

Chapter 2

Integrated Care and Specialty Behavioral Health Care in the Patient-Centered Medical Home

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Integrated health care represents the contemporary recognition that holistic, whole-person, and patient-centered medical home (PCMH) services are effective in terms of improved treatment outcomes for mental health (MH), substance abuse, and physical illness (Jaen et al. 2010; Butler et al. 2008), as well as more cost-effective for both patients and health-care systems. These benefits are obtained, for instance, through a reduction in expensive emergency department visits (Chaiyachati et al. 2014) and overutilization of health-care services (Kurdyak et al. 2014) in service delivery settings with integrated physical health primary care (PC) and behavioral health services. In fact, evidence suggests that the myriad benefits of integrated care (IC) models, and more specifically, PCMH models encompass additional positive outcomes including increased consumer satisfaction, decreased provider burnout, increased access to care, improved patient adherence to treatment recommendations, and reduced stigma toward accessing behavioral health care (Blount 2003). Recent federal efforts toward health-care reform including policy changes such as those enacted through the Patient Protection and Affordable Care Act (ACA), as well as systems change reforms like PCMHs, dovetail nicely with the major paradigmatic shifts in health-care service conceptualization and provision occurring throughout PC and behavioral health (McDaniel and deGruy 2014).

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IC: A Brief History

In the *Social Transformation of American Medicine* (1982), Paul Starr traces the historical growth of modern medicine (i.e., roughly 1760 forward) along two paths: “the rise of professional sovereignty” and “the transformation of medicine into an industry” (pp. ix). Together, these developmental tracks set broad and lasting foundations for present-day health-care systems in several ways. The unchecked development of increasingly specialized providers within the health-care system had the unfortunate effect of underscoring a tendency in health care for treatment to be rendered in “parts” to patients, as if patients themselves were able to be partitioned and as if treating a given patient’s diabetes in one setting and his depression in another reflected an actual lack of interdependence and reciprocity among the endocrine and neuropsychiatric systems within a single patient, rather than these separations representing an artifact of outdated paradigms that still dominate modern approaches to health-care training, service delivery, and even payment and reimbursement policies. These carve-outs in health care perpetuate a fragmented health-care system that encourages passive and generally uninformed participation of patients in a complex system that is expensive and unable to meet their needs.

Specialized treatment and/or treatment providers for each of a patient’s problems or symptoms, as opposed to a whole-person approach that presumes irreducibility—or at the very least, interconnectivity—among bodily and behavioral systems within a given human being may have very old roots. The seventeenth-century metaphysical dualism popularized by Descartes’ “*cogito ergo sum*” promulgated the notion that the mind and the body are distinctly separate entities within a given person; (American) medicine embraced this dualism in force with respect to the separation of physical disease/health and mental disease/health. For centuries, medicine existed under the reign of the biomedical model, a reductionistic model of disease that bypassed nearly all levels of systemic and holistic considerations of a patient’s presentation (e.g., the impact of psychosocial stressors on mental or physical illness; the patient’s built environment or socioeconomic status) in lieu of reducible molecular processes that could, hypothetically, be treated with “magic bullet” cures. The biomedical model produced superb results during much of the twentieth century with respect to several areas, such as combating diseases caused by germs and/or poor hygiene, providing acute pain control, and successfully containing viruses (e.g., polio) with mass vaccination and prevention efforts. In the present day, however, the vast majority of disease-related morbidity and mortality is a result of chronic, comorbid conditions that do not have simple or linear causality and frankly cannot be effectively treated with a fragmented treatment system (McDaniel and deGruy III 2014).

In some cases, the fragmentation and specialization of health care are so extreme that even if providers of different specialties in separate care facilities wanted to consult or share information about the same patient; many times they are effectively not even speaking the same language when conceptualizing and communicating about patient care. George Engel aptly and cogently addressed this historical and incomplete approach to medical care in his seminal work elucidating the biopsychosocial model of care in the 1970s (Engel 1977). While Engel’s model gained much

ground over the past four plus decades in many circles and provider systems, the largest system of patient care in the USA is the PC medical setting, which in many ways maintains allegiance to the biomedical model. Given that the PC system appears particularly essential to the health of a given population (reference), continued efforts to broaden the scope of training for medical and behavioral health professionals (BHPs) to include the ability to deliver care in a comingled, shared fashion are vital.

PC generally followed (and in the majority of cases, still follows) the siloed model of care until early efforts at integrating medical and behavioral health care emerged in recent decades. The previously mentioned disadvantages of fractioned care plague the current health-care environment, such that in the USA, unprecedented costs and increased health-care expenditures have not produced commensurate improved treatment outcomes. The potential positive health and wellness outcomes linked to engagement with a PC clinic are limited in many cases by a myopic approach to diagnosis, assessment, and treatment that summarily dismisses attention to the care of mental, behavioral, and chronic health conditions. Fortunately, on the heels of Engel's seminal explication of and demand for a theoretical paradigm shift in medical treatment, practitioners and researchers eager to improve healthcare outcomes began efforts to explore and implement integrated care services, particularly in the primary care setting. For example, early pioneers of PC and behavioral health integration in Washington state during the 1990s developed care models focused on depression treatment in the PC setting. This work represented a population-based, epidemiologically sound model of care for depression that provided "the best care for the most patients most of the time" (Quirk et al. (2000), pp. 82). While a small percentage of depressed patients may ultimately require referral to specialty care outside of (or in concert with) the PC setting, in general, the majority of the population will not require such services in order to improve functionality and to decrease symptomology.

The Case for PC

The majority of patients with MH, substance abuse, and behavioral health conditions seek treatment in the PC setting, and accordingly, most of the treatment occurs in these settings as well (for instance, PC providers (PCPs) provide more psychotropic medications every year in the USA than do psychiatrists). Generally, patients prefer treatment for behavioral health issues at their PCP's office, as noted earlier, for multiple reasons including the convenience, reduced wait times, decreased stigma, and increased trust while accessing a broad array of services in a familiar and trusted (i.e., PC) setting Byrd et al. 2005. Major MH concerns and psychosocial stressors interfere with health status in a complex fashion. For example, mental illness and stress issues, including anxiety and depression, tend to worsen health outcomes; indirectly, these issues negatively impact adherence to treatment regimens (and are thus implicated in the course and prognosis of even the most "purely biological" of illnesses). Even when PCPs have the training and/or awareness to

refer a patient for specialty behavioral care, the majority of patients do not follow through with these referrals. Furthermore, a case can be made that in systems lacking coordination and integration, treatment as usual does not translate into acceptable outcomes regardless of where it occurs (i.e., primary or specialty setting; see, for instance, Quirk et al. (2000)).

Typically, most medical professionals are not sufficiently trained in behavioral or MH treatment and desire and appreciate the support of BHPs (psychologists, licensed social workers, care managers) in patient care. In particular, the shift from acute illnesses toward chronic conditions as the nation's primary causes of morbidity and mortality (chronic conditions which are not adequately managed with traditional biomedical approaches) and the associated recognition of the necessity of behavioral, lifestyle, psychoeducational, and motivational interventions to improve overall health and wellness have reinforced the necessity for BHPs in the PC setting (Collaborative Family Health Care Association, CHFA; Peterson et al. 2014). Mokdad et al. (2004) examined modifiable factors that contributed to death in the USA: Nearly, half (48.2 %) of all deaths were explained by a limited number of largely preventable behaviors (i.e., by modifiable risk factors). Additionally, individuals with mental and substance abuse disorders may die decades earlier than the average person (Substance Abuse and Mental Health Services Administration (SAMHSA), n.d.). MH service use is underutilized but still overburdened with long waits and disproportionately so in minority populations, which may be a function of how distress is interpreted, defined, and communicated (Zuvekas and Fleishman 2008). PCMHs are defined to be culturally sensitive, to provide integrated, coordinated care, and to include social and community resources for health improvement (Peikes et al. 2011). PCMHs may reduce health disparities for racial and ethnic minorities (Petersen et al. 2011; Blount 2003; Sanchez et al. (2012) as well as improve access to care in rural populations (Smalley et al. 2012)). In discussing the multiple barriers to care for underserved, rural, and frontier populations, the case for medical and behavioral health integration is noted to positively impact barriers related to the "accessibility, affordability, acceptability, and availability" of behavioral health services (Smalley et al. 2012).

Conceptually speaking, the term "primary care" may be defined by some as simply put, the first point of contact with the health-care system (literally, a *primary* entrance). With this broad definition, PC services and settings may then range the full gamut from an acute illness or injury with an unplanned and costly emergency department visit to a scheduled, preventative care visit with one's own family physician, the latter of whom typically sees the patient as well as his or her family members for a wide variety of concerns throughout the life span. A more helpful and targeted definition of PC from the Institute of Medicine (IOM) defines "PC" as the provision of integrated, accessible health-care services by clinicians who are accountable for addressing a large majority of personal health needs, developing a sustained partnership with patients and practicing in the context of family and community" (IOM 2001).

IC typically occurs in PC settings. Bruce Chafee (2009) defines IC as such health-care service delivery models that integrate behavioral health providers

(BHPs/BHCs) into PC and/or specialty care settings and operations. BHPs are frequently colocated in medical clinics, and their scheduling and practice patterns may be altered from those of specialty behavioral health providers (SBHP/SMHP), for example, seeing patients in brief (15–20 min) sessions versus the traditional (45–50 min) psychotherapy visits.

A more concise definition from the federal Agency for Healthcare Research and Quality (AHRQ 2008): “Integrated care occurs when MH specialty and general medical care providers work together to address both the physical and MH needs of their patients (p. 1).”

Specialty behavioral health care denotes the traditional care delivery model for behavioral health services as a separate medical specialty, typically initiated by either the patient or by referral from PC physicians; its associated services regularly include 60–90-minute initial diagnostic evaluations, the traditional “50-min hour” individual psychotherapy session, and group psychotherapy (Chafee 2009).

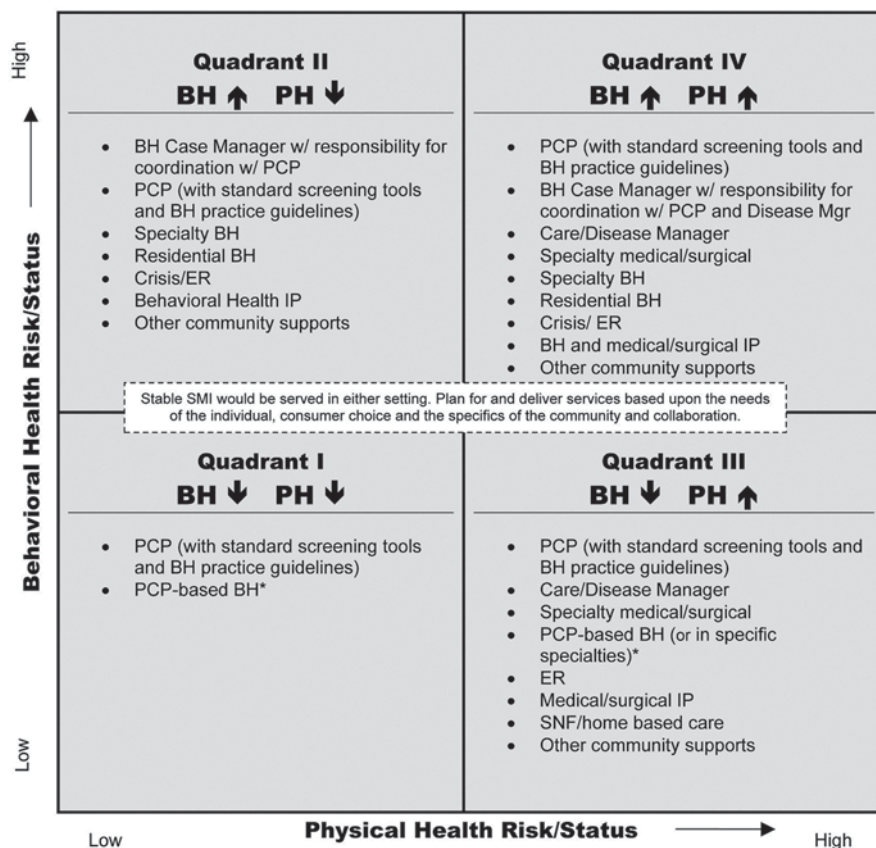
At this point in time, few believe that the mind and body are separate and should be treated as such. Some physicians may still hold this premise; however, with appropriate education and support, these individuals transition to what is accepted as common best practice knowledge. It is common knowledge that one’s genetics and biology, mental and emotional health, and behaviors interact in complex and dynamic ways within the embedded context of one’s social, socioeconomic, and physical environment. Recognizing these interactions between internal and external systems in the development of illness or disease within a given patient subsequently results in the need for a parallel system of care that provides treatment that also considers and addresses these systemic and contextual features. This method of providing treatment is the basis of evidence-based medicine.

Models of IC

Multiple models of integrated and collaborative care exist in the literature and in practice, and a full elucidation of each individual model is beyond the scope of this chapter. However, a review of some of the major or seminal programs is certainly worth discussion here. Additionally, core components shared by successful integrated programs, as well as functional pathways of care, also warrant consideration. Broadly speaking, models tend to differ across both system design (e.g., type of providers comprising the interdisciplinary team) and service delivery elements (e.g., integration of processes of care; Lambert and Gale 2014).

The widely adopted four-quadrant model is a population-based planning tool for health- and mental-health-related services developed by Barbara Mauer and the National Council for Community Behavioral Healthcare (Mauer 2003). The four-quadrant model assists providers with treatment decisions for individual patients by providing guidelines for assigning treatment location and responsibility between integrated and specialty services. See Fig. 2.1 which illustrates the four-quadrant model.

The Four Quadrant Clinical Integration Model



*PCP-based BH provider might work for the PCP organization, a specialty BH provider, or as an individual practitioner, is competent in both MH and SA assessment and treatment

Fig. 2.1 The four quadrant clinical integration model (NCCBH 2003)

Specifically, this model classifies levels of integration based on two dimensions: PC complexity and risk, and MH and/or substance abuse complexity and risk (SAM-SHA–HRSA Center for Integrated Healthcare Solutions). Typically, individuals who fall into quadrant I (low BH/PH) and quadrant III (low BH/high PH) are often served in integrated behavioral health settings, although quadrant III patients may also need specialized medical treatment at times (e.g., emergency room). Individuals who fall into these quadrants (I and III) are often served in integrated behavioral health due to the low behavioral complexity and risk, common mild-to-moderate symptoms and functional presentations. The target for integrated BHPs is to positively impact overall health and wellness with conjunctive medical consultative with these patients and self-management support services. Quadrant I and III may also include of individuals with more serious and persistent mental illnesses dependent on functioning

and presentation. While SBHPs most often serve and are allocated to quadrant II: high behavioral health, low physical health complexity/risk and quadrant IV: high behavioral, high physical health complexity/risk. Individuals who meet these quadrants are often served in specialty MH or reverse integration sites (reverse integration sites are sites which are primary MH and incorporate medical services) due to the common symptoms and functional presentations of persistent and severe mental illness, children and youth with serious emotional disturbances or conduct, co-occurring complex medical conditions, and requiring supportive services of case managers, disease managers, crisis care, inpatient care for medical or MH needs, and/or home health needs. Individuals who meet these quadrants are often served in integrated behavioral health due to the common symptoms and functional presentations of generalized mild to moderate anxiety and depression, and low to high complexity and risk regarding medical health conditions, with evidence of behavioral concerns needing addressing, which will positively impact overall health and wellness and conjunctive consultative and self-management support services. With appropriate assessment and screening of patients' physical, mental, behavioral, and substance abuse symptoms and needs, the most suitable referrals for care may be provided.

Doherty et al. (1996) developed a five-level classification system of mental and physical health-care integration: (1) separate systems and facilities, (2) basic collaboration from a distance, (3) basic collaboration on site, (4) close collaboration in a partially integrated system, and (5) fully integrated system.

Utilizing an imaginary continuum, one can imagine "no collaboration among service providers" on one end and "fully integrated service provision" on the other. No collaboration, of course, represents significant divisions in treatment and service delivery, which each "part" of a given individual treated by a different type of provider, at a different location, with no communication or shared treatment planning among providers. In this case, the PCP may serve as a "gatekeeper," who refers the patient to specialty services (e.g., specialty MH) as deemed appropriate. In some cases, patients may self-refer to SMHPs; in either case, this model is grounded in the limited biomedical model where specialty care is delivered in a disconnected fashion from PC.

With Doherty et al.'s model, moving along the proposed continuum toward increasing integration is "basic collaboration from a distance." This model is similar to the referral model above in that service providers do not routinely share in treatment planning. With this level of integration, however, there is at least basic communication among service providers when needed, although the team members do not share colocated space. Level 3 shares these same aspects of basic collaboration, yet the interprofessional providers are located in the same physical location. Of note, even with shared communication and shared location among providers, these services are still a long way from full integration and reflect more of an SMH model rather than addressing, for example, a patient's behavioral health needs from a functional perspective, or fully incorporating the biopsychosocial model of assessment, diagnosis, and treatment.

As systems move toward increased multidisciplinary IC, one finds models of both partially and fully integrated PC and behavioral health services. These models

represent care provision that is theoretically driven by the biopsychosocial model of care, which emphasizes the reciprocal interactions among a given patient's biological, behavioral, psychological, social, cultural, spiritual, environmental, and economic circumstances, and health-care providers and systems factors in the development, maintenance, and exacerbation of disease and illness. In IC models, PCPs and BHPs are located in the same area of a clinic, and they collaborate and consult in a seamless fashion to provide patients with whole-person primary, behavioral, and MH treatment in a single PC setting. Treatment planning is completed in a collaborative fashion as well, meaning that PCPs, BHPs, and other team members (e.g., nurses, case managers) work together seamlessly to address patients' presenting complaints.

Wagner's chronic care model describes and emphasizes the need for integrated services with respect to chronic illnesses, in particular, depression (Coleman et al. 2009). Recognizing the massive rates and still burgeoning development of chronic physical and mental illnesses in the USA, along with the associated disproportionately high medical costs and utilization, provider burnout, and high rates of patient morbidity and mortality, this model aims to use integration as a means of improving the quality of service provision and even potentially reducing or preventing the exponential rates of chronic illness in America (Bodenheimer et al. 2009). The model is well grounded in systems principles and includes an "informed, activated patient" as a critical component of effective chronic care treatment. The contrast between the outdated model in which a given patient identifies as a passive recipient of medical treatment provided by an expert authority, and the notion of "activated and engaged patients" could not be more stark. Current policy initiatives toward the development of PCMHs in which patients are, quite literally, at the center of care vis-à-vis decision making for themselves and for the health-care systems (Peikes et al. 2011), support Wagner's model.

Patient-Centered Medical Homes

The world of PC was radically changed when the joint principles of the PCHM was introduced in 2007. These principles helped to define the fundamental features of a fully IC team for the delivery of PC services. The PCMH model of care is aligned with person-centered, coordinated, continuous, and comprehensive service delivery, addressing a person's whole health-care needs in a culturally competent manner. The success and proliferation of this model are underscored by the Patient Protection and ACA (ACA 2010), which further led the health-care industry toward health homes and IC coordination. The development of PCMH concepts and integrated health-care services has decreased the delivery of fragmented, siloed care and demonstrated improved patient satisfaction and health outcomes, all while decreasing costs ensuring the commitment and attainment of the triple aim (Paustian et al. 2014). To succeed, these models must establish IC teams of health professionals, care coordination and information sharing, and health information technology for quality improvement and tracking of service delivery (National Committee on Quality Assurance 2014; Matthews 2013).

The PCMH model is based on the premise of comprehensive, IC coordination, and service delivery while maximizing health outcomes. Although not clearly defined by PCMH, the care team is typically described as a partnership, consisted of the patient, the patient's family and/or support network, a personal physician (PCP), mid-level medical professionals, nursing staff, medical assistants, and behavioral team members (inclusive of behavioral health, case managers, dietitians, and/or health coaches). This team advocates for and supports the patient in receiving high-quality, coordinated care from a variety of medical and health professionals working to the full extent of their training. In addition, this expansion to team-based care assists and encourages medical practices to develop and expand the roles of other medical staff members, such as front-office staff to assist in the role of population health management and care delivery. Researchers have found common improvements in the delivery of coordinated care within self-management and outcomes, cost savings and containment, and decreased specialty, emergency room, and hospital admissions (Ackroyd and Wexler 2014; Cooley et al. 2009; Flottemesch et al. 2012; Graham et al. 2014; Nielson et al. 2012; Paustian et al. 2014). The National Committee for Quality Assurance (NCQA) leads practices toward PCMH accreditation, and in 2014, "raised the bar" toward a more refined evolution of practice standards, which emphasized behavioral health's role in PCMH (National Committee on Quality Assurance 2014). Behavioral health team members are becoming even more essential in the medical care team due to their adaptability, flexibility, interpersonal communication skills, and knowledge and application of evidence-based practices, behavioral management, solution focused care, and assessment of biopsychosocial care needs. Team-based care is leading to improved patient outcomes, patient satisfaction, provider satisfaction, and quality of data reporting which may lead to higher levels of reimbursement (Bitton et al. 2012; Korda and Eldridge 2011).

Behavioral Health Providers in Practice

As BHPs engage in collaboration within the health system, their focus is on the mind-body-behavior connection and providing brief, solution-focused assessment, and intervention. BHPs utilize a multimodal approach to assessment and intervention developed with the care team delivery system in mind and focused on effective consultation, health promotion, symptom mitigation, and functional improvement (Hunter et al. 2009; O'Donohue and James, 2009; Robinson and Reiter 2007). BHPs may direct consultative care to the physician, care team, and/or patient. In addition, BHPs may provide individualized and group intervention and assessment. Consultation, individualized, and group care typically include skill development for effective management of medical, behavioral, or emotional difficulties through behavior change plans, lifestyle modification, resource building, and targeted person centered, culturally competent, brief interventions (Hunter et al. 2009; O'Donohue and James 2009; Robinson and Reiter 2007).

BHPs typically demonstrate proficiency and use of the following therapeutic modalities, but not limited to cognitive-behavioral therapy, solution-focused therapy, problem-solving therapy, goal setting, motivational interviewing, mindfulness, relaxation training, biofeedback, rational emotive behavioral therapy, acceptance and commitment therapy, behavioral analysis, and other specific evidence-based treatments (Hunter et al. 2009; Funderburk et al. 2011; O'Donohue and James 2009; Robinson et al. 2010; Robinson and Reiter 2007; Rollnick et al. 2008; Weisberg and Magidson 2014). Therapeutic services within IC typically follow a 30-min session model, averaging 1–4 sessions. These sessions are brief, solution focused, with interventions and communications modeled to support medical team, patient, and family efforts and goals (Beehler and Wray 2012; Funderburk et al. 2011; Hunter et al. 2009; O'Donohue and James 2009; Robinson and Reiter 2007; Weisberg and Magidson 2014). Communications and records within the integrated model are shared among care team members, inclusive of the patient, physician, BHP, and adjunctive medical personnel. Patients are referred by the PC physician or care team member. BHP in integrated settings must rely on skills of flexibility, rapidity, and generalizability.

(Glasgow and Nutting 2004; Glasgow 2010; Goldstein et al. 2004; Hunter et al. 2009).

Therapeutic sessions in integrated behavioral health focus on health and wellness with the physician's medical concerns in context and align with the 5A's of behavioral change in PC (Dosh et al. 2005; Glasgow and Nutting 2004; Glasgow 2010; Goldstein et al. 2004; Hunter et al. 2009). Refer to Fig. 2.3 for the 5As cycle. The 5As cycle, also known as behavior change counseling model, uses five key strategies to support people to manage their identified condition (health and wellness): assess, advise, agree, assist, and arrange. BHPs assess through exploring the patient's knowledge, beliefs, and values related to their health and wellness (Glasgow and Nutting 2004; Glasgow 2010; Goldstein et al. 2004; Hunter et al. 2009). BHPs assess the patient's specific knowledge about their illness and ability to effectively self-manage. Advising encompasses building on what the patient already knows about their health, wellness, and condition. BHPs target risks, health promotion behaviors, and adherence using the patient's own verbiage, avoiding medical jargon, ensuring direct communication, and shared understanding. Joint goal setting and action plans are created with the patient's strengths, confidence, conviction, priorities, and preferences in mind. Utilizing rating scales for assessing importance and confidence in ability to accomplish the plans is an associated intervention, which improves likelihood of accomplishment (Anstiss 2009; Britt et al. 2004; Rollnick et al. 2008). BHPs assist the patient through facilitating discussions surrounding identifying, problem-solving solutions to potential barriers, and identifying supportive resources and people. Arranging is inclusive of setting follow-up of communication with PCP, care team, and/or return with behavioral health, identifying time frame for achieving action plans or goals, and specific support planning (Glasgow and Nutting 2004; Glasgow 2010; Goldstein et al. 2004; Hunter et al. 2009) (Table 2.1).

Specialty care model therapy services often vary from a 45–50-min traditional session with averaging length of service dependent on population served and individualized treatment planning. Therapeutic modalities further include specialties such as, but not limited to eye movement desensitization and reprocessing (EMDR),

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