NATIONAL REGISTER

OF HEALTH SERVICE PSYCHOLOGISTS

Interfacing in the Primary Care Environment and Models of Integrated Behavioral Health

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Cultural Differences

Consider the following series of characterizations . . . which have not come without reasonable historical data points to substantiate them

Outpatient Mental Health

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Outpatient Mental Health

- Does change happen **inside** or **outside** the therapy room?
- If you are sick one day, **can another psychologist simply see your patients** for you?
- **Do we really need a 50-minute hour** to deliver something helpful to patients?

Outpatient Mental Health

- **How many treatments are "enough"** or sufficient?
- **What is the goal** of psychotherapy?
- **How many hours** does a high quality psychological battery take—2? 10?

Outpatient Mental Health

Do we foster a **dependency between our patients and ourselves?**

...is this beneficial?

...when?

...to which types of patients?

...why or why not?

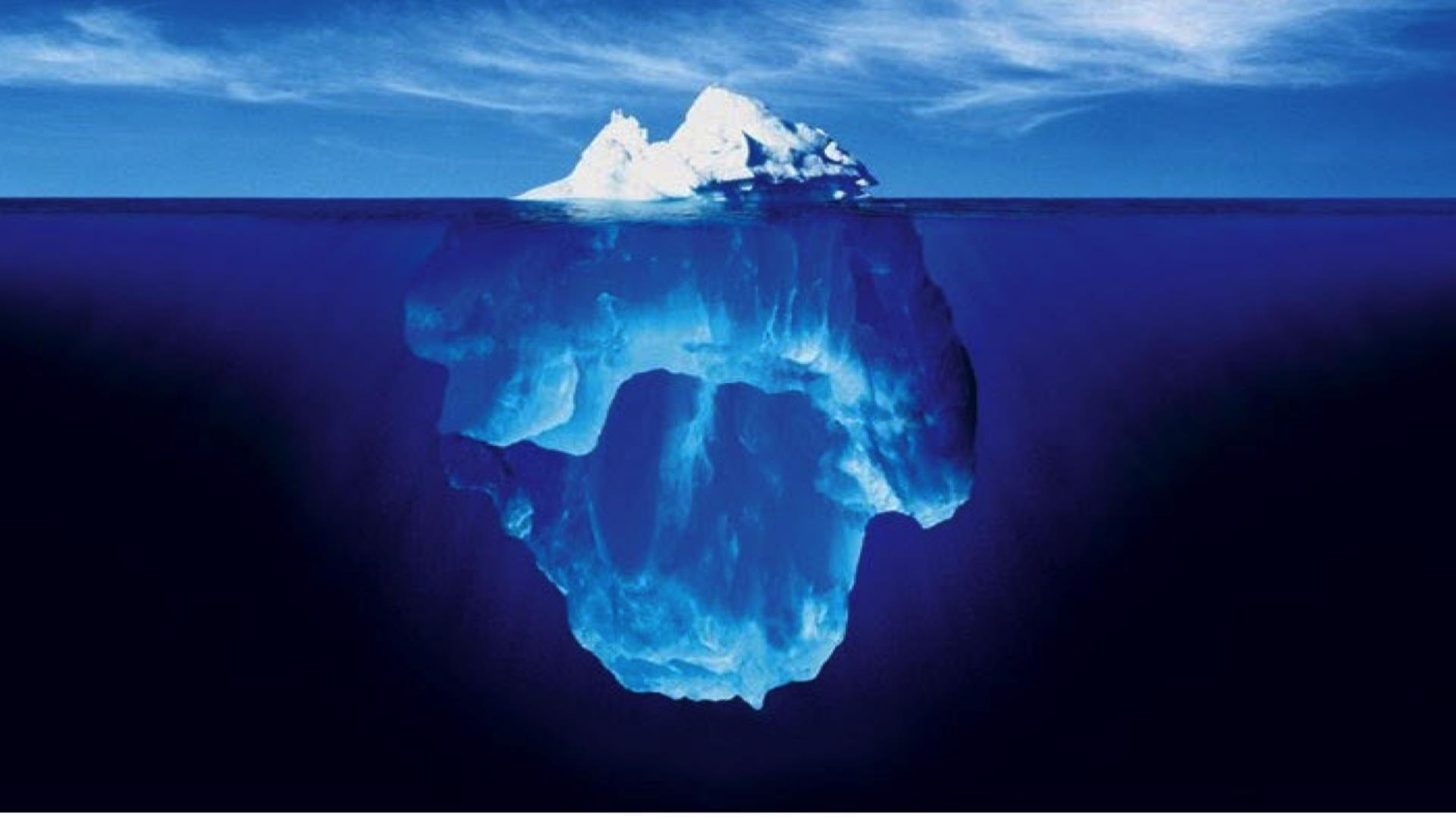
Outpatient Mental Health

Are the goals and directions of mental health services clear?

...Always? Often? Sometimes? Rarely?

Outpatient Mental Health

Are patients in charge and well informed of how to best use our services?



Outpatient Mental Health versus **Primary Care**

Seeing **5 patients/day** for **60 minutes each**

OR

Seeing **60 patients/day** for **no more than 5 minutes each?**

Outpatient Mental Health versus **Primary Care**

Working **alone**

OR

Working **in a team**

Outpatient Mental Health versus **Primary Care**

Responsively accepting referrals

OR

Proactively **finding ways to add value** and contribute to the betterment of an **entire population of patients—**prevention, outreach, etc.

Primary Care

Serving patients AND **other medical providers** who are also charged with helping patients become healthier (mental health or physical health)

Primary Care

5 Formal models of integration

Innumerable **informal models of integrating**

...but **uncertain to produce success or positive results**...including the Triple Aim

Service Delivery Model	Practice Level	Third-Party Payment Ease	Training Needed	Services Included and Problems Treated	Research Support	Caseload Size	Role of BHP and PCP	Comments
PCBH	Provider	Fairly easy; state-by-state differences for treating general health conditions	Some training needed; very little training needed if hiring a clinical health psychologist or someone whose degree is specialized in primary care integration	Mental health, some substance abuse, and any general health condition that behavioral medicine helps; services include education and self-management skills with patient	Some empirical, theoretical and conceptual research; observational studies	Published guidelines advise up to 16 patients per day and population containing at least 3K to 10K patients	BHP does not "own" the patients; care is adjunct to PCPs' treatment plans; all visits last 15 to 30 minutes and are solution-focused	A versatile model; training is available in university and non-university settings; does not provide specialty level of mental healthcare—only the primary level (i.e., helps patients self-manage their symptoms); very collaborative with PCPs
Co-located specialty mental health	Provider	Easy Requires ensuring provider is on all panels needed for reimbursement	None beyond graduate level of education; familiarity with primary care culture needed	Mostly mental health and some substance abuse; services involve psychotherapy if hiring a non-psychiatric prescriber; may include medication management (i.e., "shared care" in Canada) if hiring a psychiatrist or psychiatric nurse practitioner	None for psychotherapy delivered in this capacity; "shared care" has some empirical, theoretical, and conceptual research	No published guidelines available; no more than 8 patients usually seen in an 8-hour day	BHP "owns" his/her patients and may work independently of PCP; PCP may have more oversight in "shared care" models; visits last 30 to 60 minutes	Probably the easiest to start; least extent of integration; only solves the problem of poor access—partially; little teamwork between PCP and BHP required; most BHPs practicing this model lack skills needed to work in an integrated way
MFT	Provider	Fairly easy; state-by-state differences for treating general health conditions; family therapy is not reimbursed by most third-party payers	Some training needed	Family psychotherapy preferred; family issues as they relate to general or mental health and some substance abuse issues; when time does not permit, these BHPs may also do brief work (i.e., help patients self-manage symptoms)	Some theoretical and conceptual research	No published guidelines available; likely between 8 and 16 patients per day	BHP may "own" patients but will operate very collaboratively with PCPs; visits last 15-60 minutes and may involve family members—depending on patient need and time available	A versatile specialty—not a separate model in and of itself as it delivers specialty and primary levels of care; training is available only within university degree programs
Care Management	Non-provider	More difficult; varies by state; nurse time may be paid by third party, but psychiatric prescriber's services are not; "shared care" delivered by psychiatrists are widely paid by third parties	A little training is needed; more training needed if service will include helping patients self-manage symptoms	Telephonic medication management monitoring and treatment adherence by nurse; any mental health problem for which medications are the first-line treatment; part-time psychiatric prescriber serving a consultation and liaison function	Empirical, theoretical and conceptual research; experimental studies (high-quality, randomized controlled trials)	No published guidelines, but recommended for patient population over 3K and common caseloads have been 80 patients; if optimized and streamlined 150 to 300 may be possible	BHP does not "own" the patients, care is directed by PCPs and managed by nurses	Narrow model of integration; organized around a specific disease; psychiatric prescribing advisor can be located outside the clinic when performing consultation and liaison role
Reverse/ Bidirectional Integration	PCP Provider	Easy when there are state and federal grants available	BHP training is needed on physical health conditions; PCP training on mental health conditions is needed; shared language, communication, and team- based care training	Primary care services delivered in a behavioral health setting (e.g., community mental health center; federally qualified behavioral health home)	Some theoretical and conceptual research	No published guidelines, but one PCP is usually integrated to implement basic primary care services		Only helpful if your population involves severe mentally ill patients AND you are responsible for providing their mental healthcare

1. What kind of **site license** does your organization have?
2. How is your site **classified?** (e.g., **FQHC, hospital, ACO**, etc.)
3. Who are your **payors?**
4. What kinds of **license** does your integrated behavioral health provider have?
5. What **service delivery model** will you use and how will you code for the work?

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