care psychologist, serves in this role.

Rather than the 50-minute visit, behavioral health consultants work with patients in shorter increments, typically 15 to 30 minutes. They stagger their schedules so they can handle follow-up appointments *and* be available for warm handoffs. "When a primary care provider has a patient in the room, they can refer that patient to us right away. We walk into the room right away and start working with the patient right then." (For a more detailed description, see the accompanying sidebar on next page.)

Behavioral health consultants can provide support for mental health concerns such as depression, anxiety or ADHD as well as physical health concerns such as management of diabetes, hypertension or sleep issues to name a few.

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Follow-up visits may be with the PCP, the behavioral health consultant, or both.

In this model, the behavioral health consultant does not have a separate caseload of patients. “We simply work with the panel that the primary care provider has, and we flexibly interface with the patient and their primary care provider throughout that person’s episode of care,” he explains. “We are a resource the primary care

provider can use to bring us in and support that individual patient. The care team is our first customer.”

From helping connect patients to social services, to ensuring that a comprehensive care plan is in place, the case manager has an important role in the PCBH model. They are ideally suited to support chronic disease management follow-up, Serrano says. And like the behavioral health consultant, the case manager needs to be visible.

“Even if your office is on another floor or far from the clinical area, I would encourage you to take the time to get to know the behavioral health consultants,” Serrano says. “You’re going to hear stories; you’re going to say, ‘Hey, I can actually help with that situation.’” A case manager’s physical presence makes warm handoffs possible. “That’s often what really works well in a PCBH model—everybody starts thinking in terms of warm

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PCBH in action

Betsy visits her PCP, Dr. Lopez, presenting with back pain and insomnia. But after talking to her for a while, Dr. Lopez realizes that depression is a key component. Dr. Lopez asks a behavioral health consultant to come to the exam room to talk Betsy. Dr. Lopez then goes to her next patient.

The behavioral health consultant conducts a brief intervention with Betsy, develops a follow-up plan, and may make medication recommendations to Dr. Lopez.

“The professionals divided the work and did as much as they possibly could in one visit, as opposed to wasting a lot of time and rolling the dice on an outside referral,” Serrano says. “Betsy goes home happy because she had all her needs addressed—without the hassle of a visiting another provider. And that’s what we mean by good PCBH.”

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The PCBH model does not focus on a particular diagnosis or disease state, he says. In contrast, the Collaborative Care Model *does* focus on particular conditions in order to improve quality and continuity of care.

CoCM: Chronic disease management for behavioral health

CoCM is a systematic approach to treatment that involves the integration of care managers and consulting psychiatrists to support the PCP

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and to more proactively manage behavioral health disorders as they would any other chronic disease. It’s adapted from that chronic disease management model, but applied to behavioral health conditions—typically depression, but that is expanding.

Unlike the PCBH model, CoCM focuses on particular disease

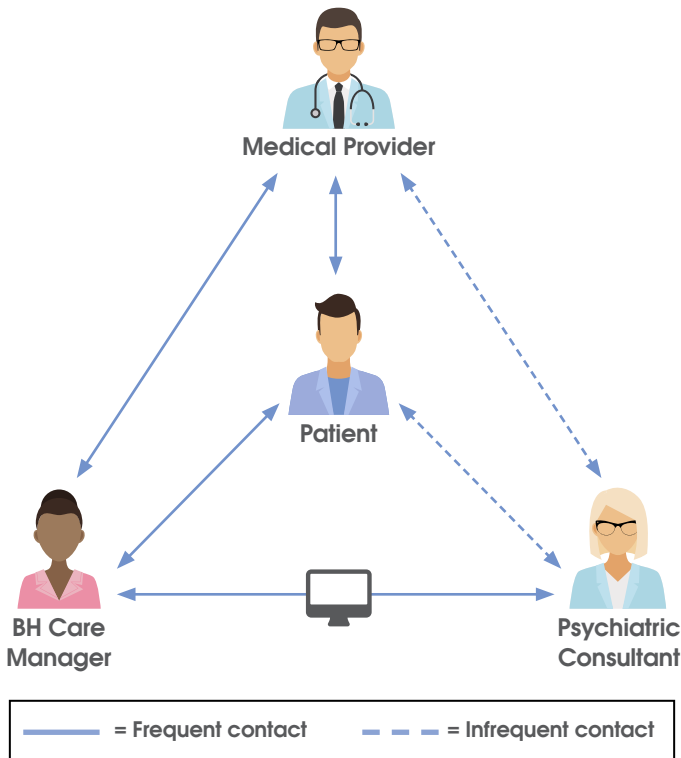
conditions and a specific cohort of registry-defined patient populations. Figure 1 below, illustrates how this model works in practice. The registry allows the care team to track patients and monitor their improvement. If the patient isn’t improving, the team can adjust the care plan as needed.

The point person in this model is the care manager, who, among other things, looks at the registry every day and determines who needs follow up and/or additional support. Care managers have varying levels of professional backgrounds. A case manager could, in this model, take on the role of the care manager, Serrano says. “There’s a lot of overlap with case management.”

CoCM also includes a consulting psychiatrist, who oversees the prescribing of medications for that patient. If a patient isn’t improving, the care manager may ask the consulting psychiatrist to review that patient’s chart or, in some cases, meet with the patient. The psychiatrist makes an assessment and provides feedback to the PCP about the prescriptions, Serrano explains. “Because the consulting psychiatrist is such a rare resource, we try not to overwhelm them and try to make direct contact with the patient as infrequent as possible. We really want to maintain care with the primary care provider.”

As part of the CoCM team, case manager can work in a variety of areas, including addressing social determinants of health. A care manager could flag certain patients in the registry who require

Team Structure Collaborative Care Model



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Figure 1

“When your behavioral health colleague and your medical colleague and your nurse colleague and your registration colleague and care manager and your consulting psychiatrist and your pharmacist and your diabetes educator, are all working to the top of their license, it enables you as a case manager to find pathways for your patient to get their needs met, and for you to be able to focus on your job.”

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or would benefit from case management support in particular areas. “And that is when you come in as a case manager to support that work and report back to the care manager, ‘Hey, this is happening. This may be why your patient’s PHQ-9 score isn’t improving. And so, this is what I’m going to do, and this is what I think you should do.’”

Integrated and coordinated

The two models work well together and a case manager can play a key role in coordinating all the elements.

It works best when everyone focuses on what they do best: “When your behavioral health colleague and your medical colleague and your nurse colleague and your registration colleague and care manager and your consulting psychiatrist and your pharmacist and your diabetes educator, are all working to the top of their license, it enables you as a case manager to find pathways for your patient to get their needs met, and for you to be able to focus on your job.”

A change is coming

When behavioral health is integrated into primary care, and when that care is coordinated, patients experience better outcomes, says Treiger. “The separation of medical and mental health care has always mystified me both professionally and personally, especially how insurance companies often have mental health coverage carved out and managed by an entirely different company.”

She sees this as a symptom of a larger stigma associated with mental health care—a stigma that seems to be fading. “Ideally, we’ll fully integrate behavioral and physical health. The CoCM and PCBH models can help that happen. Insurance companies and other payers will begin to realize the importance of the integration of behavioral health and primary care so that transitions are seamless.”

This will only happen with a coordinated, team-based approach, Serrano says, adding that health care

delivery is moving in that direction. “The modern health care team is designed around the idea that teams care for patients more effectively than individuals. It really requires a team of professionals coming together, each sharing their expertise, each sharing their particular perspectives, and each understanding how each other work in order to make each other’s work better.”

But, he adds, it cannot be piecemeal, a project here and a project there. Such integration must be the rule, not the exception, Serrano says. “We want to connect the modern care team. We want to make these models a standard of care, not a novelty.” ■

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About the Experts

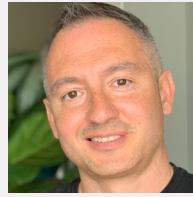


Teri Treiger, RN, MA, CCM, CHCQM, FABQAURP

Teri Treiger is a thought leader inspiring Conscious Case Management® practice across the health care continuum. She earned her undergraduate degrees in nursing and healthcare administration from Laboure and Stonehill Colleges, respectively. She achieved her Masters of Organization Management at the University of Phoenix. Teri's nursing practice concentrated on acute care, neurosurgery, orthopedic trauma, respiratory intensive care, and emergency/urgent care before shifting to business-focused care coordination and utilization management at managed care organizations and practice management. Subsequently, Teri worked as a clinical product manager developing care management and population health programs at McKesson. Teri oversaw the development and implementation of an uninsured care management program in collaboration with Baptist Health in Montgomery, AL.

Teresa is a prolific author in journals and books related to the subject of case management and care coordination. In addition, she is an editor and featured columnist of Professional Case Management's *The Heartbeat of Case Management*. Previously, Teresa served as a founding board member of the National Transitions of Care Coalition (NTOCC) and is a past National President of the Case Management Society of America (CMSA).

Teri is founder and principal at Ascent Care Management located in Quincy, MA, where she provides private case management, consulting, professional education, peer mentoring, and publication services.



Dr. Serrano, Chief Executive Officer of the Collaborative Family Healthcare Association

Dr. Serrano is the Chief Executive Officer of the Collaborative Family Healthcare Association, a national not-for-profit organization dedicated to promoting integrated care as the standard of care for all. He has devoted the majority of his career to working with federally qualified health centers (FQHC), starting integrated care programs and consulting with clinics in underserved settings to assist with implementation of primary care behavioral health (PCBH) programs.

Dr. Serrano's research interests include program development evaluations and outcome studies related to PCBH, particularly in underserved settings. In 2014 Dr. Serrano edited an e-book titled, *The Implementer's Guide To Primary Care Behavioral Health*, a practice management handbook. One of Dr. Serrano's most outstanding contributions to the field of psychology has been his passion to teach and train the future PCBH workforce. In 18 years of practice he has trained over 100 students and professionals in the practice of Behavioral Health Consultation in primary care.



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