Working in Primary Care Settings: Perspectives from a Primary Care Psychologist and Physician

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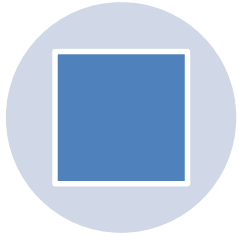
Speaker Disclosures

- No relevant conflicts of interest to disclose

Learning Objectives

DESCRIBE INTEGRATED CARE DELIVERY MODELS

DEFINE PSYCHOLOGY ROLE IN INTEGRATED CARE



IDENTIFY CASES THAT BENEFITED FROM INTEGRATED CARE

DISCUSS CONSIDERATIONS FOR WORKING WITH PSYCHIATRIC CONSULTANTS

In what types of models and settings do you practice/have you practiced?

A. Collaborative Care
B. Primary Care Behavioral Health (PCBH)
C. Outpatient mental health
D. Federally Qualified Health Center
E. Outpatient primary care
F. Other

respond at **PollEv.com/leahmarcotte606**

INTEGRATED CARE DELIVERY MODELS

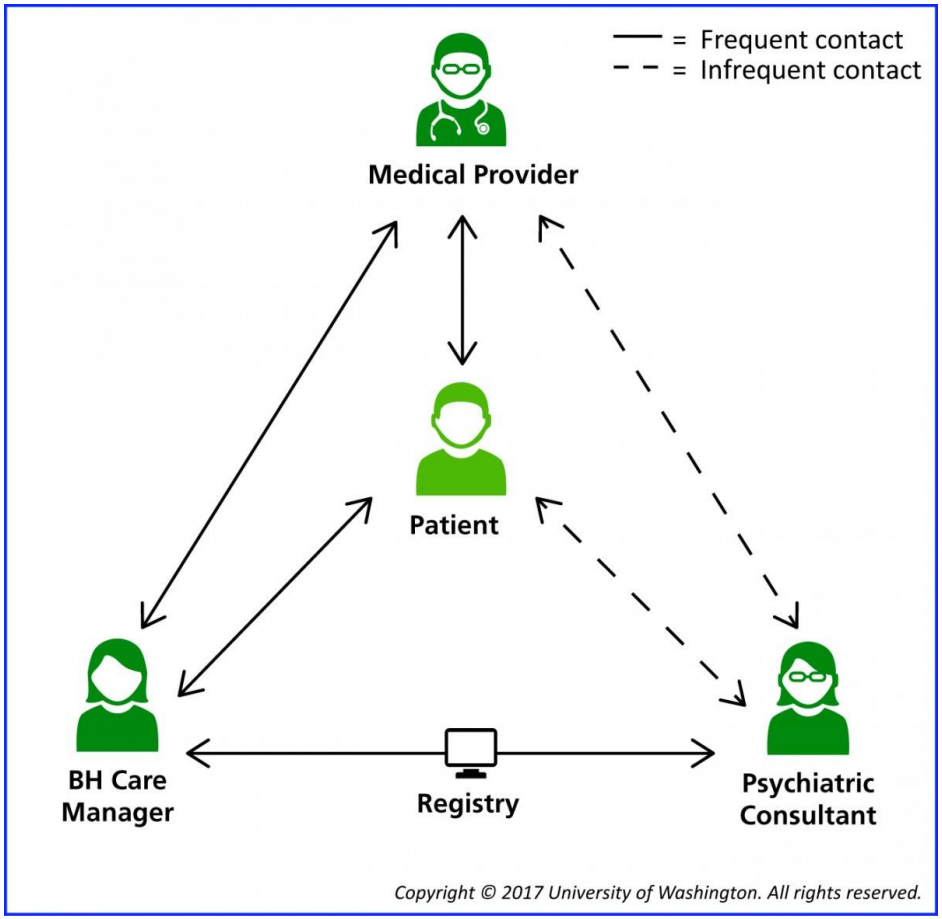
3 Models of Behavioral Health Integration

	Coordinated Care	Co-located Care	Integrated Care
Physical Setting	Primary Care office conducts routine screening of behavioral health	Medical and behavioral health services located in same facility	Medical and behavioral health services located in same facility or separate locations
Initiation of BHI Care	Referral relationship between primary care and behavioral health settings	Referral process for medical cases to be seen by behavioral health clinicians	One treatment plan with behavioral and medical elements
Nature of BHI Interaction	Routine exchange of information between both settings to bridge cultural differences, usually via case/care manager	Enhanced informal communication process between primary care provider and behavioral health provider due to physical proximity	A team working together to deliver care using a pre-arranged protocol

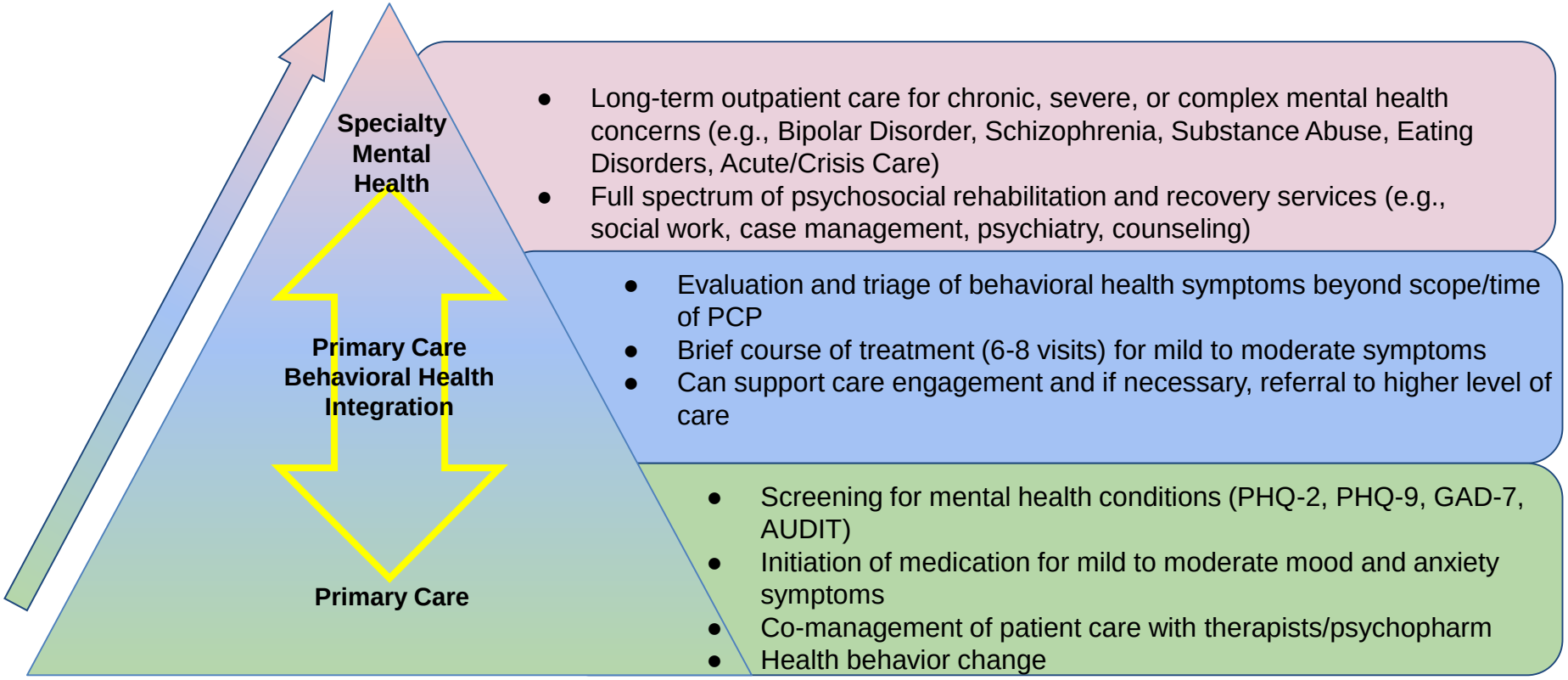
BHI = Behavioral Health Integration

(Rajesh , Tampi, & Balachandran, 2019, p. 279)

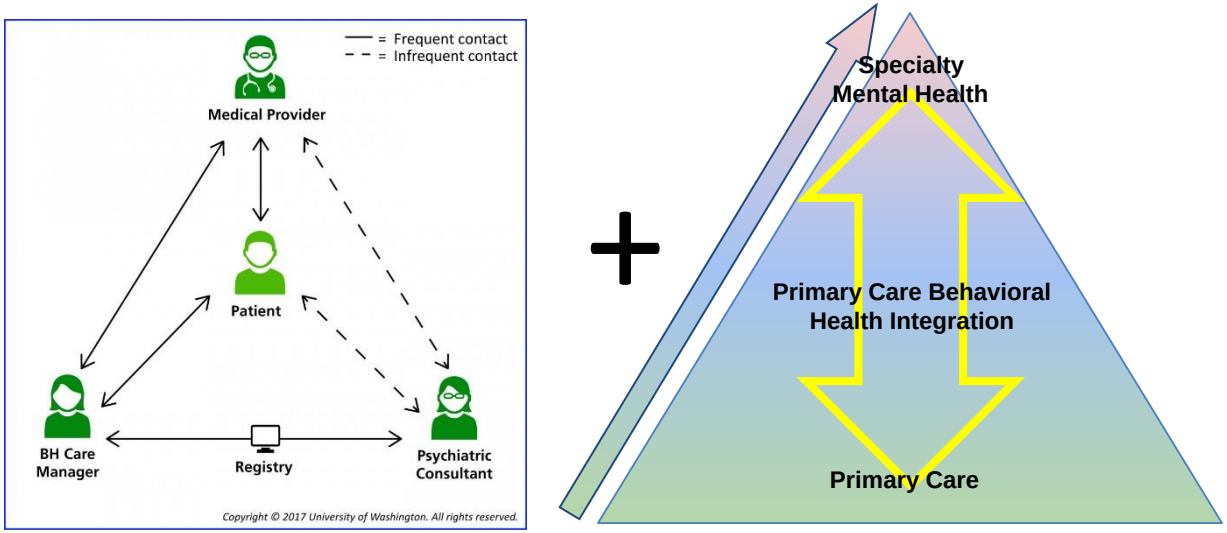
Collaborative Care



Primary Care Behavioral Health (PCBH)



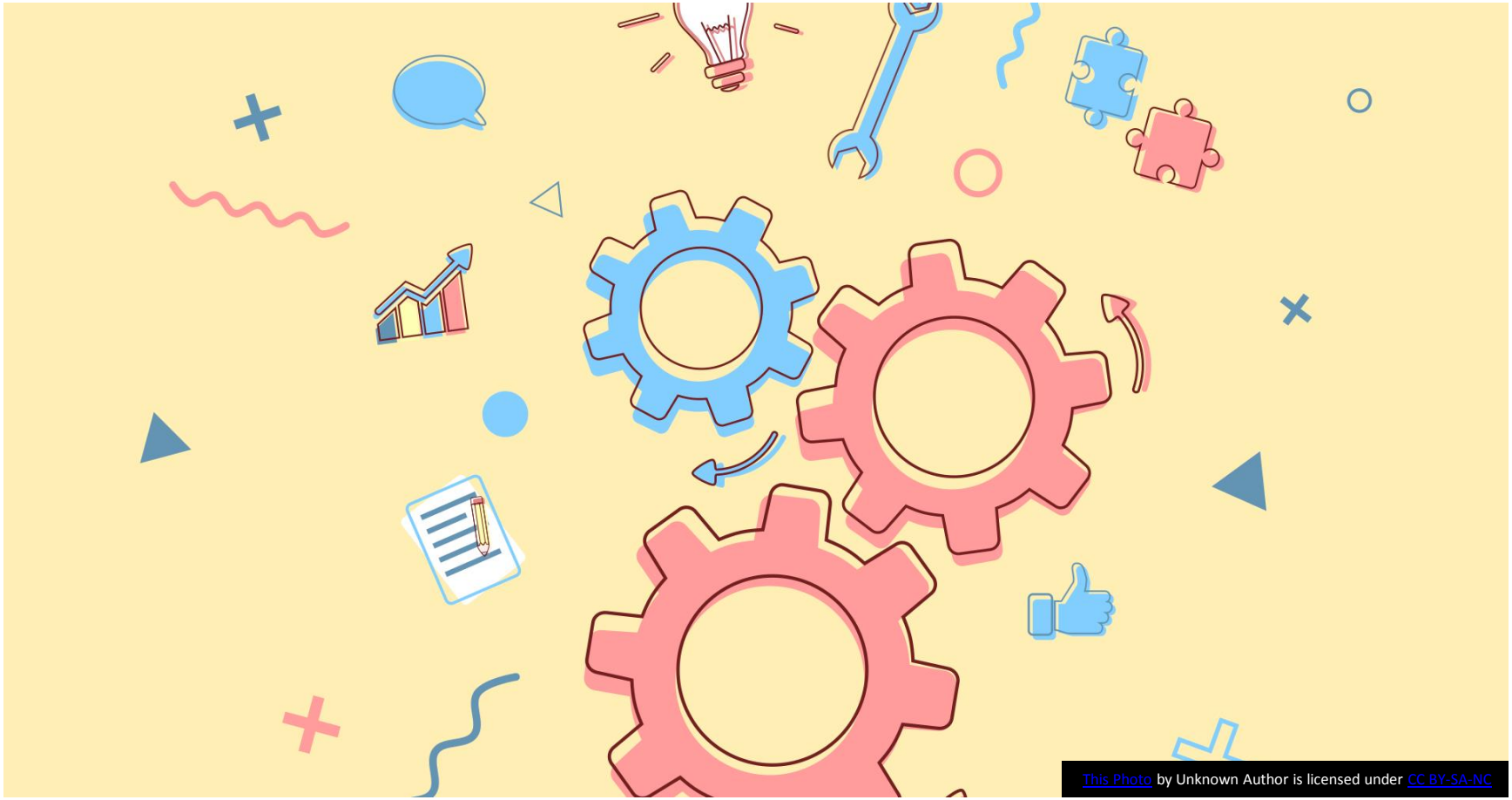
In an ideal world, we merge the models…



"PCBH and CoCM have actually been implemented together in every system I've been a part of. The point I always make is that they have complementary goals and ways of functioning. For example, patients can be lost to f/u in the PCBH model, but in CoCM the tracking helps prevent that; and in CoCM the scope of problems helped with is limited, but in PCBH it is broad. So, used together, they can create a nice system"

(Sunderji, Polaha, Ratzliff, & Reiter, 2020).

The Role of Psychology/Behavioral Health Consultant (BHC) in Integrated Care



The "GATHER" Acronym for a Behavioral Health Consultant (BHC)

GENERALIST: provides care to patients of any age with any health condition

ACCESSIBLE: strives to intervene with patients on the day they are referred

TEAM-BASED: shares clinic space and resources and assists the team in various ways

HIGH VOLUME: engages with a large percentage of the clinic population

EDUCATOR: helps improve biopsychosocial intervention skills and processes

ROUTINE: is a routine part of the whole person care

VA Puget Sound Health Care System

- Large primary care clinic with internal medicine residents
- Primary Care Mental Health Integration Team
  - Psychologist
  - 2 psychiatrists
- PACT (Patient Aligned Care Teams)
  - Pharmacy
  - Social Work
  - Etc.
- Outpatient Mental Health

Iora Primary Care

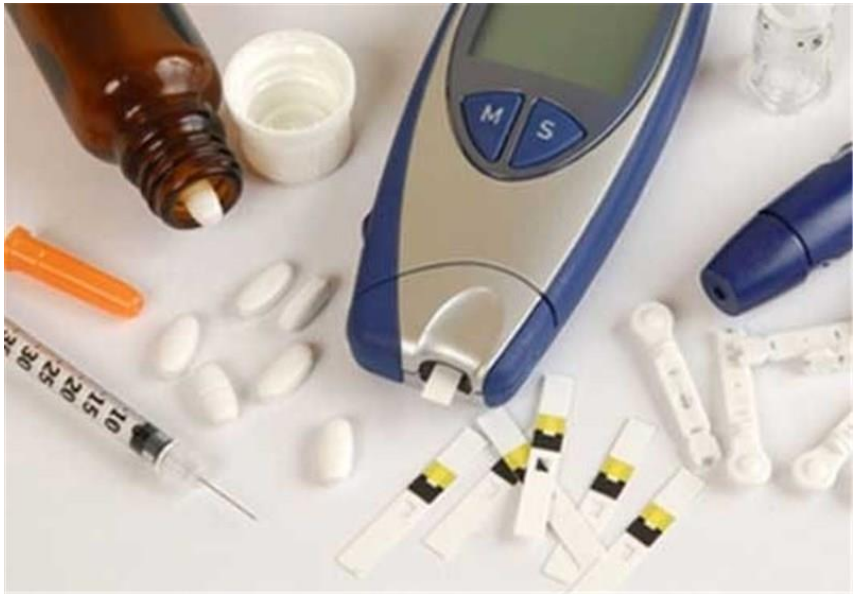
- Primary Care for approximately 4,000 Medicare beneficiaries in the state of WA (2018)
- Value-based payment model
- Team-based care approach
- Integrated care with Behavioral Health Specialist

Cambridge Health Alliance

CHA Cambridge Health Alliance

HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

- Regional Primary Care and Safety Net System with 2 main hospitals
- Multiple Accountable Care Organization contracts
- Team-based care
- Primary Care Behavioral Health Integration (PCBHI)
  - Co-located
  - Psychiatry
- Outpatient Mental Health clinics



Cases that Benefit from Integrated Care

Insomnia

A 54-year-old woman is seen by her PCP with chief concern of insomnia worsened in the last few years since menopause. She has eliminated afternoon caffeine and does not drink alcohol. She falls asleep easily most nights around 10pm but finds that she consistently wakes up around 1am. She thinks about work and family stressors and finds it difficult to fall back to sleep. She is usually awake for 3-4 hours and is exhausted when her alarm clock wakes her up at 7am. She takes escitalopram 20mg for anxiety which is helpful, but she still notes significant anxiety symptoms impacting sleep and work. GAD-7 is 12 and PHQ-9 is 3. Her BMI is 35.

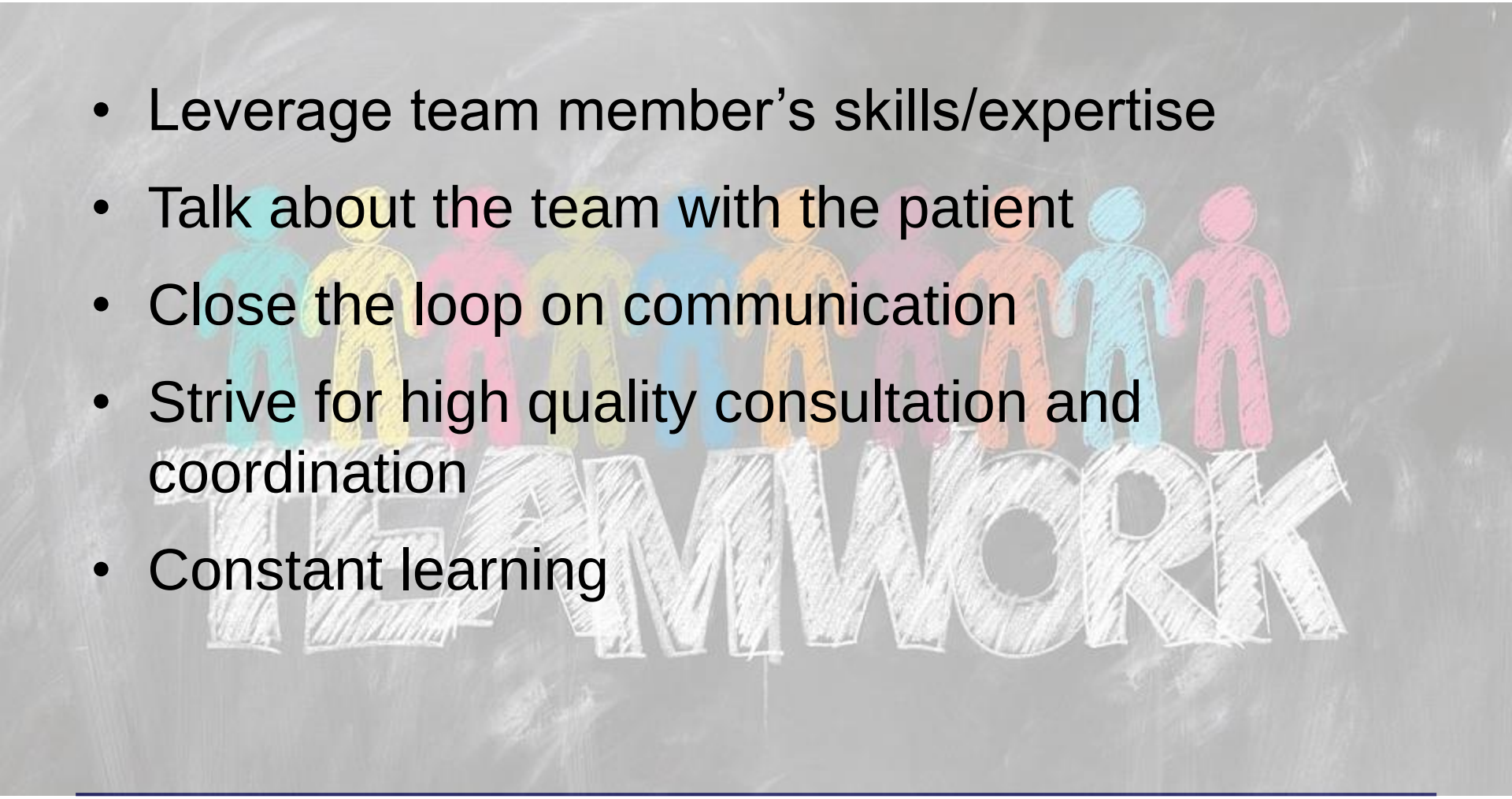
Dementia

An 86-year-old man is brought in to see his PCP by his daughter due to concerns about worsening memory. He has been forgetting family events such as his granddaughter's birthday. His daughter is concerned that he is not taking his medications regularly. She bought him a mediset and has been filling it for him but notes at the end of the week, there are multiple days with pills in the set. She is also concerned that his self-care has declined as he has appeared disheveled when in the past, he has taken a lot of care in his dress and appearance. His spouse died 2 years ago. His daughter has noted these changes in the last 6 months. A MoCA is done at the visit and is 16. PHQ-9 is 6.

Diabetes

A 32-year-old gender non-binary individual (pronouns they/them) with depression and type 2 diabetes sees their PCP for diabetes follow up . They share difficulty with glycemic control and weight loss. They are currently in graduate school and finding it hard to balance coursework with regular exercise and choosing healthy foods. They find that they snack regularly while studying in order to cope with stress. Their depression symptoms are always worse in the wintertime and now exacerbated with setbacks in diabetes control and weight gain. They take sertraline 100mg daily and bupropion XR 300mg daily and do not think these medications are effective, although have taken for years. They also take semaglutide which initially was very effective to improve diabetes and resulted in 15 lb weight loss. However, they have now regained some of that weight and A1c is 9.2% which is quite above their goal. They did not tolerate metformin and would like to avoid insulin. Their depression symptoms are affecting their motivation to improve diet and exercise and they also find work and school performance suffering as a result. PHQ-9 is 18 (no SI).

Working together



- Leverage team member's skills/expertise
- Talk about the team with the patient
- Close the loop on communication
- Strive for high quality consultation and coordination
- Constant learning

Takeaways

Both models add value to patient care and team-based approaches. Ideal state would be to have both.

Team-based care is rewarding, supports patients, team members, and can buffer against burn-out (somewhat!)

Certain clinical presentations are best supported by a team (e.g., dementia, diabetes)

Additional Free Resources for Washington State Healthcare Providers

*No cost

EDUCATIONAL SERIES:

- AIMS Center office hours
- UW Traumatic Brain Injury – Behavioral Health ECHO
- UW Psychiatry & Addictions Case Conference ECHO UW PACC
- UW TelePain series About TelePain (washington.edu)
- TeleBehavioral Health 101-201-301-401 Telehealth Training & Support - Harborview Behavioral Health Institute (uw.edu) | bhinstitute@uw.edu

PROVIDER CONSULTATION LINES

- UW Pain & Opioid Provider Consultation Hotline Consultation (washington.edu) – 844-520-PAIN 7246)
- Psychiatry Consultation Line - (877) 927-7924
- Partnership Access Line (PAL) (pediatric psychiatry) - (866) 599-7257
- PAL for Moms (perinatal psychiatry) - (877) 725-4666

Questions and Discussion

- Ask questions in the chat or unmute yourself

Registration

- If you have not yet registered, please email uwictp@uw.edu and we will send you a link