Operational and Clinical Components for Integrated-Collaborative Behavioral Healthcare in the Patient-Centered Medical Home

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Behavioral healthcare will be an essential piece of meeting the patient-centered medical home (PCMH) principles of easy access and whole person, coordinated, and integrated care as primary care clinics transform themselves into PCMHs. As this transformation occurs, PCMH clinic staff and behavioral health providers must carefully consider how to adapt their operations to include the provision of integrated-collaborative behavioral health services within the PCMH. Without this careful consideration, integrated-collaborative behavioral healthcare will likely fail to reach its full potential. We discuss the operational and clinical components that appear to be important for success when integrating behavioral healthcare into the PCMH.

Keywords: patient-centered medical home, integrated, collaborative, behavioral health, primary care, mental health

The core principles of the patient-centered medical home (PCMH) are not fully attainable unless behavioral health providers (BHPs; e.g., psychologists, psychiatrists, social workers, master’s level therapists, marriage and family counselors) are a standard and integrated component of care (Crogan & Brown, 2010). Moving BHPs to the PCMH, without changing operational and clinical functioning or addressing financial concerns, will most certainly minimize integrated-collaborative care impact (Blount et al., 2007; Craven & Bland, 2006; Hunter, Goodie, Oordt, & Dobmeyer, 2009; Kathol, Butler, McAlpin, & Kane, 2010 Peak, 2008). Although a one-size-fits all model does not exist, there are basic behavioral health operational and clinical components that appear to be essential if the promise of PCMH goals are going to be fully realized. Drawing from research, clinical experience and expert opinion, we present operational and clinical components that are likely to promote the effective incorporation of BHPs in a PCMH. Before considering those components it is important to clarify the diverse, confusing terminology in the existing literature.
Descriptors and Models of Care Terminology

Descriptors
Terminology including colocated, embedded, integrated, and collaboration/collaborative are often used interchangeably to describe methods and models of behavioral health (to include services for health behavior change like weight loss, substance dependence/abuse/misuse, behavioral medicine interventions, like chronic pain management, and general mental health services, like panic disorder) practice in primary care. The overlapping definitions of these descriptors contribute to confusion about the types of services being delivered or evaluated. Others have addressed the terminology challenge (e.g., Blount, 2003; Strosahl, 1998), yet no consensus on the use of these terms exists (Butler et al., 2008; Collins, Hewson, Munger, & Wade, 2010). To enhance the clarity of this article, we provide operational definitions of these terms as we use them.

Colocation or Colocated Service
In a colocated service, a behavioral health and primary care provider (PCP) offer services within the same physical structure, but maintain their own standards of care and separate records. PCPs typically refer patients to BHPs to receive specialty behavioral health services (Blount, 2003).

Embedded Service
In an embedded service, a BHP works as a member of a PCMH team, seeing patients in the PCMH clinic, documenting patient screenings, assessments, and interventions in the medical record, while maintaining the PCMH standards of care. PCPs may take patients directly to the BHP (i.e., a “warm handoff”) for assessment and clinical consultation.

Integrated Care
Typically, “integrated care” is a general overarching concept covering a range of healthcare delivery models (Butler et al., 2008). Confusion occurs when “integrated care” is defined as a specific model or component of a model. All definitions of “integrated care” require some collaboration (communication or coordination) between providers to meet the behavioral health and medical needs of their patients (Butler et al., 2008). To maintain its general overarching meaning, in this article “integrated care” refers to models of care where BHPs and PCPs interact in a systematic manner along the population care continuum to meet the behavioral health and physicals health needs of patients.

Collaborative Care/Collaboration
Similar to “integrated care,” there are diverse definitions of the umbrella term “collaborative care” (Butler et al., 2008), which describes how PCPs and BHPs interact to deliver healthcare (Collins et al., 2010; Craven & Bland, 2006). “Collaborative care” is not a model of care. In this article, we use “collaborative care” to describe the relationships (ways of interacting) between clinicians (e.g., BHPs and PCPs) over time (Doherty, McDaniel, & Baird, 1996) for the purpose of developing treatment plans, providing clinical services and coordinating care to meet the physical and behavioral health needs of patients.

Integrated-Collaborative Care
Debates on how to operationally define “integrated care” and “collaborative care” have lasted for days with no final resolution (e.g., Miller, Kessler, Graham, Stewart, & Spano, 2009). In fact, it could be argued that the terms as defined here are not conceptually different. In an effort to avoid further confusion, in this article we combine the terms (i.e., “Integrated-Collaborative Care” [ICC]) to describe care in which BHPs and PCPs systematically in-
teract to meet the behavioral and medical health needs of their patients through the collaborative development of treatment plans, provision of clinical services, and coordination of care. ICC is NOT a specific model of care; ICC refers to the range of models falling under this umbrella term.

**Models of Care**

A continuum of behavioral healthcare models and their interface with primary care have been described elsewhere (Collins et al., 2010). The models of care aligned most closely with the PCMH core principles are the Care Management model (CM; Nutting, Gallagher, Riley, White, Dickinson, Korsen, & Dietrich, 2008; Williams, Gerrity, Holsinger, Dobscha, Gaynes, & Dietrich, 2007), the Primary Care Behavioral Health model (PCBH; Robinson & Reiter, 2007), and a blended model of care (Zeiss & Karlin, 2008).

**Care Management Model**

The CM model is a population-based model of care using specific pathways to focus on a discrete clinical problem (e.g., depression). The PCP refers patients to a care manager with special behavioral health training (e.g., nurse or provider with a master’s degree in behavioral healthcare). The care manager follows a standard method for assessment, planning, and care facilitation and communicates with the PCP and specialty psychiatric prescriber. PCPs and care managers share information regarding patients with a shared medical record, treatment plan, and standard of care. Typically, there is some form of systematic interface with the specialty psychiatric prescriber (e.g., weekly case review and treatment change recommendations). Care managers may work from a separate geographical location, but they are usually colocated or embedded with the primary care clinic. CM models improve the treatment of depression (Nutting et al., 2008; Williams et al., 2007). Unfortunately, using the CM model alone will not completely meet the PCMH core principles of comprehensive population health impact. Because the CM model focuses on a specific group (e.g., those with depression), patients with other health problems that might benefit from behavioral health interventions (e.g., anxiety disorders, asthma, chronic pain, eating disorders, obesity, sleep disorders) receive no additional behavioral health in the PCMH services. Although an important and efficacious model, the CM model alone does not result in a comprehensive health impact.

**Primary Care Behavioral Health Model**

The PCBH model comes closer to achieving the principles of the PCMH goals than the CM model of care. The PCBH model has a population health focus; the goal is to see a much higher percentage of the primary care population than could be seen in other models of ICC. In the PCBH model, BHPs are embedded within the PCMH as a team member to address the full spectrum of concerns that patients bring to the clinic, including conditions typically addressed by clinical health psychologists and behavioral medicine specialists (e.g., chronic pain, headache, health risk behavior, medical nonadherence, sleep disturbance, smoking cessation, weight management). BHPs deliver care in the PCMH clinic where patients are seen by the PCPs (e.g., exam rooms) with the goal of creating a team-based management approach. Patients’ needs are addressed in a shared treatment plan and medical record. Behavioral healthcare becomes a routine part of care services provided in the PCMH. The PCBH model provides real-time access to care at the exact time the need is identified. This is the only model where one of the primary espoused goals is to transfer behavioral intervention skills to the PCP through repeated application of consultative interactions. Researchers have begun to show the effectiveness of the PCBH model (e.g., Bryan, Morrow, & Appolonio, 2009; Cigrang, Dobmeyer, Becknell, Roa-
Blended Model
A blended model combines an embedded care manager using the CM model and a BHP using the PCBH model. The care manager and BHP work in tandem to support the needs of the PCMH. Specific pathways for identifying and treating problems are developed, while the broader behavioral health needs of the population are addressed. A Department of Defense working group recommended the blended model and plans to evaluate the effectiveness of the model. The Department of Veterans Affairs has also implemented a blended model, with the CM model component operating outside (not embedded) the primary care clinic. To date, no studies have been completed that examine the efficacy or effectiveness of a blended model.

OPERATIONAL COMPONENTS
Operational components are those factors that are necessary for accomplishing clinical care (Peek, 2008). Implementing ICC within the PCMH requires the stakeholders to consider the model of care they want to employ, the professional training of the individuals providing the behavioral healthcare, the number of staff that will be needed and can be supported, the physical facilities, and the administrative support resources. These operational components are the foundation of ICC; some may be difficult to change (e.g., space), but also guide pragmatic decision making when implementing ICC in the PCMH.

Selecting a Model of Care
Stakeholders must carefully select the ICC model of care (e.g., CM, PCBH, or blended) to implement in their PCMH. The model of care will influence all other operational decisions and will determine the breadth of problems that can be addressed in a patient population.

Staffing
There is no “one-size-fits-all” staffing recommendation for the number of BHPs in an ICC model. One approach is to base the model of care and staffing on the number of patients empanelled to the PCMH. A second approach uses the number of PCPs to determine staffing ratios.

Patient Empanelment Guided Staffing
A working group was convened in the Department of Defense to examine the best ways to develop ICC. The group decided to use the number of patients empanelled to a clinic as a guiding approach for BHP in primary care staffing. The working group included members from the Army, Navy, Air Force, and Public Health Service, from a range of professional backgrounds (e.g., family physicians, psychologists, psychiatrists, and social workers) and solicited expert input from nine different organizations/projects (Department of Veterans Affairs, Cherokee Health, HealthPoint Community Health Centers, Integrated Behavioral Health Project, Mountain Area Health Education Center, Maine Health, DIAMOND Project, Hogg Foundation, Intermountain Health Care).

The working group recommended that clinics with 7,500 or more empanelled patients use a blended model of care. At least one full-time BHP, following the PCBH model, would deliver services within the primary care clinic. At least 32 hours per week would be devoted to patient contact, treatment planning, and consultation with medical providers. In addition, BHPs would conduct educational presentations, program development, and attend staff meetings. The clinic would also employ one full-time healthcare professional (e.g., nurse) to fulfill the CM model responsibilities of this blended model. The care manager would
spend 32 hours per week delivering depression care management pathway services. These services could be expanded to include clinical pathways for other problems (e.g., anxiety, obesity, diabetes, etc.) as indicated by clinic need and time availability. The BHP would serve as a clinical supervisor for the care manager when appropriate.

In smaller clinics with 1,500–7,499 empanelled patients, it was recommended that the clinic employ one full-time BHP delivering services consistent with the PCBH model, or one full-time care manager providing CM model services, or a full-time BHP delivering PCBH and CM model services. Providing options for smaller clinics was intended to allow for clinic flexibility based on local needs and funding. It is the authors’ opinion that a full-time BHP delivering services using PCBH model and CM model program components is the best fit to fully meet PCMH goals for these smaller clinics.

Provider Ratio Guided Staffing

The National Naval Medical Center recently convened a PCMH summit (Dorrance, 2009). A breakout PCMH team design working group comprised of family medicine physicians, nurses, practice managers and a psychologist developed a set of PCMH staffing recommendations including a BHP staffing ratio. The team design working group recommended a ratio of a 0.25 full-time BHP for every one full-time PCP, who typically manages an enrollment of 1200 patients. Using this ratio, one BHP would be employed for every four PCPs or every 4800 enrollees, which is roughly equivalent to the Department of Defense working group staffing recommendations if patient empanelment had been used instead. These recommendations were geared for military settings, and can serve as a compass to guide staffing in the civilian market. At the same time, regardless of the type of setting (e.g., civilian, Veterans Affairs, or military), taking into consideration the level of behavioral health integration desired, and the need of the population being served, are likely to be important factors when determining BHP staffing ratios for the PCMH.

Facilities

Operating under the assumptions of an optimal model of ICC for the PCMH, BHPs would work in the PCMH clinic in the same manner as the rest of the staff. There is no need for special equipment or resources when using an ICC model. Patients can be seen in the same clinic rooms used to deliver medical care. Computer access and a method for storing handouts facilitate the BHP’s ability to deliver care. Regardless of the model, proximity of the BHP to the PCMH facilitates ease of collaboration, treatment planning, consultation, and having multiple team members see patients in the same visit or see patients at the same time.

Administrative

Patients, regardless of whether they have an appointment with the PCP or a BHP, go to the same check-in point, wait in the same waiting room, and are seen in the same clinic. All notes go into a shared medical record and are accessible to any of the team members as needed to provide efficient and appropriate care. Patients are booked and billed using the same process regardless of whether they are seeing the PCP or BHP.

Coding

A system for coding BHP visits needs to be developed by the clinic. Coding is a complex issue that is highly variable from state to state, and is impacted by Medicare regulations. The Air Force (United States Air Force, 2010) developed a detailed manual to guide coding, but this is a capitated system that may not generalize to civilian institutions. It is beyond the scope of this article to provide guidance about the best ways to ensure appropriate reimbursement (see Kathol, Butler, McAlpine, and Kane.
(2010) for discussion of the financial barriers of ICC). Reimbursement has been one of the most significant rate-limiting steps in the expansion of ICC and it must be considered and addressed in ICC operational and financial components.

**Clinical Components**

Unlike many operational components, which largely are unchanged with increased integration, successful ICC requires special attention to clinical components as integration increases. The fundamental question is not about what profession works best in ICC, but rather what skills are necessary to operate efficiently and effectively given the model of care being employed. A variety of individuals (e.g., Hunter et al., 2009; McDaniel, Hargrove, Belar, Schroeder, & Freeman, 2003; O'Donohue, Cummings, & Cummings, 2009; Robinson & Reiter, 2007) have written about the need for a different skill set when working in primary care. One significant problem is finding ways to learn these skills. Graduate schools and internships, like the literature, are inconsistent in how ICC training is defined (Alschuler, Hoodin, Bierenbaum, & Beacham, 2009). Organizations such as the Air Force and Department of Veterans Affairs have developed specific training programs, with identified trainers and practice manuals, designed to teach BHPs how to function in ICC. Beyond degree-related training, practical, evidence-based clinician-focused texts (e.g., Hunter et al., 2009; Robinson & Reiter, 2007) can serve as an excellent foundation for working in, assessing and treating efficiently and effectively in the PCMH. In addition, workshops at national conferences (e.g., Collaborative Family Health Care Association, Society of Behavioral Medicine, American Psychological Association) and other training programs/services (e.g., The University of Massachusetts Medical School Certificate Program in Primary Care Behavioral Health and Mountainview Consulting Group) can help BHPs develop the necessary skills for ICC.

The following is a list of skills and knowledge that are likely to be important for BHPs to have (regardless of profession) if they are going to maximize their efficiency, effectiveness and long-term impact in a way that aligns with the PCMH core principles.

**Clinical Problem Knowledge Breadth**

In a PCMH, PCPs are prepared to provide comprehensive care and to coordinate care with other specialties when necessary. Consistent with this model, BHPs accept all referrals and find ways to assist anyone who comes into the clinic whether it is through direct care or by assisting in the coordination of care with other specialty behavioral health or community services. To accomplish this goal, BHPs need to be familiar with a broad range of clinical conditions, assessments, and treatments. It is important for BHPs to not only be knowledgeable about general mental health problems (e.g., anxiety disorders [generalized anxiety disorder, panic disorder, post traumatic stress disorder], bereavement, mood disorders, eating disorders, substance misuse/abuse dependence), but also to have broader familiarity with common clinical health psychology problems (e.g., chronic pain, diabetes, HIV/AIDS, obesity, sexual disorders, sleep disorders, tobacco use and dependence, women’s health). Primary care settings, particularly Family Medicine, require an understanding not only of individual and adult problems, but also child and family problems. Therefore, the BHP may also need to be familiar with a range of common child and adolescent behavioral health problems (e.g., autism spectrum disorders, ADHD, conduct disorders, learning disorders), pediatric health (e.g., asthma, chronic illness coping, elimination disorders, habit disorders), and family problems (e.g., parenting skills, relationship difficulties).
Ability To Adapt Assessments and Treatments

Much of the current evidence for how to assess and treat behavioral health problems has been gathered in tertiary care behavioral health or clinical health psychology settings. It is important that BHPs are able to evaluate the research base, identify the core-components of interventions, and appropriately adapt assessments and interventions for the PCMH.

Overarching Heuristic for Assessment and Intervention

Behavioral health assessments and interventions in the PCMH should align with the work flow and culture of the setting. Being evidence-based, patient-centered, and adaptive to the range of problems people bring to the clinic is important. Consistent with the Chronic Care Model, it is important for BHP services to include patient education, have patients play an active role in their care, have organized treatment protocols and include monitoring, follow-up, and coordination with other PCMH team members (Crogan & Brown, 2010). The 5A’s model (Whitlock, Orleans, Prender, & Allan, 2002): Assess, Advise, Agree, Assist, and Arrange is an evidence-based clinical heuristic that meets these demands. The 5A’s format was strongly recommended for assessment and intervention across a range of problems in primary care (Goldstein, Whitlock & DePue, 2004). At its core, the goal is to produce a personalized action plan for the patient, which is shared with the PCMH team that includes observable goals, strategies to change health behaviors, and a specified follow-up plan. Although the specific tasks within each of the 5A’s will vary depending on the nature, severity, and complexity of the problems (Whitlock et al., 2002), this operational heuristic can be readily used in any PCMH, applied to any patient, with any problem. Consequently, it is important that BHPs have a basic understanding of the 5A’s and use it as a foundation for assessment and intervention.

Assess Phase

An initial assessment in the PCMH involves gathering information on physical symptoms, emotions, thoughts, behaviors, and important environmental variables such as family, friends or work interactions. From a biopsychosocial perspective the goal is to determine what variables are associated with patient symptoms and functioning. Then, based on the patient’s values and what is possible to change, determine what changes the patient might make that could decrease symptoms and improve functioning. The time constraints of the PCMH require that assessment measures are focused and functional, specifically targeting the presenting problem(s).

Advise Phase

During the advise phase, BHPs summarize their understanding of the problems and describe the possible interventions based on the information gathered in the assessment phase. The advise phase provides an opportunity for reflection and summarization. BHPs can explain how interventions can help patients change what is most important to them. This allows the patient to make an informed, collaborative decision about what intervention options they believe will work best for them.

Agree Phase

To ensure a collaborative relationship toward care, the BHPs takes time during this phase to discuss what the patient wants to do, based on the options discussed in the advise phase. Patients may decide they do not like any of the options and may suggest some of their own; they may want more time to think about their options or an opportunity to discuss options with significant others in their lives. Patients must agree on the problem and goals of an inter-
vention to have the best chance of successfully addressing the problem.

**Assist Phase**

At the assist phase the BHP's job is to help patients learn new information, develop new skills, problem-solve and/or overcome environmental or personal barriers to implementing changes. This is where the “formal” intervention takes place.

**Arrange Phase**

In the arrange phase, BHPs collaborate with patients to determine if and when follow-up appointments will occur, whether those appointment will be with the BHP or their PCP, or whether a referral to specialty behavioral healthcare is needed. In the arrange phase the BHP also discusses the information and skills that will be reviewed and the likely intervention outcomes.

Overall, the use of the 5A's produces a personalized healthcare action plan. The plan is specific, focused on health behavior change, and an integrated piece of the overall healthcare plan of patients. All professionals, regardless of their discipline, can understand, monitor, and if necessary, change the plans that result from following the 5A's. Following and documenting encounters in a manner that is consistent with the 5A’s allows PCMH providers and team member to understand the rationale for interventions and to know what the expected outcomes are from those interventions. The clarity that arises from following a systematic and objective method such as the 5A's allows the healthcare team and the patient to know whether interventions are working or not.

**Clinical Core Competencies**

Regardless of the problems being addressed by a BHP, there are core skills across assessments and interventions (Strosahl, 1998; United States Air Force, 2002) that can be used to measure the fidelity of a BHP's practice. These clinical core competencies are helpful for distinguishing between specialty mental healthcare and ICC.

**Applies Principles of Population-Based Care**

PCMHs are designed to facilitate quality, accessible care for large numbers of people every day. It is important that the BHP be capable of providing care across the spectrum of patients needing care for acute problems, chronic disease care and prevention interventions. Determining what behavioral health needs are appropriate to manage in the PCMH and what needs to be referred to other levels of care based on need or patient and PCP preferences is another important skill for a BHP to develop. Although there are no steadfast rules, many problems that patients bring to their PCPs involve thoughts, behaviors, emotions, environments and social interactions that either promote health or initiate and exacerbate problems. It may be important for the BHP to expand his or her knowledge about evidence-based assessments and interventions for the range of problems that are being seen in their clinic to best meet this core competency.

**Defines Behavioral Health Provider Role**

Unlike in a specialty behavioral health clinic where a consent for treatment document is reviewed, BHPs at a minimum should briefly (e.g., 2 min) explain their role in the clinic and appropriate limitations on the care and confidentiality that can be provided.

**Rapid Problem Identification**

Specialty behavioral healthcare settings often involve comprehensive biopsychosocial assessments. The time constraints associated with providing care for the population of the PCMH means that it is important for BHP's to quickly determine whether the patient's perceptions of the primary problem matches what the PCP identified as the problem.
Uses Appropriate Assessment

Providing effective evidence-based behavioral healthcare in the PCMH requires an alteration in the style and content of questions. To more carefully guide the assessment, closed-ended questions are used more frequently compared with specialty behavioral health settings. Assessments are focused on the presenting problem and elicit how the patient’s physical condition, thoughts, emotions, behaviors, habits, and environment impact the identified problem and functioning.

Limits Problem Definition/Assessment

When providing behavioral health services in the PCMH, the BHP must understand the referral problem well enough to implement the most appropriate evidence-based behavioral health intervention for this setting. As such, the scope of the assessment would likely focus on the factors affecting the presenting problem and typically would not go far beyond that assessment in the initial appointment. Risk assessments (e.g., suicide and homicide risk) are conducted as appropriate in those patients at increased risk (e.g., depression, hopelessness, life threatening chronic disease diagnosis).

Functional Outcomes and Symptom Reduction Recommendations and Interventions

It should be clear to the BHP, patient, PCP, as well as any other PCMH team member, whether the recommendations and interventions have successfully resolved or managed the presenting problem. Identifying objective methods for determining whether progress is being made is an important component of delivering services in this setting.

Uses Self-Management Skills/Home-Based Practice

The majority of what patients do to decrease symptoms and improve functioning is done outside of the PCMH appointment. The BHP should consider providing patients with ways to make changes when away from the clinic (i.e., homework). This is consistent with the PCMH goal of the patient being an informed active participant in his or her healthcare. The BHP might assist the patient in self-care through the use of patient handouts, website recommendations, community resources or classes provided through the PCMH.

Specific and Supportable Interventions

Recommendations made in the PCMH must be understood by not only the BHP and the patient, but also other PCMH team members who may be involved in maintaining behavior change plans. Interventions might involve observable and measurable behaviors (e.g., increase fun activities [read Mon, Wed, Fri from 1300–1330 in home office], increase exercise [Mon-Fri from 1700–1730, 30-min on stair-stepper], or use relaxation skills [practice deep breathing for 20 min every day]).

Clear Understanding of Relationship of Medical and Psychological Systems

BHPs will be better able to provide assessment and intervention services that are in concert with the PCMH concept of whole person care if they have a clear understanding of the biopsychosocial model of physiological disorders. Being able to describe to patients and PCMH team members how physical factors, behaviors, thoughts, environment, and interactions with others impact symptoms and functional impairments will likely increase patient and team buy-in on the types of interventions needed to produce change.

Basic Knowledge of Medicines

Medications are a common course of treatment in PCMH care. BHP recommendations and interventions are often offered in addition to medication interventions. PCPs may look to BHPs for guidance on
medications to consider for some problems (e.g., anxiety, depression). For effective communication with patients and PCPs, BHPs need to be familiar with the medications (e.g., analgesics, anxiolytics, antidepressants, hypnotics, opioids), common side effects, complications, and prescribing practices that are common for each PCP in clinic. It can be helpful to have access to commonly used, reliable databases of medications (e.g., Epocrates, Medline Plus) to use as a reference and to maintain a knowledge base. BHPs must also understand and acknowledge their limits when discussing medication use with patients and providers.

**Practice Management Skills**

Perhaps the most challenging skills for a BHP originally trained to work in specialty behavioral health clinical settings are the practice management adaptations that are necessary for ICC in primary care. These practice management skills require BHPs to make fundamental changes to the way they practice.

**Efficient Use of Appointments**

The BHP in the PCMH uses a more focused appointment (e.g., 10, 15, 20, or 30 min) approach than a behavioral health professional is traditionally accustomed to using for assessments and interventions. BHPs will very likely need to adapt the amount of time allocated for new and return appointments to the time-model used by other PCMH team members. Successfully incorporating the clinical core competencies will help the BHP adhere to these time constraints. Assessments on the referral problem, consistent with the “assess” part of the 5A’s model focuses on gathering information on physical symptoms, emotions, thoughts, behaviors, and any environmental variables like family, friends, or work interactions that might be contributing to the problem, with no or minimal time spent on more distally related subject matter. There is not sufficient time for the use of extensive assessment measures; but brief and targeted measures such as the Duke Health Profile, Patient Health Questionnaire (PHQ-9) or Generalized Anxiety Disorder 7-item scale (GAD-7) may be appropriate. The focus would be on the negative functional changes that have occurred and how those functional changes can be improved. For example, for a patient presenting with depressive symptoms it may be important to assess the depressive symptoms, including suicidal ideation, the possibility of anxiety symptoms and sleep-related problems; however, it may not be necessary to obtain a full social history and understand the relationship of the patients with their parents and siblings. Similarly, during return appointments the BHP focuses on teaching skills and developing concrete, measurable goals with the patients. For example, engaging the patient in a brief discussion focused on what can and cannot be changed (i.e., we may not be able to completely control our emotions or stop ourselves from having any negative thoughts, but we can spend time in value-based behaviors) and then set specific goals associated with behavioral activation, all of which can be made to fit into a brief appointment. It is helpful for both initial and return appointments for BHPs to use pre-printed or prepared electronic templates to guide the appointments.

**Staying on Time**

BHPs can quickly sabotage their schedule and the schedules of the patients waiting to see them if they are unable to manage their time in the clinic. Spending just 5 min longer with three patients can mean that subsequent patients are waiting 15 min or longer for their scheduled appointments. Asking closed-end (e.g., yes or no) or menu option questions (e.g., poor, fair, good, excellent), can help elicit information in a timely manner that is respectful, consistent with the pace of the PCMH and still allows for extended discussion or follow-up on a question when needed.
Using Intermittent Visit Strategies

Unlike specialty behavioral health clinics that use a standard one to two week interval between appointments, in a PCMH the BHPs might use a follow-up strategy that makes the most sense for the presenting problem. Patients may not come back at all, or may come back the next day, in a week, in one month, or in 6 months. The driving force that will likely determine when patients return to the clinic is what is necessary to improve and maintain improvements of the patients’ functioning. Many problems may require only 1 or 2 visits, but others, such as chronic disease management (e.g., diabetes) may require periodic contact over long periods of time. Consistent with the PCMH, BHPs might consider alternative methods of contact beyond face-to-face appointments. Patients can be contacted by phone or secure email systems (e.g., RelayHealth). BHPs can leverage the use of other PCMH team members, such as care managers, who can contact patients and help monitor progress.

Appropriate Specialty Care Use

ICC will never replace specialty behavioral health services. BHPs can work with the PCMH team and the patient to determine when a patient’s problems might not be best managed exclusively in the PCMH, but might also be appropriate to include coordinated care with a specialty behavioral health clinic. There are no absolute determinants of what types of problems might benefit from coordinated specialty care. Rather, the determination might be based on the BHPs scope of care, the intensity of the problem, the availability of specialty behavioral health services, and the patient’s willingness to engage in specialty services.

Appropriate Community Resources Use

Beyond specialty behavioral healthcare there are often community-based services and groups that may be helpful for patients to consider. If appropriate, there may be support groups that patients could attend or participate with online that the BHP can encourage the patient to attend. If BHPs are recommending a particular group or community resource (e.g., Alcoholics Anonymous, Alzheimer’s Support Group, Weight Watchers) being familiar with how the groups function and the costs involved with the groups can be helpful in facilitating patient engagement in these resources. It can be helpful for the BHP and the PCMH team to maintain a file of handouts related to the most common resources to facilitate patient follow-through. Involving, case managers, nurses, PCPs and other support staff in the PCMH can help to develop a diversified list of community resources that can be used by the whole team.

Consultation and Communication Skills With Medical Providers

One of the most valuable benefits of ICC at any level is the improved communication between BHPs and medical providers. Successful communication requires that BHPs adapt the ways that they communicate with medical providers to a form that facilitates the medical provider to be able to efficiently hear and use the feedback.

Focusing On and Responding To Referral Question

Answering the PCP’s referral question is important. If the patient’s perception of what is most important is different than the referral question, the BHP can still work to answer the referral question or, at minimum, provide a rationale for why that question was not answered. If BHPs are not perceived as being responsive to questions the PCMH team has, they can quickly be seen as nonteam players, limiting the important role they can have within the PCMH.
Tailoring Recommendations to Work Pace of Primary Care

The PCP should be able to easily understand the recommendations for patients and be able to quickly facilitate the continuation of those recommendations when seeing patients at follow-up appointments. For example, a BHP should not simply write “Encourage behavioral activation,” instead be specific “Encourage patient to plan an enjoyable activity (e.g., hiking, watching a movie) at least one time on the weekend.”

Conducting Effective Feedback Consultations

It is important for a BHP to provide feedback to a PCP quickly and use clear, concise explanations for the rationale for, and the content of the interventions. When explaining the rationale for behavioral activation the BHP might say to a PCP, “I encouraged the patient to engage in at least one potentially enjoyable activity each week to give herself the opportunity to experience pleasure, which she had taken out of her life.”

Persistent Follow-Up

Sometimes patients present with concerns that require immediate attention (e.g., side effects of medications, alarming medical symptoms). It is important for the BHP to be able to distinguish which situations may require urgent medical attention versus those that can be managed at a future appointment with the PCM.

Recommendations Reduce PCP Workload

BHPs should be able to demonstrate and communicate to PCPs how the BHP visits help to reduce the PCPs workload. The BHP follow-up appointments might focus on reassessing depressive symptoms in two weeks and the BHP offers to help the PCP by also asking about side effects associated with a recently started antidepressant.

Documentation Skills

In specialty behavioral healthcare, patient notes, particularly new patient notes, are intended to summarize complete biopsychosocial functioning of the individual. The standard of care in primary care requires that notes capture the important signs and symptoms affecting patient functioning, but are not viewed as comprehensive reflections of the patient’s historical and current functioning.

Medical Notes Clear and Concise

The content of the notes should focus on the referral problem and describe the onset, frequency, intensity, and duration of signs and symptoms, while describing the functional impairment. Recommendations at the end of the note should be focused and use measurable outcomes.

Documenting Encounter While Seeing Patient

The patient flow and time constraints of primary care requires efficient and effective time management. Documenting while seeing the patient, helps to ensure that important information is immediately recorded and less time is spent recalling the appointment. Documenting while seeing patients must be balanced with remaining engaged with patients and ensuring that active listening is maintained. For example, it would be inappropriate to turn away from patients when they are demonstrating emotional distress.

Notes Consistent With PCP Feedback

What is written in the note should reflect what is verbally communicated to the PCP. The verbal feedback allows PCPs to know immediately what the plan is for their patient, but it is unlikely that they will remember the specific details of the care plan when patients are seen again.
unless it is documented in the medical record.

**SUMMARY**

The PCMH represents a paradigm shift in the way we think about primary care. It offers an opportunity for professionals trained to focus on behavioral healthcare to become more involved in healthcare delivered to a population of individuals that they would likely never see in an outpatient behavioral health clinic. Primary care has evolved to maximize its capacity to serve large numbers of people in short periods of time. Adapting BHP practice in the PCMH to mesh with this population focus is vital. The PCBH model requires the most BHP adaption compared with other models, but it also offers the most comprehensive solution for targeting the behavioral health needs of the individuals looking to the PCMH to provide comprehensive quality care. Clinical experiences and research will ultimately guide the role of BHPs in the PCMH; at the same time, it is prudent for stakeholders to understand the terminology of ICC and carefully consider its operational and clinical components. Without this understanding and consideration, ICC in the PCMH will ultimately fall short of intended goals.

**REFERENCES**


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