Primary Care Behavioral Health

Past  Present  Future

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Primary Care Behavioral Health Implementation Project

Objectives

• **Define** Primary Care Behavioral Health (PCBH) Consultation model.

• **Describe** the development of the PCBH model over time.

• **Identify** at least one future direction in PCBH Consultation model.
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What do we know about Healthcare?

Patients do not present their illness as physical vs. mental
Comorbidity is **the commonality**

Chronic disease account for **7/10** deaths in the US

(includes heart disease, cancer & stroke which account for 50%)

25% of people with chronic conditions have difficulty with activities of daily living

Chronic diseases share common **risk** factors which are modifiable

BH Comorbidity is linear with physical health concerns & costs 46% more

Largest percent of frequent ED users present with mental / behavioral health issues

80% of healthcare dollars are spent by 20% of the population

66% of Medicare spending = patients with 5 or more chronic disease

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**CANCER:**
- 50% of cancers could be prevented if people made lifestyle improvements

**HYPERTENSION:**
- 1 in 4 adults have hypertension, 1/3 don't know it
- Less than 1/3 are controlled

**ASTHMA:**
- Asthma is 3rd leading cause of presentation in ED
- 60% people with asthma are not properly controlled

**DIABETES:**
- Almost 9% of adult world population has diabetes

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(MedPac, 2012; Hastings Center, 2015); Original source data is the U.S. Dept of HHS the 2002 and 2003 MEPS. AHRQ as cited in Peterson et al. "why there must be room for mental health in the medical home. (Graham Center One-Pager)"
Behavioral Health & Primary Care

67% with a behavioral disorder do not get behavioral health treatment.

30-70% of referrals from primary care to an outpatient behavioral health clinic or provider don’t make the first appointment.

Top disability concerns are behavioral.

50-80% with depression/anxiety present physical complaints primary.

Top 5 health care costs:
- Depression
- Obesity
- Arthritis
- Pain
- Anxiety
84% of the time, the 14 most common physical complaints have no identifiable organic etiology

80% with a behavioral health disorder will visit primary care at least 1 time in a calendar year

50% of all behavioral health disorders are treated in primary care

48% of the appointments for all psychotropic agents are with a non-psychiatric primary care provider

45% of completed suicides see PC within 30 days

20-40% of general primary care patients have behavioral health needs

30-70% presenteeism and absenteeism due to behavioral health concerns and conditions

Context 1: The Patient
What happens after your patients leave your office?

- 80% of your conversation is forgotten
- 20% of your conversation is retained
- Only half of what is retained is accurately remembered
- 10% of what is remembered is misunderstood
- 80% forgotten immediately
**Context 2: The Primary Care Physician**

- Provide **high quality care** in a **time limited** setting (Mauksch, Dodson, Epstein, 2008).
- Address **bio-medical** concerns in a **psychosocial** context (ACGME FM Milestones).
- PCP is generally presented with **3-6 concerns per visit** or more (Braddock, Edwards, Hasenberg, Laidley, Levinson, 1999).
- **Insufficient training** in conceptualizing **behavioral health issues** or in applying behavioral principles for change (Brandt-Kreutz, Ferguson, Sawyer, 2015).
- Overworked, underpaid with **high rates of burnout** (Philips, 2015).

**Context 3: The Primary Care System**

- Focus on all health needs
- Continuous person-centered care
- Responsible for keeping people healthy (primary)
- Treatment occurs before major problems develop
- Spend less money, make less referrals, prevent over treatment
- Produce an effective healthcare system

Institute of Medicine, 1996; World Health Organization; Philips & Bazemore, 2010
“Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.”

A **culture of health** could be enabled by closing the artificial division between mind and body and focusing, instead on **health and wellness** that address comprehensive, **whole person care**.

**INTEGRATION** is the standard

**How do we integrate than should we integrate?**
Primary Care Behavioral Health

PCBH model is a team-based primary care approach to managing behavioral health problems and biopsychosocially influenced health conditions. The model's main goal is to enhance the primary care team's ability to manage and treat such problems/conditions, with resulting improvements in primary care services for the entire clinic population.

Stress-linked physical symptoms:
- Headaches
- Irritable bowel syndrome
- Obesity
- Sleep hygiene
- Psychosomatic issues

Sub-threshold symptoms:
- Marital conflict
- Intimate partner violence
- Family transitions
- Parenting stress
- End of life / death / caregiver

Preventive / Lifestyle Care:
- Behavior activation
- Motivation for behavior change
- Habit formation
- Habit reversal
- Lifestyle changes

Chronic Disease Self-management:
- Diabetes
- Hypertension
- Obesity
- Depression
- Anxiety
Behavioral Health Consultant (BHC) extends and supports the Primary Care Provider and team. BHC works as a generalist and an educator who provides high volume services that are accessible, team-based, and routine part of primary care.
PCBH model is a team-based primary care approach to managing behavioral health problems and biopsychosocially influenced health conditions. The model’s main goal is to enhance the primary care team’s ability to manage and treat such problems/conditions, with resulting improvements in primary care services for the entire clinic population.
1977
George Engel: The need for a new medical model: A challenge for biomedicine
Birth of the biopsychosocial model

1980s
Patricia Robinson & Kirk Strosahl begin experiments in primary care at Group Health Cooperative, Washington

1994
Institute of Medicine’s definition of Primary Care

1996
2013

A STANDARD FRAMEWORK FOR LEVELS OF INTEGRATED HEALTHCARE AND UPDATE THROUGHOUT THE DOCUMENT

SAMHSA-HRSA
Center for Integrated Health Solutions

MARCH 2013
<table>
<thead>
<tr>
<th>COORDINATED KEY ELEMENT: COMMUNICATION</th>
<th>CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY</th>
<th>INTEGRATED KEY ELEMENT: PRACTICE CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEVEL 1 Minimal Collaboration</td>
<td>LEVEL 2 Basic Collaboration at a Distance</td>
<td>LEVEL 3 Close Collaboration Onsite with Some System Integration</td>
</tr>
<tr>
<td>In separate facilities, where they:</td>
<td>In same facility not necessarily same offices, where they:</td>
<td>In some space within the same facility, where they:</td>
</tr>
<tr>
<td>➤ Have separate systems</td>
<td>➤ Have separate systems</td>
<td>➤ Have separated systems, like scheduling or medical records</td>
</tr>
<tr>
<td>➤ Communicate about issues only rarely and under competing circumstances</td>
<td>➤ Communicate periodically about shared patients</td>
<td>➤ Communicate in person as needed</td>
</tr>
<tr>
<td>➤ Communicate, driven by provider need</td>
<td>➤ Communicate, driven by specific patient issues</td>
<td>➤ Collaborate, driven by need for each other's services and more reliable referral</td>
</tr>
<tr>
<td>➤ May never meet in person</td>
<td>➤ May never meet in person</td>
<td>➤ Meet occasionally to discuss cases due to close proximity</td>
</tr>
<tr>
<td>➤ Have limited understanding of each other's roles</td>
<td>➤ Appreciate each other's roles as necessary</td>
<td>➤ Feel part of a larger, yet ill-defined team</td>
</tr>
</tbody>
</table>

Past | Present | Future
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2016

Patricia J. Robinson - Jeffrey T. Reiter

Behavioral Consultation and Primary Care
A Guide to Integrating Services
Second Edition

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Payment
Digital
Educated and informed public
Physician champion
Equity in healthcare

Future of PCBH
Health