Facilitator Guide for the Lecture: Introduction to Integrated Behavioral Health in Primary Care

Introduction:

This lecture introduces learners to the limitations of access and barriers to mental health care. It covers different integrated care consultation models that were developed to improve access to care. The focus of this lecture is the Collaborative Care consultation model, which is newer and is the only evidence-based consultation model.

Learning Objectives for this Lecture:

By the end of this didactic, residents will be able to:

1. Describe various integrated care models
2. List at least 2 pros and cons of integrated care models
3. Understand the evidence base for the Collaborative Care consultation model
4. Describe the roles of the Collaborative Care team
5. List and describe the principles of the Collaborative Care Model

Faculty Notes:

Acronyms Used:

CoCM	Collaborative Care Model
BH CM	Behavioral Health Care Manager
PC	Psychiatric consultant

Slide	Faculty Notes
Slide 4	Important to emphasize limited resources and access being a problem. As mental health providers we are only touching a very small percentage of the population with mental health disorders. Among the population who identify as having mental health or substance use disorders: - Only approx. 40% of people get mental health treatment - Only approx. 10% saw a psychiatrist - Only approx. 20% saw primary care
Slide 5	The next thought that comes to mind is, "Why don't we just refer these patients to outpatient psychiatric clinics? Why are we thinking of newer ways to approach access problems?" - Of patients (Grembowski et al 2002) who are referred, only half of them end up following up on that referral. Patients who do connect tend to have difficulty engaging with providers, and the average number of visits for mental health referral is just two. And two visits are not enough to have significant impact on treatment for most mental health disorders. - Kathleen Thomas 2009 article: Nearly all (96%) of US counties have some unmet need for prescribers to care for mental health concerns. 75% have a severe need, in which over half of their mental health needs are unmet.
Slide 6	Now that we know there is a problem, let's talk about ways to improve access.
Slide 12	Engage trainees and get to know their understanding and knowledge about integrated care.
Slide 13	Integrated care is the general term for mental health care joined with other medical services – there are many ways to do this. We'll cover the examples of traditional consultation model, co-located care model and the Collaborative Care Model here; there are others, too. Most of the older models were developed based on the need for better access to mental health care, but the Collaborative Care Model is the only model which is evidence-based and built on the chronic care model.
Slide 14	Traditional Consultation Model: In this model, the PCP makes a referral to a psychiatrist, typically at another clinic. The patient goes to that clinic and is assessed directly by the psychiatrist. Notes and treatments or recommendations are communicated via medical records or email/fax if not the same EHR. It works best for one-time or acute issues that don't need follow-up. Improves access to mental health care. Limitations: Psychiatrist is limited in their capacity and availability,

	requires patient to go to a different clinic and provide the information, little/no direct communication between providers, no education or collaboration.
Slide 15	Co-Located Model: In this model the psychiatrist shares a location with the PCP, receives referrals, sees patients individually for outpatient consults (not regularly for long term mental health care), offers recommendations and communicates (via notes, direct messages/conversations, etc.) with the PCP. They're in the same system and sometimes in the same physical building/clinic.
Slide 16	Ask trainees to think about pros and cons.
Slide 17	In co-located models, co-location helps to improve access and communication. It does not guarantee that behavioral health providers and PCPs work together, can lead to "parallel play" where providers share a space but are not working together. Still have issues of no-shows, limited patient slots, etc.
Slide 19	Collaborative Care Model (CoCM): This is a newer integrated consultation model and the only consultation model which is evidence based. It is a team-based approach that treats a larger population. Use of a registry (which is a list of all patients active in treatment with key data and information about the patients) and structured collaboration with a care manager and PCP helps to use scarce mental health resources more efficiently. CoCM strengthens the relationship between primary care and mental health care, better uses scarce mental health resource, helps to monitor all patients in treatment through use of a registry, and delivers psychoeducation to primary care providers.
Slide 20	This is the team involved in CoCM. Behavioral Health Care Manager (BH CM) and Psychiatric Consultant (PC) are two new roles in primary care. In this model each team member has a clear role, and understanding of that role is important for the team to work efficiently and for the model to be consistent with the Collaborative Care Model. The role of each team member will be reviewed later.
Slide 21	Why learn about this model? It is worth spending a couple of minutes for trainees to think through this. Some examples: It is population-based care, and since access is a problem in most US counties, it is important for trainees to be familiar with ways to leverage their skill; collaborating with a team helps to share responsibility while providing high quality of care; psychiatric providers can have a larger impact.
Slide 22	Principles of CoCM: All these principles must be in place for the model to be consistent with CoCM.

	Patient-Centered Team Care: Team of providers including primary care, psychiatric consultant, and care manager work together with patient to support the patient. Each team member has a clear role. **Population-Based Care**: The goal is to track all patients who are active in treatment by using a registry so that no one falls through the cracks. **Measurement-Based Treatment to Target**: Symptoms are measured by regular use of screeners every 2 weeks in appointment with BH CM. This helps to monitor symptoms and make timely changes in treatment for patients who are not doing well. **Evidence-Based Care**: Care provided is evidence based, including brief behavioral interventions and medication recommendations. **Accountable Care**: Providers are accountable for patients' clinical outcomes.
Slide 23	Let's walk through an example on how this model works. We will discuss the role of each team member while going through this example. Example: Mara (patient) comes in to see her PCP; she reports new panic attacks, irritability, and insomnia. Mood has been more down. A lot of stress in life. She's interested in getting help.
Slide 24	Example: PCP discusses the CoCM with Mara and makes referral to BH CM. PCP role: Does initial evaluation, refers patient for treatment in this model, explains how this model works (so PCP's understanding of it is important). PCPs manage medications based on recommendations of the psychiatric consultant. They should be clear on which patient population is appropriate for treatment in CoCM in their clinic and communicate with BH CM regularly.
Slide 25	Example: Mara schedules an appointment with BH CM who does intake appointment and collects information through interview and screening tools. BH CM sets a treatment goal with Mara. BH CM can be one of many different clinicians (licensed clinical SW, counselor, psychologist, MSW, RN, etc.), but **does need to have specialized training in behavioral health**. They are the primary mental health contact for both the patient and the PCP. Once the patient is referred, the BH CM meets with the patient for orientation, explains the CoCM again, enrolls patient in the program if appropriate, and adds them to the registry. Discusses with patient the treatment goal. If patient is not appropriate for CoCM, then they provide appropriate resources for the patient. The BH CM role can be divided in two parts: Clinical: includes doing evidence-based brief psychotherapy with patient (every 1-2 weeks) and meeting with psychiatric consultant regularly to discuss patients on registry. Non-clinical/administrative: includes coordination of care/communication in the team and managing the registry (keeping the patient data and information in registry up to date).

Slide 26	Example: Once Mara is enrolled in the program and added to the registry then BH CM presents this patient to the psychiatric consultant (PC) and discusses treatment goal(s). The PC writes a note on Mara based on information gathered and provides appropriate recommendations to the PCP. PC works with BH CM directly and meets with BH CM on a regular basis, such as weekly. The psychiatric consultant's 3 main roles in this model include: **Clinical**: Most of the clinical work in this model is through indirect consultation. The PC and BH CM have a regular systematic case review meeting in which they discuss patients on the registry and provide appropriate treatment recommendations based on the information provided by the BH CM. For this to be effective the BH CM has to be clear on the information the PC needs to make good treatment recommendations. In some clinics the PC also has some time to do direct consultations on patients who are diagnostically challenging or not improving, etc. **Education:** In this role the PC is also educating the team via notes by writing a teaching point or two about that patient, doing formal teaching seminars in provider meetings, and providing education in weekly meetings with the BH CM. **Leadership**: The psychiatric consultant is responsible for ensuring the model is consistent with CoCM, making sure the patient population is getting high quality of care, checking with BH CM about burnout, and building collaborative relationships with the providers.
Slide 27	Example: BH CM relays recommendations to Mara and the PCP (sees the note from PC). BH CM will continue to track Mara, offer reminders, discuss with psychiatric consultant again if needed. BH CM discusses with PC if patient is not improving/not tolerating meds so that timely med or treatment changes can be done. PCP will prescribe meds, order labs, etc. PC may see patient directly for one-time consult or keep managing indirectly. PC provides psychoeducation through notes or verbal discussion.
Slide 28	<u>Wrap up Example and Impact on patient:</u> With time, Mara may: - Improve and move to maintenance care, which is monthly check in for 3 months, and then successfully be discharged back to PCP - Not improve, requiring change in treatment - Worsen or require more intensive care For the patient this model provides faster, more intensive access to mental health care. They get access to mental health care in a familiar setting with the partnership/involvement of an already-familiar provider, their PCP.
Slide 29	Let's pause and review the psychiatric consultant role again. It is a different role, population focused instead of just focusing on individual patients. Larger impact.

	Discuss with trainees: What qualities would this role require? Is it for everyone? Examples: This role suits providers who are more open to flexibility, interested in teamwork and psychoeducation, and open to getting information from a different provider.
Slide 30	Reflection and discussion with trainees: Do any limitations, challenges, or concerns come to mind? (Does anyone worry about whether psychiatrists will be losing their jobs? Does anyone think that this role is good for everybody? Does anyone wonder whether this model can be used for every patient? → slide 33 shows different disorders and evidence for CoCM)
Slide 31	So to review, this model offers improved access to mental health for patients – they receive more active care from the BH CM, oversight from a specialist, and ongoing primary care. There is regular communication both with the patient and between medical and mental health providers. Also, one psychiatrist can cover many more patients than they could alone, even working in this model one day a week.
Slide 33	Collaborative Care has shown to be effective for depression across the age range from depressed adolescents to depressed older adults. There is also a growing evidence base for other mental health disorders, including anxiety, bipolar disorders, psychotic illnesses, substance use disorders, and post-traumatic stress disorder, as well as in other populations, such as child and maternal populations.
Slide 34	Let's talk about the largest trial to date showing the effectiveness of CoCM for treatment of depression – the IMPACT Trial.
Slide 35	What we learned was Collaborative Care doubled the effectiveness of usual care for depression. This graph shows the 8 participating organizations. The blue bars represent usual care. Again, remember those are the patients who were referred to outside providers, could still get care from their local providers and could get medications prescribed – whatever they would normally receive for mental health problems in that practice. The purple bars represent IMPACT care (or the Collaborative Care Model), where a whole team of people were taking care of the patients with depression in a new way. This difference was seen in every single one of the organizations we worked with.

Resources:

- Satiani A, Niedermier J, Satiani B, Svendsen DP. Projected Workforce of Psychiatrists in the United States: A Population Analysis. *Psychiatric Services.* 2018;69(6):710-713.
- Thomas KC, Ellis AR, Konrad TR, Holzer CE, Morrissey JP. County-Level Estimates of Mental Health Professional Shortage in the United States. *Psychiatric Services.* 2009;60(10):1323-1328.
- Wang PS, Lane M, Olfson M, Pincus HA, Wells KB, Kessler RC. Twelve-Month Use of Mental Health Services in the United States: Results from the National Comorbidity Survey Replication. *Arch Gen Psychiatry.* 2005;62(6):629–640. doi:10.1001/archpsyc.62.6.629
- Park-Lee E, Lipari RN, Hedden SL, et al. Receipt of Services for Substance Use and Mental Health Issues Among Adults: Results from the 2016 National Survey on Drug Use and Health. 2017 Sep. In: CBHSQ Data Review. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2012-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK481724/
- AIMS Center | Advancing Integrated Mental Health Solutions in Integrated Care (uw.edu)