TRAINING THE INTEGRATED PRIMARY CARE PROFESSIONAL

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OBJECTIVES

• At the end of this presentation, participants will be able to:
  • 1) Discuss current trends in graduate behavioral health education;
  • 2) Discussion current trends in graduate medical education (specifically family medicine);
  • 3) Identify the core components of interprofessional education; and
  • 4) Identify one interprofessional training approach that can be used in integrated behavioral health clinical training settings.
INTRODUCTIONS – WHO ARE YOU?

• Profession?
• Role in organization?
• What brought you to this talk?

PRIMARY CARE: IOM DEFINITION

• The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community (IOM, 1996).
WHAT IS “BEHAVIORAL HEALTH”?

• Behavioral Health is an umbrella term for care that addresses any behavioral problems impacting health, including mental health and substance abuse conditions, stress-linked physical symptoms, patient activation and health behaviors. The job of all kinds of care settings, and done by clinicians and health coaches of various disciplines or training.


WHY INTEGRATE BEHAVIORAL HEALTH INTO PRIMARY CARE?

• 1) Behavioral health problems are common
  • Two third of primary care patients have psychiatric diagnoses or psychological symptoms that impair their function.
• 2) Behavioral health problems are expensive.
  • Individuals with behavioral health and substance abuse conditions cost 2-3 times as much as those without1
• 3) Behavioral health problems are disabling.
  • Behavioral health disorders account for half as many disability days as “all” physical conditions2
• 4) When behavioral health is treated, costs go down and people get better.
  • Medical use decreased 15.7% for those receiving behavioral health treatment while medical use increased 12.3%1 for controls who did not receive behavioral health treatment

LEVELS OF BH INTEGRATION

<table>
<thead>
<tr>
<th>Referral</th>
<th>Co-Located</th>
<th>Integrated</th>
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<tbody>
<tr>
<td>Key Element: Communication</td>
<td>Key Element: Physical Proximity</td>
<td>Key Element: Practice Change</td>
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<tr>
<td>Level 1 Minimal Collaboration</td>
<td>Level 2 Basic Collaboration at a Distance</td>
<td>Level 5 Close Collaboration Approaching an Integrated Practice</td>
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<tr>
<td>Level 3 Basic Collaboration On-Site</td>
<td>Level 4 Close Collaboration On-Site with Some System Integration</td>
<td>Level 6 Full Collaboration in a Transformed/ Merged Integrated Practice</td>
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Behavioral health, primary care and other healthcare providers work:
- In separate facilities
- In separate facilities
- In same facility not necessarily same offices
- In same space within the same facility
- In same space within the same facility (some shared space)
- In same space within the same facility, sharing all practice space

Doherty, McDaniel, & Baird, 1996

WE KNOW THIS IS GOOD – WHERE’S THE TRAINING?
WHERE’S THE TRAINING?

- Which pre/post-degree training programs for integrated care are you familiar?
- How do you onboard?

WHERE’S THE TRAINING?

- Organizations developing a step-wise onboarding process (post-licensure)
- Examples:
  - Cherokee Health System
  - Department of Defense
WHERE’S THE TRAINING?

• Certificate programs in IBH (post-licensure)
• Examples:
  • UMASS (Center for Integrated Primary Care)
  • University of Michigan
  • Baylor University (new)

TRAINING APPROACHES: GRADUATE BEHAVIORAL HEALTH
TRAINING: GRADUATE BEHAVIORAL HEALTH: COUNSELING (MASTERS PROGRAMS – CLINICAL MENTAL HEALTH COUNSELING)

• FOUNDATIONS
  • history and development of clinical mental health counseling
  • theories and models related to clinical mental health counseling
  • principles, models, and documentation formats of biopsychosocial case conceptualization and treatment planning
  • neurobiological and medical foundation and etiology of addiction and co-occurring disorders
  • psychological tests and assessments specific to clinical mental health counseling

From: http://www.cacrep.org/section-5-entry-level-specialty-areas-clinical-mental-health-counseling/

TRAINING: GRADUATE BEHAVIORAL HEALTH: COUNSELING (MASTERS PROGRAMS – CLINICAL MENTAL HEALTH COUNSELING)

• CONTEXTUAL DIMENSIONS
  • roles and settings of clinical mental health counselors
  • etiology, nomenclature, treatment, referral, and prevention of mental and emotional disorders
  • mental health service delivery modalities within the continuum of care, such as inpatient, outpatient, partial treatment and aftercare, and the mental health counseling services networks
  • diagnostic process, including differential diagnosis and the use of current diagnostic classification systems, including the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD)
  • potential for substance use disorders to mimic and/or co-occur with a variety of neurological, medical, and psychological disorders
  • impact of crisis and trauma on individuals with mental health diagnoses
  • impact of biological and neurological mechanisms on mental health

From: http://www.cacrep.org/section-5-entry-level-specialty-areas-clinical-mental-health-counseling/
TRAINING: GRADUATE BEHAVIORAL HEALTH: COUNSELING
(MASTERS PROGRAMS – CLINICAL MENTAL HEALTH COUNSELING)

• CONTEXTUAL DIMENSIONS (Con’d)
  • classifications, indications, and contraindications of commonly prescribed psychopharmacological medications for appropriate medical referral and consultation
  • legislation and government policy relevant to clinical mental health counseling
  • cultural factors relevant to clinical mental health counseling
  • professional organizations, preparation standards, and credentials relevant to the practice of clinical mental health counseling
  • legal and ethical considerations specific to clinical mental health counseling
  • record keeping, third party reimbursement, and other practice and management issues in clinical mental health counseling

From: http://www.cacrep.org/section-5-entry-level-specialty-areas-clinical-mental-health-counseling/ 

TRAINING: GRADUATE BEHAVIORAL HEALTH: COUNSELING
(MASTERS PROGRAMS – CLINICAL MENTAL HEALTH COUNSELING)

• PRACTICE
  • intake interview, mental status evaluation, biopsychosocial history, mental health history, and psychological assessment for treatment planning and caseload management
  • techniques and interventions for prevention and treatment of a broad range of mental health issues
  • strategies for interfacing with the legal system regarding court-referred clients
  • strategies for interfacing with integrated behavioral health care professionals
  • strategies to advocate for persons with mental health issues

From: http://www.cacrep.org/section-5-entry-level-specialty-areas-clinical-mental-health-counseling/
TRAINING: GRADUATE BEHAVIORAL HEALTH: “HEALTH SERVICE PSYCHOLOGY” (DOCTORAL PROGRAMS/APA ACCREDITED)

- Students must demonstrate competence in the following areas:
  - Research
  - Ethical and legal standards
  - Individual and cultural diversity
  - Professional values, attitudes, and behaviors
  - Communication and interpersonal skills
  - Assessment
  - Intervention
  - Supervision
  - Consultation and interprofessional/interdisciplinary skills


ACGME, FAMILY MEDICINE, AND BEHAVIORAL HEALTH
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

ACGME, 2015
ACGME, Family Medicine & Behavioral Health

“...primary care specialty which demonstrates high quality care within the context of a personal doctor-patient relationship and with an appreciation for the individual, family, and community connections...”

“There must be faculty members dedicated to the integration of behavioral health into the educational program...”

“...Other specialists should not see patients in the FMP site unless their presence enhances the experiences and learning of the residents...”

ACGME, Family Medicine & Behavioral Health

“..each FMP site must involve all members of the practice in ongoing performance improvement, and must demonstrate use of outcomes in improving clinical quality, patient satisfaction, patient safety, and financial performance...”

Must demonstrate competence independently:

“...diagnose, manage, and coordinate care for common mental illness and behavioral issues in patients of all ages...”

“...assess community, environmental, and family influences on the health of patients...”

“... evaluate patients of all ages with undiagnosed and undifferentiated presentations...”
ACGME, Family Medicine & Behavioral Health

“...The curriculum must be structured so behavioral health is integrated into the residents’ total educational experience, to include the physical aspects of patient care...”

“... There must be a structured curriculum in which residents address population health, including the evaluation of health problems of the community...”

ACGME MILESTONES

- Significant point in development
- Developmental outcomes demonstrated by resident progressively by resident and fellows from beginning of their education through graduation and unsupervised practice of their specialties
COMMONALITIES?

• Working with systems that focus on biopsychosocial model of care

INTERPROFESSIONAL EDUCATION (IPE): CORE COMPETENCIES FOR COLLABORATIVE PRACTICE
CORE COMPETENCIES FOR COLLABORATIVE PRACTICE

1) Values/Ethics
   - “…shared purpose to support common good in health care…”

2) Roles/Responsibilities
   - Understanding how professional roles complement each other in patient-centered/population-based care

From [http://www.asha.org/uploadedFiles/Interprofessional-Collaboration-Core-Competency.pdf](http://www.asha.org/uploadedFiles/Interprofessional-Collaboration-Core-Competency.pdf)

CORE COMPETENCIES FOR COLLABORATIVE PRACTICE

3) Interprofessional Communication
   - Using language that other team members, patients, and families can understand that promotes team approach to health promotion and treatment
   - Feedback: Timely, sensitive, instructive

4) Teams/Teamwork
   - Using principles of team dynamics to deliver patient-centered care and population health
   - Cooperating so redundancies and gaps are avoided
   - “…relinquishing professional autonomy to work closely with others…”; improved patient outcomes

From [http://www.asha.org/uploadedFiles/Interprofessional-Collaboration-Core-Competency.pdf](http://www.asha.org/uploadedFiles/Interprofessional-Collaboration-Core-Competency.pdf)
The climb towards IPE in integrated primary care settings

1. Bridging cultures
2. Letting go of “rules”
3. Team-based care training – becoming the norm

EXAMPLE: TRAINING WITHIN PCBH MODEL
TRAINEE ROLES

Primary Prevention

- Promotion of healthy behaviors and environments across the life course

Secondary Prevention

- Screening
- Case finding
- Early intervention
- Control risk factors (lifestyle and medication)

Tertiary Prevention

- Maintenance
- Rehabilitation
- Self-management
- Complications management

PRIMARY PREVENTION

- Interdisciplinary in-service training
- Education tools
- Health Education Class (e.g., stress management, sleep)
- Education at routine visits (e.g., WCC, WWE, AWV)
SECONDARY PREVENTION

• First and second stage screenings
• Quality improvement projects on screening processes
• Registries

TERTIARY PREVENTION

• Self-Management Interventions
• MI and Stage of Change
• Group Medical Appointments (DIGMA and Cluster Visits)
EXAMPLE: ACGME AND THE PCBH MODEL

PCBH Competency
• Assessment
• Conducts a brief, well organized, comprehensive biopsychosocial interview; touches on functional analysis and life context
• Uses structured self-report assessments to complement interview data.

Milestone
• Milestone MK-2 Applies critical thinking skills
• Milestone C-1 Develops meaningful, therapeutic relationships with patients and families
• Communicates effectively with patients, families, and the public

EXAMPLE: ACGME AND THE PCBH MODEL

PCBH Competency
• Conceptualization
  • Integrates interview and self-report survey information into a clinically useful picture of the patient’s problems
  • Recognizes features of behavioral health conditions, health risk factors, barriers to successful self-management of chronic disease
  • Gauges patient’s motivation level and change readiness.

Milestone
• Milestone PC-4 Partners with the patient to address issues of ongoing signs, symptoms, or health concerns that remain over time without clear diagnosis despite evaluation and treatment, in a patient-centered, cost-effective manner
• Milestone PROF-2 Demonstrates professional conduct and accountability
• Milestone PROF-3 Demonstrates humanism and cultural proficiency
EXAMPLE: ACGME AND THE PCBH MODEL

PCBH Competency

- **Intervention**
  - Presents problem summary statement to the patient
  - Collaborates with the patient to create ownership of a behavior change goal
  - Focuses on creating a limited number of behavior change goals
  - Able to use evidence based behavior change interventions
  - Shows ability to match intervention to motivational readiness level

Milestone

- Milestone SBP-4 Coordinates team-based care
- Milestone C-1 Develops meaningful, therapeutic relationships with patients and families
- Milestone C-2 Communicates effectively with patients, families, and the public

EXAMPLE: BHCS IN THE ROOM

- BHCs in precepting room
  - Provides “on-demand” feedback to residents (as well as availability for a warm-hand off or conjoint visit)
  - More than just “co-precepting”
  - Ongoing conceptualization
  - Learning “on the fly”
RECENT ARTICLE ON PCBH WORKFORCE DEVELOPMENT

• “The State and Future of the Primary Care Behavioral Health Model of Service Delivery Workforce” (May 2017)
• Eight recommendations were offered:
  • (1) the development of an interprofessional certification body for PCBH training criteria
  • (2) integration of PCBH model specific curricula in graduate studies
  • (3) integration of program development skill building in curricula
  • (4) efforts to develop faculty for PCBH model awareness

From https://link.springer.com/article/10.1007%2Fs10880-017-9491-1

RECENT ARTICLE ON PCBH WORKFORCE DEVELOPMENT

• “The State and Future of the Primary Care Behavioral Health Model of Service Delivery Workforce” (May 2017)
• Eight recommendations were offered:
  • (5) intentional efforts to draw students to graduate programs for PCBH model training
  • (6) a national employment clearinghouse
  • (7) efforts to coalesce current knowledge around the provision of technical assistance to sites; and
  • (8) workforce specific research efforts.

From https://link.springer.com/article/10.1007%2Fs10880-017-9491-1
ADDITIONAL TRAINING RESOURCES

- Farley Center (Core Competencies): http://farleyhealthpolicycenter.org/core-competences-for-behavioral-health-providers-working-in-primary-care/
- University of Michigan (Behavioral Health Workforce Research Center) – PCBH Workforce Integration Best Practices and Barriers:

WRAP/SUMMARY

- Get creative with how you train
- Less walls = good!
- Cross contamination
- Purposeful “bumpability” (e.g., didactics, grand rounds)
- Measure what you do (IPE instruments, team based care instruments)
QUESTIONS/DISCUSSION

• What questions do you have?

Please complete seminar evaluation!

Contact: stacy.ogbeide@gmail.com

RESOURCES
REFERENCES AND RESOURCES


REFERENCES AND RESOURCES

- Reiter, J. (2016, April). Refining the understanding of the PCBH model. Presentation made to the Integrated Primary Care Group of the Hogg Foundation.
REFERENCES AND RESOURCES

American Board of Family Medicine: 2015 Special Edition on Behavioral Health Integration and the Advancing Care Together Program (Cohen et al., 2015)
Link: http://www.jabfm.org/content/28/Supplement_1.toc

Websites:
- AHRQ Academy for Integrating Behavioral Health and Primary Care: http://integrationacademy.ahrq.gov/
- AIMS CENTER: http://aims.uw.edu/
- Center for Integrated Primary Care: http://www.umassmed.edu/cipc/
- Collaborative Family Healthcare Association: www.cfha.net
- Lexicon for Behavioral Health and Primary Care Integration. AHRQ 2013: http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf
- National Alliance on Mental Illness. Integrating Mental Health & Pediatric Primary Care Resource Center: http://www.nami.org
- SAMHSA/HRSA Center for Integrated Health Solutions: http://www.integration.samhsa.gov

Some of the information from this presentation was adapted from PCPCC’s Behavioral Health Task Force Slide Deck. Last updated September 2014. Link: https://www.pcpcc.org/