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

KENT A. CORSO, Psy.D., BCBA-D

President, NCR Behavioral Health
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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Healer?
Teacher?
Consultant?
Coach?
Therapist?
Counsellor?
Friend?
Doctor?
Healthcare Provider?
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
<table>
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<tr>
<th>Service Delivery Model</th>
<th>Practice Level</th>
<th>Third-Party Payment</th>
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<th>Services Included and Problems Treated</th>
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<tr>
<td>PCBH</td>
<td>Provider</td>
<td>Fairly easy; state-by-state differences for treating general health conditions</td>
<td>Some training needed: very little training needed if hiring a clinical health psychologist or someone whose degree is specialized in primary care integration</td>
<td>Mental health, some substance abuse, and any general health condition that behavioral medicine helps, services include education and self-management skills with patient</td>
<td>Some empirical, theoretical and conceptual research; observational studies</td>
<td>Published guidelines advise up to 16 patients per day and population containing at least 3K to 10K patients</td>
<td>BHP does not “own” the patients; care is adjourn to PCPs; treatment plans; all visits last 15 to 30 minutes and are solution-focused</td>
<td>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</td>
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<tr>
<td>Co-located specialty mental health</td>
<td>Provider</td>
<td>Easy</td>
<td>Requires ensuring provider is on all panels needed for reimbursement</td>
<td>None beyond graduate level of education; familiarity with primary care culture needed</td>
<td>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</td>
<td>None for psychotherapy delivered in this capacity; “shared care” has some empirical, theoretical, and conceptual research</td>
<td>No published guidelines available; no more than 8 patients usually seen in an 8-hour day</td>
<td>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</td>
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<td>MFT</td>
<td>Provider</td>
<td>Fairly easy; state-by-state differences for treating general health conditions; family therapy is not reimbursed by most third-party payers</td>
<td>Some training needed</td>
<td>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)</td>
<td>Some theoretical and conceptual research</td>
<td>No published guidelines available; likely between 8 and 16 patients per day</td>
<td>BHP may “own” patients but will operate more collaboratively with PCPs; visits last 15–60 minutes and may involve family members—depending on patient need and time available</td>
<td>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</td>
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<tr>
<td>Care Management</td>
<td>Non-provider</td>
<td>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</td>
<td>A little training is needed; more training needed if service will include helping patients self-manage symptoms</td>
<td>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</td>
<td>Empirical, theoretical and conceptual research; experimental studies (high-quality, randomized controlled trials)</td>
<td>No published guidelines; but recommended for patient population over 3K and common case loads have been 80 patients; If optimized and streamlined 150 to 300 may be possible</td>
<td>BHP does not “own” the patients; care is directed by PCPs and managed by nurses</td>
<td>Narrow model of integration; organized around a specific disease; psychiatric prescribing advisor can be located outside the clinic when performing consultation and liaison role</td>
</tr>
<tr>
<td>Reverse/Bidirectional Integration</td>
<td>PCP Provider</td>
<td>Easy when there are state and federal grants available</td>
<td>BHP training is needed on physical health conditions; PCP training on mental health conditions is needed; shared language, communication, and team-based care training</td>
<td>Primary care services delivered in a behavioral health setting (e.g., community mental health center, federally qualified behavioral health home)</td>
<td>Some theoretical and conceptual research</td>
<td>No published guidelines; but one PCP is usually integrated to implement basic primary care services</td>
<td>Only helpful if your population involves severe mentally ill patients AND you are responsible for providing their mental healthcare</td>
<td></td>
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</tbody>
</table>
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 **payers**?

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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