

**The Primary Care Behavioral Health Model:
Applications to Prevention, Acute Care and Chronic Condition Management**

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Research findings consistently suggest that most people receive behavioral health (BH) services in the primary care setting (Narrow, et al., 1993). The annual rate of onset of mental and addictive disorders hovers in the vicinity of 27%, and the vast majority of those afflicted by these problems seek care from primary care providers (PCPs) (Kessler et al., 1994; Reiger et al., 1993). People present to primary care for assistance with a myriad of other BH problems, such as nicotine addiction, obesity, chronic pain, medical non-adherence, insomnia, and learning problems. For most problems that challenge the quality of life for citizens of any age, primary care is the beginning and ending point of care. It is unfortunate that most PCPs need to see 20-35 patients a day to stay in business, as the time constraints alone make it nearly impossible for them to detect and treat the BH needs of the patients filling their waiting rooms. Limited training and a growing lack of access to BH providers for consultation further frustrate the typical primary care provider's efforts to address the BH needs. When not addressed effectively, BH problems contribute to higher medical costs, as well as poorer medical, functional and behavioral

outcomes (Simon, 1992; Spitzer et al., 1995; Strosahl & Sobel, 1996; Wells et. al., 1989). Given this dire situation, primary care systems, both large and small, are exploring collaborative care options.

Numerous BH providers practice collaborative care in numerous medical settings, including hospital-based behavioral medicine programs, free standing multi-disciplinary pain centers, family practice and internal medicine residencies, and publicly and commercially funded primary care clinics. Given the diversity in settings, the diversity in the models of collaborative care is no surprise. Next to the word “love,” the most frequently misunderstood terms in the English language may well be “collaborative” and “integrated” care. They often include an array of practice styles, ranging from collegial information sharing between a medical and BH provider to active co-management of patients by a multidisciplinary medical team. While the proliferation of models of collaboration and integration generates different strategies for providers in different practice settings, it contributes to conceptual problems, limits the design of needed research studies, and obstructs implementation efforts with fidelity to a specific model. What are the hallmarks of an optimally integrated program in the primary care setting? As this our area of clinical and consulting expertise, this is the question we address in this chapter. In doing so, we will describe the Primary Care Behavioral Health (PCBH) model (Robinson & Reiter, 2007; Strosahl, 2001) and present three cases to illustrate its wide-ranging applications to the cause of improving health care.

Six Vectors in Three Worlds

CJ Peek's "Three Worlds" model provides an interesting framework for approaching the question of integration (Peek, 2002). What is the ideal arrangement for clinical services? What is the best approach allocating resources for administration and day to day operation? Implementation of the following six vectors enhances the likelihood of optimally positive returns for primary care integration efforts.

Mission Integration

Mission integration is difficult as it requires providers from a variety of disciplines to embrace a common mission. The mission of primary care is to achieve the best health status possible for the most members of the community. This population-focus is the sine qua non of contemporary primary medicine. To achieve improvements to the health of the population, PCPs work in a biopsychosocial model and adapt empirical findings to implementation at the clinic rather than the case level. The effort is to prevent illness and to maintain health while attending to both preventive and acute care needs. The BH provider trained in cognitive behavioral therapy and program evaluation can play a core role by providing preventive and acute care services and assisting primary care colleagues in developing population-based care programs powered by the most potent behavioral technology.

Clinical Integration

This vector describes the extent to which the clinical activities of primary care team members, including BH providers, are seamlessly connected. Optimal clinical integration involved the use of shared protocols that describe the activities of each team member, as well as active co-management of patients supported by the same patient

education and assessment materials. This is possible in behavioral integration models that emphasize same-day, brief visits with the BH provider and co-creation of clinical pathways by primary care and BH providers.

Physical Integration

While it is possible to practice collaboratively without being co-located, it is not possible to be integrated without being co-located. This is because mission and clinical integration are not possible when medical and BH providers practice in separate spaces. However, physical integration alone does not assure other aspects of integration. In fact, one the co-located specialist approach is common and its integration is limited to physical integration for the most part. In this model, the BH provider limits services to those involved in delivery of specialty therapy services to patients referred by PCPs. Optimal physical integration of behavioral services occurs when the BH provider works in the heart of the clinic, where PCPs receive visual reminders of immediate access for consultation and creation of programs, as well as referral of patients.

Operations Integration

This vector measures the extent to which the BH provider and PCP practice on the same operations platform. Examples include common appointment scheduling and billing programs, parallel forms related to documentation of patient encounters, similar productivity and outcome standards, and shared reception, nursing and other support staff.

Information Integration

This vector describes the ability of the PCP and BH provider to share clinically relevant information in real time and without needless barriers to access. This includes such strategies as documentation in a common medical record, placement of the BH notes in the chronological record, an integrated problem list, and an aggressive culture of “curbside consultation”.

Financial and Resource Integration

This vector concerns the comparability of strategies used to support and finance the BH integration program used to those used to support medical services. In addition to billing practices, this vector includes BH provider compensation. Ideally, BH providers receive compensation that is related to productivity and that is in keeping the scale of pay used for fellow medical team members.

The Primary Care Behavioral Health Model

The Primary Care Behavioral Health (PCBH) Model (Robinson & Reiter, 2007) of integration is at the forefront of the integration movement in the United States. First described over a decade ago (Strosahl, 1994, 1997), a variety of large delivery systems employ this approach, including the United States Air Force and Navy, Veteran’s Administration, and Kaiser Permanente. In 1999, the Health Resources Services Administration and the Bureau of Primary Care began providing both financial funding and technical assistance training to implement this model in Federally Qualified Health Centers across the United States. Several edited address various clinical applications of the PCBH model and similar integration approaches. However, Robinson and Reiter (2007) offer the first comprehensive text on the model, and it includes strategies for

operations, financing, training, and evaluating the model, as well as numerous clinical examples for individual and group interventions and training PCPs in common cognitive behavioral interventions.

The PCBH model requires BH providers to make significant shifts from traditional BH practice, some subtle and some obvious but all profound and challenging for many BH providers. First, the model describes the mission of primary care BH as that of improving the overall health of the population. Robinson and Reiter (2007) recommend that the BH provider pursue this lofty goal in two ways: 1) by augmenting the usual preventive and direct care for behaviorally-based problems; 2) through educational interventions and changes to the system of care that improve the primary care system's ability to provide such care. Achievement of this mission is possible through on-going assessment of patient health-related quality of life. The PCBH model envisions the process of achieving good health as a social activity that occurs within biopsychosocial constraints. Good health means freedom from premature disease and implies on-going efforts to develop skills necessary to living a meaningful life. Immediate patient access allows distribution of limited BH resources across the largest possible number of patients in the clinic population. The Behavioral Health Consultant (BHC) consultant is co-located in the exam room area and functions as a core medical team member whose services are apart of routine daily practice. The modal patient referral is a warm hand-off where the PCP introduces BHC services as a routine part of care. Given this high level of integration, the BHC is likely to see 12 or more patients in a typical 8-hour day.

The PCBH model involves a shift from a traditional therapy model to a consultation approach. The BHC functions as a consultant to the referring PCP and the patient, rather than as a therapist. The PCP is the primary “customer” in this model, and the ideal outcome is to enhance the PCP’s ability to help the patient with whatever problem has surfaced. Because of this, consultation visits are typically shorter (15-30 minutes) than the traditional fifty-minute hour of psychotherapy. There are typically fewer consultative visits with any one patient (1-3 on average), and the PCP continues to be in charge of the patient’s ongoing care. The high practice volume allows the consultant to teach core behavioral intervention skills to PCPs in the context of real time patient care. This increases the likelihood that PCPs will use optimally effective behavioral interventions with the majority of patients, most of whom will not see the BHC directly.

The PCBH goal of consultation and temporary co-management is not to cure the patient of all symptoms, but rather to improve the patient’s functional status over time and to empower the potential of patient-primary care relationship over the long haul. This means the focus of consultation is not on providing a full mental health evaluation and differential diagnosis, but rather on identifying valued directions and defining concrete, functional goals that the PCP and patient think are vital to improving the patient’s quality of life. This involves a greater emphasis on using strengths-based interventions, psycho-educational strategies and home-based practice to achieve mutually agreed upon goals. All of these intervention strategies are designed to fit the five-minute hour of the primary care visit. Since the BHC service is a part of routine care and is often immediately

available in the PCBH model, most patients feel no stigma and readily accept the idea of coaching support for making changes important to health.

Applications to Preventative Care, Acute Care and Chronic Condition Management

The beauty of the PCBH model is that it empowers the PCP to better address any number of BH issues. The PCP has options, including consulting with the BHC about a patient, referring the patient for a direct contact with the BHC, and recruiting the BHC's service in co-creating a clinic-wide program to address specific health conditions. Clinical pathways define a specific population of interest (e.g., patients with diabetes or ADHD) and suggest specific assessments and interventions that various members of the primary care team may provide to improve the health of the patient population of concern. Given the fact that chronic diseases—such as cardiovascular disease, cancer, and diabetes—are among the most prevalent, costly, and preventable of all health problems, BHCs need to present a power-packed approach for this large and growing group. Chronic, disabling conditions result in major limitations in activity for one of every 10 Americans and seven of every 10 Americans who die each year, die of a chronic disease. The PCBH model positions the BHC to help primary care providers improve outcomes for patients with preventive, acute, and chronic care patients.

Prevention In Action: A First Panic Attack

Lucy is a 32-year old, married white female mother of two young children. After presenting to a local emergency room over the weekend, she comes to see her primary care doctor on Monday. She explains that she experienced chest pain, rapid heart beat, and dizziness Saturday evening and went to the emergency room because she feared that

she was having a heart attack. Since her blood pressure and heart rate were clinically elevated, she underwent further testing. Cardiology exam findings were negative and she left the hospital with a prescription for benzodiazepines.

At the primary care clinic the BHC worked, patients seen in the emergency room for symptoms of chest pain, dizziness, and anxiety, were referred by protocol for BHC services at their first clinic follow-up visit. The PCP brought Lucy to the BHC with a request for behavioral interventions and a recommendation concerning the usefulness of medications.

In the initial 25 minute consultation, Lucy explained that she was high strung and prone to worry. She had never seen a counselor for anxiety or taken medications for emotional problems. She reported increased stress at home, which started three months ago when her husband was laid off from his job. She worked full-time, but her income did not provide adequate resources for the entire family. She complained that her husband wasn't trying hard enough to get a job, that he didn't help as much as he could at home, and that he was more irritable. She was sad about having so little time with her children. Lucy indicated that she had walked her treadmill at least three times a week until a few months ago, when she simply didn't have the time for it. She had slipped back into smoking recently after having quit for a 2-year period. Smoking was about her only way to relax. The episode of chest pain and panic terrified her. She wanted to stop smoking but felt she couldn't. She had trouble concentrating on routine activities because she was trying to monitor her heart rate. Lucy felt relieved about the test results from the hospital,

but she worried that they might have missed something. The BHC provided the following interventions during the initial consultation with Lucy:

- 1) Information about the behavioral, physical, and cognitive aspects of chest pain and other panic symptoms, supported by an interactive patient education pamphlet that included strategies for working with panic symptoms;
- 2) Instruction in a simple mindfulness-based breathing strategy and a recommendation of twice daily practice
- 3) Encouragement to resume all normal activities and to use the mindfulness technique in response to urges to avoid activities
- 4) Encouragement to gradually resume her previous exercise program

During the post-visit curbside consultation, the PCP was advised to reinforce these interventions in a planned follow-up with Lucy in two weeks. The BHC recommended against prescribing a medicine at this time and agreed to see her for follow-up in one month. This interaction between the PCP and BHC took approximately two minutes.

The patient returned approximately one month later and reported no troubling symptoms of panic. She was exercising three to four times per week and felt more relaxed. She also enjoyed her mini-mindfulness sessions and was noticing how much muscle tension she carried around on a daily basis. She had in fact noticed some physical symptoms that she associated with her initial panic attack but was not frightened by them. She had reduced her smoking to about a half pack a day and her goal was to stop smoking altogether in the next month. In response to this information, the BHC offered the following interventions:

- 1) Encouragement to incorporate exercise and mini-mindfulness sessions into her daily lifestyle
- 2) Continuation of all normal daily activities and mindfulness response to urges to avoid specific activities in an effort to control anxiety
- 3) Review of specific plan concerning smoking cessation

The BHC talked briefly with the PCP at lunch that day and reviewed the interventions, giving particular attention to motivational interviewing and stages of change. Lucy planned to follow-up with her PCP in two weeks. The BHC did not plan follow-up with Lucy. Four months later, while discussing the relationship between smoking and symptoms of panic with the BHC, the PCP mentioned that he had seen Lucy recently and that she had stopped smoking.

Acute Care: Adolescent Rapid Weight Loss

Maria, a 13-year old Hispanic female, was referred by her pediatrician for unexplained weight loss. He asked the BHC to complete a functional analysis to further inform a treatment plan, while he awaited results from multiple tests conducted to rule-out an organic basis. Marie had lost 27 kilograms over a 5-month period. While her father was worried, she was not. She attributed her weight loss to a change in eating, which started when she had braces placed on her teeth. She was sensitive to the pain, particularly after periodic tightening, and she found the hygiene requirements cumbersome. Marie weighed 70.4 kilograms at the visit with the BHC and measured 68 inches in height, resulting in a BMI of 23.5. She appeared to be a happy, carefree youngster, and she related to her parents in a loving, respectful way. She was an above

average student, who planned to become a lawyer. Recreational activities included playing soccer and basketball and serving as the team manager on the school volleyball team. She denied any persistent worries and indicated that she felt she looked okay the way she had looked before her weight loss.

Since a few days had passed between the pediatrician's referral and the BHC visit, the labs requested by the pediatrician were available to the BHC and all indicated good physical health. The functional analysis did not suggest an eating disorder, and, therefore, BHC interventions focused on re-assurance and education, including the following:

1. Support of the family's relationship with the pediatrician and reassurance about his thoroughness
2. Education about the Body Mass Index concept
3. Brief overview of guidelines for a healthy lifestyle supported by a patient education handout
4. Suggestion that Marie shop for groceries with her parents
5. Brief exploration of social and emotional meanings of eating and weight in the family and a suggestion

Since the father in particular saw Marie's decrease in appetite as a sign of unhappiness, it was decided that Marie would make more of an effort to express her love and happiness to her father and that the father would focus more on social aspects of Marie's day, and less on what she ate during conversations at the family's evening meal. Follow-up services included visits with the pediatrician in one week and the BHC in 2 weeks.

Specifically, the BHC planned to evaluate the results of the planned interventions and to see if Marie's weight stabilized at the follow-up.

When Marie returned, she had gained 2 kilograms and she explained that there had been some great food at several recent family celebrations. Her parents were adjusting to her new appearance and her independence in eating. She enjoyed shopping for groceries with her parents and planned to continue with this. The BHC provided a handout on label reading and briefly reviewed the results of several studies indicating the importance of breakfast to academic success in children and youth. Follow-up plans included Marie seeing her pediatrician in 6 weeks or sooner if Marie or her parents had concerns.

Chronic Care: An Opiate Dependent Older Woman with Multiple Chronic Conditions

Sherry, a 61-year old widow, was referred by her family practice physician for participation in the primary care clinic chronic pain program, the "Pain and Quality of Life" (P & QOL) program. Sherry had multiple health problems, including osteoarthritis of the lumbar spine, shoulders and knees; hyperlipidemia; hypertension, and mild congestive heart failure. She was obese and had become socially isolated since the death of her husband. Her physician had recently asked her to try methadone for pain control, but when she experienced central nervous system side effects, he continued her on low-dose chronic opioid therapy. The use of pain medication seemed to improve her functioning, and he had not seen evidence of medication abuse.

The BHC saw Sherry for a P & QOL orientation visit and provided the following services:

1. Review of program contract, which included the requirement that she attend a monthly 1-hour class in order to receive her opioid prescription
2. Explanation of acute versus chronic pain
3. Importance of shifting focus from pain elimination to functioning and quality of life
4. Introduction to assessment approach used in the monthly class
5. Education about the difference between goals and values and the use of values to guide behavior change
6. Introduction to Acceptance and Commitment Therapy (ACT) (Hayes, Strosahl, & Wilson, 1999) as the dominant approach used in P & QOL class activities

Sherry responded well to the initial consultation and stated that she looked forward to “going to school again.”

Over the following 27 months, Sherry attended the class faithfully. Her only misses were anticipated and planned and related to surgery or a special family occasion. Sherry enjoyed the social aspects of the class and developed a relationship with another woman in the class who was close to her age. She told her doctor that she was learning new approaches to protecting and maintaining her health and to working with pain. Even with further decline in her health, she did not become demoralized. She was diagnosed with diabetes during her first year in the class, and she took pride in being able to make necessary changes. She underwent surgery for a bladder problem, but only missed one

class. She reduced her rate of smoking cigarettes and planted a small garden in her second year in the program. When she began to have problems with falling, she used physical therapy services to strengthen her gait and proprioception and learned to use a cane.

Her physician found BHC chart notes concerning her attendance helpful to his on-going treatment planning. He consulted with the BHC several times in order to learn more about ACT interventions mentioned in brief class chart notes. Outcome measurements also helped him make on-going decisions about treatment. During her first 14 months in the program, Sherry completed the Duke Health Profile (Parkerson, 1996) at each class. The Physical Health and Mental Health scores from the Duke are graphed in Figure 1. As can be seen, her Mental Health was a relatively strength during this time period.

During the second year of participation in the P & QOL program, Sherry completed an adapted version of the Healthy Days Questionnaire (Moriarty, Zack, & Kobau 2003). Figure 2 provides a graph of Sherry's "Healthy Days" and "Able Days" (i.e., days when she was able to engage in valued activities, even with poor physical and/or mental health). Sherry's health declined significantly during the beginning of her second year in the program. However, her Able Days scores rose consistently during the second 5-month period of the year, suggesting that she was consistently capable of engaging in valued activities at least half of the time, even with on-going health problems.

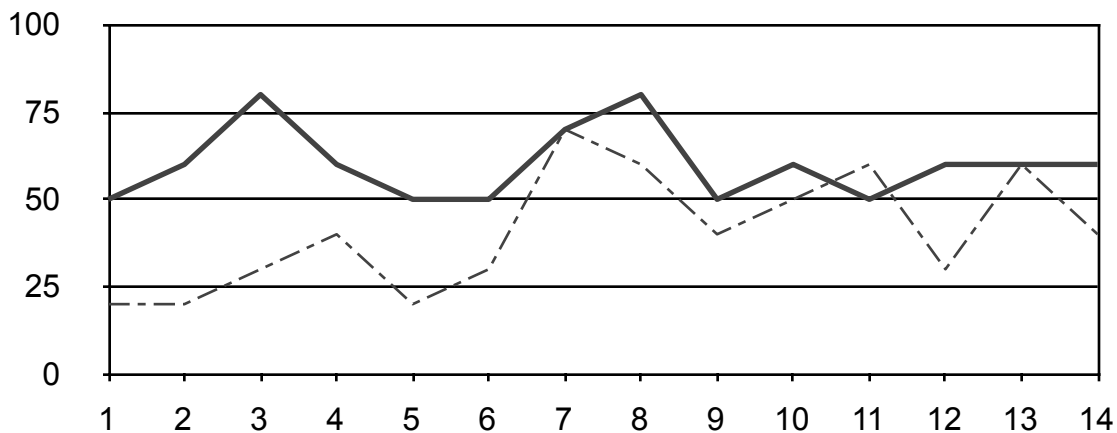


Figure 1: Sherri's Duke Health Profile Physical Health (dotted line) and Mental Health (solid, dark line) monthly scores during her first 14 months in the P & QOL Program

Note: y axis is the Duke score, which can range from 0, worst possible health, to 100, best possible health; x axis is months 1-14

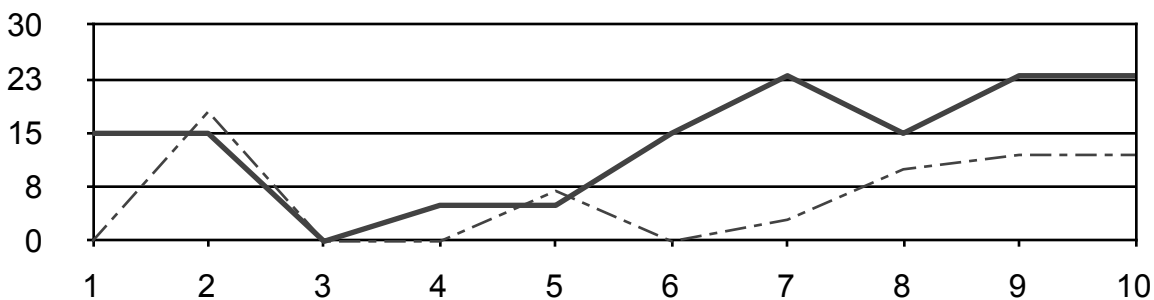


Figure 2: Sherri's Healthy Days (dotted line) and Able Days (solid, dark line) scores during her second year in the program

Note: y axis is number of days, 0 to 30; x axis is months 1-10

Summary

The Three Worlds model provides a strong conceptual framework for evaluating possible approaches to collaboration and integration. The PCBH model rates as a highly integrated approach in the six vectors of integration: mission, physical, operational,

informational, financial and resource. The PCBH model offers structure for those wanting to create, deliver, evaluate, and further develop innovative behavioral health services for the primary care setting. In this chapter, we provided an introduction to this model and examples of its use to (1) prevent onset of a relatively common mental disorder among adults, (2) address an acute medical concern in an adolescent, and (3) create a program that plays an important role in helping an older adult with multiple chronic conditions maintain vitality. Use of a consistent model in integration efforts will support consistency among behavioral health providers who work in primary care settings and allow large-scale evaluation of an effort to improve the health the majority of the members of society by providing effective behavioral health care consistent with available healthcare resources.

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