Behavioral Health
Expand Patient Care and Improve Practice Efficiency

How will this module help me?

1. Discusses 5 steps to implement your new model of behavioral health integration.
2. Provides answers to frequently asked questions about behavioral health models.
3. Shares examples of practices that successfully implemented an integrated behavioral health model.
Introduction

Many medical conditions are greatly affected by patients’ mental health and behavioral choices. Physician-led primary care teams often must address many common mental health disorders, such as depression, anxiety, and substance abuse. In addition, behavioral and lifestyle issues, such as smoking, lack of exercise, and poor sleep, impact many aspects of health. By bringing medical and behavioral health services together within primary care, the team is better able to meet both the mental and physical health needs of the patient.

Five STEPS for Integrating a Behavioral Health Model Into Primary Care Practice

1. Assess Current Needs and Resources.

2. Design a Team-Based Care Model.

3. Train Members of the Primary Care Team.

4. Implement the Team-Based Behavioral Health Model.

5. Monitor and Improve Processes.

Assess Current Needs and Resources.

Physician-led primary care teams are in a position to effectively screen patients for a range of behavioral health issues and to monitor treatment response. The practice team should review the ways in which behavioral health issues are currently being identified and followed. Defining existing behavioral treatment resources will allow a practice to identify any additional resources that might be needed, such as an embedded behavioral health specialist. Determine the practice needs for behavioral health resources based on your patient population. Caring for a large population of patients with mild or moderate depression or anxiety may warrant the development of a model with a set of resources that is different than that used for patients with chronic disease who need behavior and lifestyle support. Through this exercise, your practice will determine whether, for example, training a nurse to become a behavioral health care manager or hiring a social worker to become the practice's behavioral health specialist will work best based on your patient population's needs.

Q&A

Which patients would benefit most from an integrated behavioral health model?

This model is beneficial to patients with mild to moderate depression and anxiety. The resources allocated to support the model within the primary care practice can also be impactful for patients who have behavioral or educational needs based on a lifestyle-altering condition, such as obesity, diabetes, hypertension, or chronic pain (with or without an addictive disorder). The model is not meant to meet the needs of patients who have acute suicidal ideation or unstable psychosis. These patients should be referred to the direct care of a psychiatrist.
How many patients with behavioral health needs do I need to have to warrant embedding a behavioral health specialist?

The ideal staffing ratio depends on the model of care that is used and the patient population. The University of Washington Advancing Integrated Mental Health Solutions (AIMS) Center created a matrix of staffing ratios for diverse clinic settings with recommendations about the use of full-time equivalent (FTE) care managers and psychiatric consultants based on the size and needs of the patient population. It also includes the suggested case load for each care manager within the model. Tools like this matrix can help your practice determine the resources required to support your patients.

2. Design a Team-Based Care Model.

In an embedded behavioral health model, team members will often have complementary roles in providing patient-centered care to those with mental health conditions. Frequently, the integrated behavioral health care team will include the patient, the primary care physician, a behavioral health specialist, and a consulting psychiatrist. The behavioral health specialist may be a psychologist, licensed social worker or nurse, or another individual trained in health education or lifestyle counseling. In most models, the psychiatrist is involved on a consultative basis.

The physician-led team works together with shared goals, treatment plans, workflows and, ideally, in a partially co-located space to increase team member communication and collaboration. The primary care physician and/or psychiatrist supervise the hands-on work of the behavioral health specialist and collaborate in frequent patient panel reviews with the team to identify patient needs and opportunities for intervention. In more remote areas or smaller practices, the behavioral health specialist or psychiatrist may consult with the patient using telemedicine technologies; this may be a more cost-effective and feasible approach to offering behavioral health services.

Q&A

What should our practice’s model look like?

Models vary depending on patient needs and practice capabilities. While this module describes the optimal model for providing basic mental health care, some practices may expand their model to offer a broader panel of behavioral health services. Some models include health educators who have been trained in lifestyle counseling for weight loss, exercise, and smoking cessation. This person would function as an advanced health coach, and the position could be filled by a high-performer who already works in the practice and has an interest in additional training. Another practice model may involve a nurse or social worker who provides lifestyle counseling and addresses anxiety, depression, sleep disturbances, and social-service needs. Additionally, most models involve a psychiatrist who is available to consult in-person or virtually with the behavioral health specialist and the primary care physician on the management of patients with more complex psychiatric problems. Of these options, you may find that one model or a hybrid will work best for your practice.

What is a warm hand-off and how does it improve care?

A warm hand-off gives the primary care physician, medical assistant, or nurse the opportunity to directly hand off the patient to their behavioral health specialist. During a conversation with the patient during rooming, for example, the medical assistant may find that the patient needs a more in-depth assessment. Paging the behavioral health specialist directly to the room and involving the patient in the transition of care to that person can help increase their credibility and the patient’s trust. It also eliminates the need for the patient to schedule a follow-up appointment with a behavioral health specialist, which is an additional step that may not be taken by patients.

As many insurers are encouraging such models, checking with them how to bill to avoid a patient receiving multiple copays may be helpful. For the patient who is anxious about finances, receiving one
Could the behavioral health specialist support multiple physician-led teams in a practice?

Yes. A behavioral health specialist could support multiple clinicians within a practice. It is possible that this person could support multiple clinics, though a warm hand-off of care is ideal and is more likely to happen if the behavioral health specialist is available on-site. The practice can try to anticipate which patients will require assistance and request that the behavioral health specialist is present while those patients are in the clinic. This will ensure that warm hand-offs occur seamlessly, thereby decreasing wait time for the patients, primary care physician, and behavioral health specialist.

Train Members of the Primary Care Team.

In training the physician-led team to appropriately integrate behavioral health into patient care, there are several critical elements that should be covered.

**Know how and when to give mental health assessments.**
The team members who will be **rooming patients** and conducting **pre-visit planning** should be trained in how to perform mental health screenings using a patient health questionnaire, such as a Patient Health Questionnaire-2 (PHQ-2) or Patient Health Questionnaire-9 (PHQ-9). On a pre-visit questionnaire, there may be a question or two that is a “trigger” for a more in-depth mental health assessment, such as “Have you felt down, depressed, or hopeless lately?” or, “Have you recently lost interest in doing things you normally enjoy?”

**Recognize triggers for involving behavioral health.**
Events such as a death in the family, job loss, a recent cancer diagnosis (for the patient, a partner, family member, or friend), domestic abuse, or a history of mental health conditions should trigger a behavioral health assessment and, potentially, a behavioral health referral. For a patient who possesses one or more of these triggers, the practice may decide that they want the behavioral health specialist to be involved in the patient’s care.

**Understand the Behavioral Health Referral Process.**
When a patient requires a behavioral health intervention, make sure the team knows which pathway to follow. Should the patient be assessed that day? Do they need a full consult with a psychiatrist? Create processes and protocols for the entire care team to recognize when the behavioral health specialist should become involved. Also, ensure that the team knows which aspects of patient follow-up are their responsibility and which belong to the behavioral health specialist. This should be determined based on shared practice protocols under the physician’s leadership.

**Q&A**

**Who should provide the training?**

Online and in-person training is available through many different organizations, and the practice can find the program that is right for developing the skillset and role of the behavioral health specialist. To meet the training needs of the practice, it is common for practices or organizations to develop training based on the skillset that the designated behavioral health specialist will need. If possible, schedule a site visit to observe a practice with an embedded behavioral health model already in place. The primary care physician and psychiatrist should take the lead in determining the important skills that should be gained by the end of the training process.

**We would like to train one of our nurses to do behavioral counseling for weight loss, smoking cessation, sleep counseling, stress reduction, and exercise. Can you recommend some training resources?**

Professional health coach training could give your team the skillsets they need to more effectively educate your patients about lifestyle and behavioral issues. The curricula often include tips for patient
engagement, motivational interviewing, and creating an action plan with patients. Many training
programs exist and offer online educational options.

4 Implement the Team-Based Behavioral Health Model.

In a physician-led team-based behavioral health model, the entire team—the primary care physician, behavioral
health specialist, nurses, medical assistants, and the consulting psychiatrist—will work together to provide
collaborative care to patients.

- The medical assistant or nurse assesses the patient for mental health needs by listening for triggers and
  reviewing any screening questions on the pre-visit questionnaire.
- The primary care physician implements screening and monitoring tools for mental health disorders, makes
  the diagnosis, initiates treatment, and manages medications.
- The behavioral health specialist monitors depression symptom severity, treatment adherence, and side
effects, and reports these results to the primary care physician. Depending on training, the behavioral health
specialist can also provide motivational interviewing, problem-solving therapy, behavioral activation, and grief
support. For practices managing patients with addiction, behavioral health specialists can support patients'
addiction treatment, dosing, and recovery in consultation with the primary care physician.
- A consulting psychiatrist can assist with review of the panel of patients with behavioral health conditions and
  may answer the primary care physician's questions about diagnosis and medication management in more
  complex situations or as needed.

5 Monitor and Improve Processes.

After the new model has been implemented, the team has the opportunity to continually refine and improve
the process. Identifying metrics to track prior to implementation will help the team to stay focused and monitor
improvement over time. Include these metrics on the practice dashboard or scorecard, and consider them as part
of the practice's most important quality metrics. Examples include the following:

- Increased appropriate referrals to the behavioral health specialist.
- Increased percentage of patients on antidepressants who are seen by the behavioral health specialist.
- Increased use of the following forms:
  - PHQ-2 and PHQ-9 to screen for depression.
  - GAD-7 (Generalized Anxiety Disorder 7-item scale) to screen for anxiety.
  - AUDIT-C to screen for alcohol abuse.
- Improved medication adherence.
- Decreased depression scores.
- Fewer emergency visits.
- Fewer hospital readmissions.

Continuous education, reminders, and training opportunities for the team members, including the behavioral
health specialist, nurses, and medical assistants, will help them continue to develop their skillsets and more fully
integrate their behavioral health knowledge into their daily interactions with patients.

Finally, to keep the focus on improvement, keep the behavioral health team on the agenda at team meetings.
This will give the team the opportunity to continuously explore ways to collectively make the process better,
increase communication and keep everyone focused on providing the best care to patients.
Examples of Patients Who Received Care From an Integrated Behavioral Health Team.

**Patient 1:** Anna is a 50-year-old woman business executive who has a history of depression and has been stable for many years with the help of a daily antidepressant. At the patient's yearly physical, the medical assistant administers a PHQ-9 screen that identifies worsening mood symptoms, and the medical assistant alerts the physician. The patient confides in her physician that she and her husband have recently separated. Over several months, her primary care physician increases her antidepressant and ultimately adds another medicine for augmentation, but no improvement is seen and the patient reports experiencing unwanted side effects. She is referred to the behavioral health care manager for brief psychotherapy over six weeks. Through a routine panel management meeting, her case is reviewed with the embedded psychiatrist who recommends a transition to a different antidepressant. Her primary care physician implements this plan with the support of the behavioral health specialist. The patient is reevaluated in 6 weeks and is found to have significant improvement in her symptoms.

**Patient 2:** Rhoda is a 40-year-old woman teacher who has had stable depression for 5 years on an antidepressant. She is enrolled in a depression population registry through her primary care physician's office. The behavioral health specialist calls her every 3 months and administers a PHQ-9 over the phone. The patient had consistently scored less than 4 (favorable) until the most recent call, when she scores 17 (indicative of residual depressive symptoms). The behavioral health specialist learns of the recent unexpected death of the patient's child. An urgent appointment is scheduled with her primary care physician who diagnoses the patient with recurrent depression and adjusts her medications. The case manager provides grief counseling and also refers her to a grief support group. Over time, the patient reaches her treatment goals.

**Q&A**

**What patient outcomes should we expect to see?**

From a patient perspective, success will correlate with decreased symptoms as reflected in improved scores on symptom-based scales or improved functioning. Population health data will reflect decreased symptoms, improved functional status and enhanced well-being and quality of life for patients. The success of the program will also be reflected in the satisfaction of the health care team members as they provide their patients with quality care in a timely, integrated fashion.

**Conclusion**

Embedding behavioral health within primary care practices expands the services a patient can receive. Many medical conditions are affected by patients' behavioral choices and mental health conditions. The reverse is also true; people with chronic medical conditions have a higher risk for depression. In fact, people who have depression and another medical illness tend to have more severe symptoms of...
both illnesses. By bringing medical and psychosocial services together within primary care, the team can successfully provide patient-centered care.

Case Reports

Behavioral Health Case Report: University of Michigan

At the University of Michigan, the Tailored Mental Health Management Support for Primary Care (TaMMS) program was designed to help manage the treatment of depression and anxiety among the patient population. The model is dependent on the skills and abilities of the TaMMS care manager, who often has a social work background and plays a critical role in the care of mild to moderately depressed patients. Not only does the TaMMS care manager follow up to ensure that the treatment is working, but he or she also involves a psychiatry consultant in routine review of patient progress and in providing recommendations to the primary care physician for medication adjustment or other interventions. The TaMMS care managers also have additional important functions on the team:

- Helping triage patients to appropriate services.
- Providing short-term psychotherapy interventions, such as behavioral activation or problem-solving therapy.
- Contributing to team efforts to improve workflows, making them Lean and efficient.
- Assisting in identifying additional resources and referring behavioral health patients who require specialty mental health care.

While TaMMS was designed for patients with mild to moderate depression, the TaMMS care managers are often asked to help with patients who have serious mental illness (SMI) because of their network connections and system knowledge. Care managers can quickly answer a few questions or involve the appropriate people to make the right next steps happen for these patients. The TaMMS program is now implemented in four clinics—two community clinics and two university clinics—and will be implemented in four additional clinics (two community and two more university clinics) in 2016. The TaMMS program has been supported by funds provided by the UM health system, Blue Cross Blue Shield Foundation, Medicaid Match and, most recently, the UM Department of Family Medicine. Efforts are being made to develop a sustainable plan for funding this integrated behavioral health effort longer-term implementation.

Behavioral Health Case Report: Cornell University

A pilot program at Cornell University, a highly diverse international community of 22,000 students, demonstrated the value of an embedded behavioral health consultant (BHC) as a cost-effective, accessible, culturally sensitive approach to providing mental health care.

Each year nearly 80 percent of students use Cornell's campus medical services, and about 18 percent access mental health services, both for a nominal $10 per visit charge. Though staff share an electronic record, students access counseling and medical services through separate intake processes. Demand for mental health services continues to grow, and surveys suggest that as many as 40 percent of students could benefit from mental health care. Some of this need is experienced by medical providers as growing complexity in medical presentations. Though university leadership recognizes the importance of health to its academic mission, it would be prohibitively expensive to meet the estimated need of the student population with traditional mental health services. Additional barriers included the time required for treatment and the perceived stigma that many students have towards mental health care.
As a one-year pilot effort aiming to cost-effectively increase the quality of medical care and the reach of mental health services, a behavioral health consultant was embedded in a medical unit and assigned to work with four clinicians. The experiment proved highly successful. Students, including many who said they would not have sought traditional mental health services, found BHC interventions to be very helpful. The clinicians reported that the partnership increased the effectiveness and cultural sensitivity of their care. Mental health staff developed new appreciation for the volume and significance of mental health concerns presenting in the primary care setting. The program reached under-represented minorities, international and graduate students well beyond their proportion in the general student population, which was particularly gratifying.

Based on the success of this pilot, Cornell University Health Services Executive Director and Associate Vice President Janet Corson-Rikert, MD, decided to expand the program as a key component of their integrated health program. The program includes one behavioral health consultant on each medical team.

When asked about lessons her team would share with others implementing similar programs, Dr. Corson-Rikert suggested:

1. Set up an interdisciplinary team to support the BHC and enable nimble problem-solving around operational challenges
2. Leverage the BHC’s expertise for both behavioral and cultural concerns
3. Use regular case reviews to facilitate education and team discussion based on BHC experience

Behavioral Health Case Report: Brigham and Women’s Advanced Primary Care Associates

Brigham and Women's Advanced Primary Care Associates, located in South Huntington, MA, has been increasingly successful in implementing its integrated behavioral health model. Four after the clinic team first began integrating behavioral health into daily practice functions, the clinic director, Stuart Pollack, MD, credits the strong culture and multidisciplinary model at the practice for their continued success. Each step within the practice workflow has been thoughtfully designed by the clinical team.

The practice consists of three physician-led teams, each of which includes a physician, a physician assistant, two medical assistants, a licensed practical nurse, and a social worker who specializes in behavioral health. In addition to the core clinical members, the three teams share a pharmacist, a nutritionist, a nurse care manager, and a consulting psychiatrist.

The medical assistants play an integral role in streamlining and strengthening workflows. Using PHQ-2 and PHQ-9 screening tools, the medical assistants determine whether a patient requires behavioral health services. Medical assistants administer the questionnaires at the beginning of each patient visit. After the medical assistant completes the patient intake activities, he or she meets with the physician for a brief, in-person hand-off. During this hand-off, the physician and medical assistant determine whether the behavioral health social worker should become involved in the patient’s care. If so, the social worker will see the patient after the physician portion of the visit.

The team’s social worker maintains continuity of care by checking in with patients after their initial visit and between visits. The social worker reports back to the consulting psychiatrist and primary care physician regarding each patient’s care. The three teams in the practice together require approximately six hours per week of the consulting psychiatrist’s time. The psychiatrist attends practice meetings and is considered to be an integral member of the team. Through a multidisciplinary approach and an engaged staff, Brigham and Women’s Advanced Primary Care Associates has mobilized its collective intelligence to develop a successful embedded behavioral health model that is able to provide the best care to patients.
Learning Objectives
1. Describe steps to assess current processes and resources to determine the behavioral health model that will work best for your practice and patients
2. Explain how to integrate complementary team-based care roles
3. Determine how to incorporate behavioral health services into team-based primary care
4. Identify metrics to track and monitor the embedded behavioral health model

Article Information

AMA CME Accreditation Information

Credit Designation Statement: The American Medical Association designates this enduring material activity for a maximum of .50 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

ABMS MOC Statement: Through the American Board of Medical Specialties (“ABMS”) ongoing commitment to increase access to practice relevant Maintenance of Certification (“MOC”) Activities, this activity has met the requirements as an MOC Part II CME Activity. Please review the ABMS Continuing Certification Directory to see what ABMS Member Boards have accepted this activity.

Renewal Date: December 10, 2016; October 03, 2019

Disclosure Statement: Unless noted, all individuals in control of content reported no relevant financial relationships.

References