Answering the Call for Integration: Training Today’s Healthcare Workforce

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Introduction

- Setting?
- Role?
- What do you hope to learn today?
Objectives

At the end of this workshop, participants will be able to:

◦ Understand the basic tenets of the Primary Care Behavioral Health (PCBH) model;
◦ Understand the current requirements and the state of family medicine training in the United States with regards to behavioral medicine;
◦ List ways that training programs can incorporate core elements of PCBH into their behavioral medicine rotations in their residency programs.
WHAT IS THE “PCBH” MODEL?
**Important Terms**

**PCP = Primary Care Provider**
*Retains ultimate responsibility for patient care*

**BHC = Behavioral Health Consultant**
*Member of the primary care team*
Primary Care is the ‘De Facto’ Mental Health System

National Comorbidity Survey Replication
Provision of Behavioral Health Care: Setting of Service

Pie of all behavioral health needs

- No Treatment 59%
- 41% Receiving Care
- General Medical 56%
- Mental Health Professional 44%

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

Adapted from Katon, Rundell, Unützer, Academy of PSM Integrated Behavioral Health 2014
*Pincus et al., JAMA 1998; 279; 526-531
Behavioral Health Presence In PC

- **84%** of the time, the 14 most common physical complaints have no identifiable organic etiology\(^1\)
- **80%** of individuals with a behavioral health disorder will visit primary care at least 1 time in a calendar year\(^2\)
- **50%** of all behavioral health disorders are treated in primary care\(^3\)
- **20-40%** of primary care patients have behavioral health needs\(^4\)
- **48%** of the appointments for all psychotropic agents are with a non-psychiatric primary care provider\(^5\)

The Primary Care Behavioral Health (PCBH) Model

- The BHC works WITHIN the primary care setting
- **Brief Interventions & Pathway Services**
  - One-on-One
  - Screening
  - Classes or workshops
  - Group visits
# Scope of Integrated Behavioral Health Practice

| Patients with mental health/ substance abuse conditions / risks | • Depression / Anxiety / PTSD / ADHD, other  
| • Substance Abuse/Dependence |
| --- | --- |
| Patients with stress-linked or unexplained physical symptoms | • Headache, insomnia, pain, fatigue, dizziness, numbness, “don’t feel well,”  
• Frequent visits with no clear medical cause to symptoms |
| Patients with unmanaged behavioral risk factors in chronic illnesses | • Diabetes / High BP / Obesity / Heart Disease  
• Asthma / Childhood Chronic Illness  
• Other |
| Persons with any complex social/ medical situation that interferes with standard care | • Functional impairment, diagnostic uncertainty  
• Multiple interacting conditions  
• Distress, distraction, difficulty engaging in care  
• Lack of social safety & support  
• Disorganized care or patient-clinician relationships  
• Language / Culture / Insurance barriers |
| Clients with mental health / substance abuse conditions receiving care in intensive mental health / substance abuse settings | • Basic primary care / chronic illness management  
• Timely preventive care  
• Health behaviors |
# The Behavioral Health Consultant

<table>
<thead>
<tr>
<th><strong>Dimension</strong></th>
<th><strong>Consultant</strong></th>
<th><strong>Therapist</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary consumer</td>
<td>PCP</td>
<td>Patient/Client</td>
</tr>
<tr>
<td>Care context</td>
<td>Team-based</td>
<td>Autonomous</td>
</tr>
<tr>
<td>Accessibility</td>
<td>On-demand</td>
<td>Scheduled</td>
</tr>
<tr>
<td>Ownership of care</td>
<td>PCP</td>
<td>Therapist</td>
</tr>
<tr>
<td>Referral generation</td>
<td>Results-based</td>
<td>Independent of outcome</td>
</tr>
<tr>
<td>Productivity</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Problem scope</td>
<td>Wide</td>
<td>Narrow/Specialized</td>
</tr>
<tr>
<td>Termination of care</td>
<td>Patient progressing toward goals</td>
<td>Patient has met goals</td>
</tr>
</tbody>
</table>
Initial Consult; Follow-up As Needed

Physician refers to BHC for specific problem / question

Patient implements behavior change plan, returns for follow-up as needed

Clinician reviews recommendations; retains full responsibility for patient care decisions

Introduction
5 minutes

Snapshot
5 minutes

Functional Analysis
5 – 10 minutes

Problem Summary/Behavior Change Plan
5 – 10 minutes

Charting/Feedback to PCP
5 minutes
Triple Aim (or quadruple aim) and Workforce Development
THE ACGME & PCBH MODEL
Why is it important to train residents in PCBH?

- Provides framework for identifying patient strength/resiliency & risks
- Primary prevention – prevent problems before they occur
- Secondary prevention - treatment
- Tertiary prevention - support
- Provide context for improving quality of life vs only symptom reduction (not realistic, can be damaging)
  - Flipping the script – functionality vs symptom-focus
- Interprofessional collaboration and education
The Accreditation Council for Graduate Medical Education

Responsible for accrediting graduate training programs for physicians in the United States
6 Competencies

- Medical Knowledge
- Patient Care
- Professionalism
- Interpersonal Communication
- Practice-Based Learning and Improvement
- Systems-Based Practice
What is the purpose of Milestones?

- Monitoring of programs
- Public accountability
- Guide curriculum development
- Transparent expectations of performance
- Facilitate feedback for professional development
Requirements from ACGME

- Sets guidelines for what experiences residents need
  - Ex. Procedures, number of patients seen, etc.

- Requirements for psychosocial medicine:
  - Somewhat vague
  - Need integration within faculty
    - Focus on diagnosing and communication
      - Diversity, working on teams, etc.
Behavioral Medicine Suggestions by STFM

- Use **biopsychosocial** approach
- Promote **patient self-efficacy** and behavior change
- Integrate behavioral health
- Address **physical symptoms**
- Address **sociocultural factors**
- Understand impact of **systems**
- Apply **developmental psychology**
- **Provider wellness**
How it is typically done...

- Behavioral scientist on faculty
  - Maybe sees patients, maybe doesn’t
    - Typically as a traditional mental health provider
  - Works with residents via a RANGE of mediums
    - Structured didactics, case centered conferences, journal clubs, individual precepting, behavioral medicine rounds, co-therapy, video critique and observation, genograms and self-exploration of genograms, participation in relevant community programs, and readings
    - Typically, one month rotation in a three year residency
- Not a “wrong or bad” way of doing things… just not the PCBH (allows for the highest level of integration) way of doing things
Dr. Udell’s experience as a medical resident
Training FM residents in PCBH: An Example

- Central Washington Family Medicine Residency
  - 10-10-10 FM residency program
    - Locations in Ellensburg and Yakima, WA
  - Teaching Health Center
  - Rotations range from outpatient to OB to inpatient and to... psychosocial medicine
Overview of CWFM’s PSM curriculum

- **Rotations**
  - One month rotation during year one
  - AFM 1 month yearly rotations

- **Components of rotation**
  - Role plays and readings
  - Residents shadowing BHCs in their respective clinics
  - BHCs shadowing residents in their respective clinics

- **Didactics regarding PSM throughout the year**
Let’s dive in…

- **Readings during the rotation** (Always a challenge)
  - ABCT special edition on chemical imbalance myth
  - The realities of BH in PC
  - Adverse Childhood Experiences
  - Brief interventions for radical change
  - Real behavioral change in primary care
Let’s dive in...

- **Role-plays and discussion groups**
  - 2x’s during the month
  - All PSM and AFM residents and medical students
    - Typically 3-4 trainees
  - Role plays
    - Contextual interview
    - Behavioral interventions/providing psychoeducation
Let’s dive in…

- **Role-plays and discussion groups**
  - What causes people to change?
  - Human suffering
  - Are we treating a symptom or a disease?
  - Impact of Adverse Childhood Experiences
    - Why would someone take care of themselves when they don’t CARE about themselves?
  - Discuss their reactions to patients & job difficulties
    - How can medical providers be objective but compassionate?
      - How do we change the ‘but’ to an ‘and?’
  - Discuss assigned readings
  - Psychoeducation pieces
    - How do you explain depression to patients?
  - Practice brief interventions and metaphors
    - Three little pigs, baseball metaphor, the program metaphor
Let’s dive in…

- **Residents shadowing BHCs in BHCs’ clinics**
  - 2-3x’s per week they pair w/ BHC in their PCBH clinics
  - Complete ALL new patient contextual interviews
    - Watch how BHCs use ACT/FACT then they apply it in their clinics
  - Other expectations:
    - By the end of year one, residents will be able to **conceptualize and articulate brief behavioral interventions**
    - By the end of year two, residents should be able to **provide and implement basic and relevant behavioral interventions** (e.g., MI, SF, CBT, ACT strategies)
    - By the completion of their residency residents should be able to **instruct and implement more sophisticated behavioral interventions** (e.g., mindfulness, acceptance and values based approaches)
Let’s dive in…

- **BHCs shadowing residents in their outpatient rotations**
  - Once or twice a week
  - BHCs are “flies on the wall”
  - Evaluating and providing feedback regarding patient centered communication
    - Builds Rapport
    - Focuses the exam
    - Elicits patient’s perspective
    - Gathers and shares information
    - Reaches common ground
Resident experience with BH rotations
FUTURE DIRECTIONS IN TRAINING
Training Recommendations

- More graduate programs in counseling, social work, and psychology training our BHC force
- Medical residents/students and predoctoral interns/master’s interns working in same setting
- BHCs operating via PCBH model teaching in residencies (allows more opportunity for ongoing vs segmented training)
Summary/Wrap-Up

- PCBH → Team-Based Approach
- Medical (and behavioral) providers must be intentionally trained for increased PCBH model fidelity (full effect of integrated care model)
- This framework allows for responsible healthcare to meet the demands of primary care…
  - …opens more avenues for prevention
Questions/Discussion

• Briefly describe your training program
• What improvements in training do you plan to make within the next 12 months?
• What challenges do you face with implementing training changes?
• Other questions?
- davidbauman4@gmail.com
- bridget.beachy@gmail.com
- stacy.ogbeide@gmail.com
- https://www.youtube.com/channel/UCR_hf_LGVtUOoLa_KFvqvtQ
Resources

Please complete conference evaluation
More Resources

- Resources available online
  - [http://www.pcpci.org/resources/browse](http://www.pcpci.org/resources/browse)
    - Search ‘Behavioral Health Integration’
  - Center for Integrated Health Solutions
  - Primary Care Behavioral Health (PCBH) Special Interest Group – Collaborative Family Healthcare Association
    - [http://www.cfha.net/?page=PCBHSIG](http://www.cfha.net/?page=PCBHSIG)

Please complete conference evaluation
References

- ACGME. (2016). *ACGME program requirements for graduate medical education in family medicine*. Chicago, IL: Accreditation Council for Graduate Medical Education.