Social Workers as Behavioral Health Consultants in the Primary Care Clinic

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Since the early days of the profession, social work has recognized the interconnectedness of physical, psychological, and social well-being, leading social workers to adopt a biopsychosocial approach in their work with clients. For many years, this approach has seemed at odds with that of the U.S. health care system, which has primarily operated from a biomedical model wherein pathologies were diagnosed and treated, with limited attention given to the holistic well-being of patients (Dziegielewski & Green, 2004). Furthermore, in the past, mental and physical health conditions were typically treated separately, resulting in a fragmented health care system that has been shown to drive up costs, result in medical errors, and cause many conditions to go unrecognized and untreated (Goodrich, Kilbourne, Nord, & Bauer, 2013).

Efforts to address these systemic problems date back to at least the 1930s, and the passage of the [Patient Protection and Affordable Care Act of 2010](#) (P.L. 111-148) greatly intensified the push for better integrated health care in the United States (Kuramoto, 2014). One response to this emphasis on integrated care has been a dramatic increase in adoption of the patient-centered medical home (PCMH) model of care. PCMHs are primary care settings in which teams of professionals are responsible for meeting the large majority of their patients' health care needs, ranging from preventive care and wellness to management of chronic health conditions (Agency for Healthcare Research & Quality, n.d.). Central to the PCMH model of care is the integration of behavioral health services into primary care settings, which is often facilitated by the inclusion of behavioral health specialists (commonly referred to as behavioral health consultants or BHCs) on the primary care team (Horevitz & Manoleas, 2013).

Although much has been written about PCMHs and behavioral health integration, shifting to this

model of care can be a complex undertaking for any health care team. In this Practice Forum, we provide a detailed account of one health system's efforts to incorporate BHCs into existing primary care settings. We hope that our first-person account of the challenges we have faced and the strategies we have implemented to address those challenges will be beneficial to others working in settings in which this model of care represents a significant practice change. In addition, as our team of BHCs is primarily composed of clinical social workers, we are hopeful that our insights will help advance the profession's efforts to deliver high-quality behavioral health services in primary care settings.

INTEGRATING BEHAVIORAL HEALTH INTO PRIMARY CARE

The integration of behavioral health into the University of Missouri Health System primary care clinics dates back to the mid-1970s; however, early efforts at integration were typically limited to colocation of psychiatrists and psychologists at the primary care site. A major shift occurred in 2012 when the health system agreed to participate in a statewide Medicaid PCMH collaborative, which altered the way payments were structured. Specifically, rather than using a fee-for-service model, Medicaid began providing per member-per month payments for approximately 1,000 high-risk patients. One of the requirements for participation in the collaborative was the addition of BHCs on primary care teams, resulting in the health system's first attempt at truly integrated behavioral and physical health services in the outpatient setting. Four years later, our team of BHCs includes two clinical social workers, one clinical psychologist, and varying numbers of graduate social work interns. These individuals work in collaboration with other members of the health care team, including primary care providers (physicians,

physician assistants, nurse practitioners), licensed practical nurses, nurse care managers, patient service representatives, dietitians, pharmacists, and others.

Defining and Communicating Information about the BHC Role

The primary role of BHCs in our clinics is to help patients make behavioral changes to improve their physical health and overall well-being. Over the years, one of the major challenges we have faced has been communicating our role to other members of the health care team. When BHCs first entered primary care, most of our physician and nurse colleagues had experience working with social workers who provided more traditional medical social services such as discharge planning and identification of community resources. As such, the social workers among us were asked to assist patients with needs that, at least in our particular setting, fell outside of the BHC role (for example, assistance in completing Medicaid applications). Following our early efforts to provide education about the services offered by BHCs in our clinics, we were asked to work primarily with patients who had more traditional mental health concerns, most commonly mood disorders. Many of these patients were in need of more long-term psychotherapy than the brief 15- to 30-minute sessions typically delivered by BHCs. Ultimately, we have found that for true integration to occur we must continually emphasize the ways in which behavioral issues affect all health problems in addition to utilization of health services and adherence to medical recommendations. We welcome the opportunity to meet with patients struggling to manage symptoms of depression or anxiety, but we are equally well equipped to address many other issues in patients' lives that can prevent them from taking an active role in disease self-management. This key idea is communicated to other team members in a variety of ways both formal (departmental in-services and seminars) and informal (face-to-face conversations in the clinic).

We recognize the need to provide information about the BHC role to other members of the health care team on an ongoing basis. This is particularly true for us as employees of an academic health system wherein new medical residents and other learners join our teams each year, in addition to individuals who are hired in response to practice growth and routine staff turnover. The success of our educational efforts has varied widely. Presently, the majority of patients we see are initially connected to us by their

primary care providers. We estimate that about 25 percent of our provider colleagues routinely involve us in patient care in role-appropriate ways. Most of the remainder are likely to seek us out in particularly challenging situations or when they feel "stuck" in their efforts to help patients. Approximately 25 percent rarely ask us to see patients due to a variety of factors, including the limited availability of only a small number of BHCs and provider or patient preference.

Integrating Behavioral Health into the Clinic Workflow

An additional challenge to behavioral health integration has been incorporating BHCs into the established daily workflow of the primary care clinic. The primary tension here has been between the traditional referral model, wherein a patient is scheduled to see a BHC at some point in the future, and the preferred warm hand-off approach, which involves a medical care provider directly introducing the patient to the BHC at the time of the patient's regular appointment (Horevitz & Manoleas, 2013). In our clinics, providers who routinely involve BHCs in patient care seem comfortable with the warm hand-off approach and use it often. Because those providers are the source of most of our patient encounters, we estimate that about two-thirds of our first sessions result from warm hand-offs.

In addition, it is critical that we understand the flow of the clinic and work in such a way that we do not slow down other team members. This can be particularly challenging in clinics with physical layouts that are less conducive to collaboration. In our experience, integration is more easily accomplished in clinics with shared workspaces as opposed to offices and work areas divided by health care discipline. This consideration was one of many that prompted our health system to design its newest and largest outpatient primary care clinic with an open floor plan featuring shared workspaces. Our physical proximity in that setting makes collaborative discussions and warm hand-offs more convenient for providers and patients alike.

Independent of the physical environment, we remain mindful of our colleagues' full schedules when communicating about BHC services. We emphasize that in many instances we can increase provider and clinic efficiency by freeing up physicians who would otherwise be providing patient counseling around topics such as stress management, physical activity,

alcohol consumption, and other health-related issues. We encourage team members who are known to be time management experts to share stories of successful BHC collaboration during staff meetings, emphasizing the positive impact of BHC services on provider efficiency.

We have also found that shadowing other team members can be helpful in identifying ways to achieve integrated care, as well as building rapport with other health care professionals. For example, we may notice that a provider cares for many patients who smoke cigarettes, allowing us to work together to develop strategies to routinely offer smoking cessation services to these individuals. We may learn that another provider's patient panel comprises large numbers of patients living with chronic pain, prompting a discussion about how BHC services can be offered to assist patients struggling with this issue. Simply being present, available, and engaged in the activities of the clinic can go a long way toward supporting integration and teamwork. One of our physician colleagues refers to this as "bumpability," or the likelihood of bumping into a BHC during one's regular workday. Integrating behavioral health into the clinic workflow can be a slow and frustrating process in the beginning, but taking these steps early on can prevent problems that might arise later.

DELIVERING PERSON-CENTERED BEHAVIORAL HEALTH CARE

BHC–patient consultations typically involve brief, focused assessments and interventions (Strosahl, 2005). Treatment modalities commonly used to help patients reach their goals include motivational interviewing, behavioral activation, solution-focused techniques, relaxation training, and cognitive-behavioral approaches, among others (Horevitz & Manoleas, 2013). BHCs may also consult with other health care professionals on the team through formal case conferences and meetings as well as during less formal face-to-face interactions and warm hand-offs of patients while in the clinic. One of the most common reasons BHCs in our clinics become involved in a patient's care is to address barriers to disease self-management, often related to stress and anxiety. The following scenario is a typical one for BHCs in our clinics. A pseudonym has been used to protect confidentiality.

Carol was a 67-year-old retired woman who was seeing her primary care physician to address problems related to poorly controlled type II

diabetes. Although she had received standard diabetes education, her blood glucose levels remained higher than the goal she had set during a previous appointment. She informed her physician that she was struggling to modify her diet as recommended. After learning this information, Carol's physician stepped out of the exam room and located one of the clinic's BHCs, giving him a quick background on the challenges Carol was facing. The physician then introduced the BHC to Carol in a warm hand-off in the exam room. The BHC conducted a rapid assessment, focusing on Carol's interpretation of her health and her readiness to change. Carol stated that she knew it was important to change her diet, but that self-care was not her top priority, given multiple family stressors. At that point, the BHC focused his intervention on helping Carol manage stress more effectively. He and Carol practiced relaxation techniques together and developed specific coping strategies to use when facing stressful family situations. The BHC and Carol then set two follow-up appointments: one for two weeks after their initial meeting, and the other scheduled to coincide with her one-month follow-up with her physician. After these three 30-minute sessions, Carol's blood glucose level decreased; she was better equipped to respond to life stressors; and, perhaps most important, she reported a higher quality of life.

Carol's story illustrates successful BHC involvement in patient care; however, challenges in care delivery are not uncommon. Patients who have received more traditional psychotherapeutic services in the past may expect lengthier and less focused intervention than what they experience when working with a BHC. Preparing patients ahead of time for what to expect can be decidedly helpful in reshaping those expectations. In addition, missed appointments are a common occurrence. Coupling BHC visits with the patient's other appointments appears to reduce the number of missed appointments, and warm hand-offs from other team members remove the possibility of missed appointments altogether. Challenges reported in other settings include handling issues related to prescription medication misuse and abuse, psychiatric emergencies, and aggressive patient behaviors (Robinson & Reiter, 2007). In these situations, consulting with other members of the primary care team and other BHCs is strongly advised.

SUSTAINING BEHAVIORAL HEALTH CONSULTATION

The future of behavioral health integration in the primary care setting is largely dependent on financial considerations (Kathol, Butler, McAlpine, & Kane, 2010). If the BHC model of care is going to be sustainable, then it must be considered a funding priority. The general public, policymakers, and health care payers may benefit from education regarding the value of social work in improving both the health and welfare of patients in general and specifically in the BHC role.

Although there is significant variation based on state policies and payment source, reimbursement is often available for behavioral health consultation with health and behavior assessment and intervention (HBAI) codes, which allow billing for services that target psychosocial factors affecting physical health problems or their management. These codes are distinct from those used to bill for treatment of primary mental health conditions. In Missouri clinics, BHCs must receive specific certification in addition to their professional licensure to be reimbursed by Medicaid for services billed using HBAI codes. It is noteworthy that, at least in our state, Medicaid reimbursement rates are currently 40 percent lower for licensed clinical social workers than for licensed psychologists performing the same services (Missouri Department of Social Services, n.d.), highlighting a potential opportunity for advocacy for reimbursement rate equity. In addition, as previously described, our health care teams currently receive some payment on a per member–per month basis to support population-based health services, including those provided by BHCs. Perhaps more financially significant to the greater health system, however, are the cost savings that have been found to be associated with integrated care (Hawk, Ricci, Huber, & Myers, 2015). Moving forward, BHCs may benefit from greater organizational support if they are able to provide direct, site-specific evidence of cost savings associated with patients receiving BHC services (for example, less frequent utilization of the emergency department or reduced inpatient readmissions) (Monson, Sheldon, Ivey, Kinman, & Beacham, 2012).

CONCLUSION

Social workers are especially suited to be leaders in the integration of health care. The biopsychosocial approach taken by social workers allows us to see the whole person, which leads to consideration of

not only physical health, but also its intersection with mental and social conditions that affect the overall health and well-being of an individual (Golden, 2011). The values and ethics of the social work profession call us to serve and advocate for the most vulnerable members of society, many of whom receive inadequate or fragmented health care. We see behavioral health integration and the role of the BHC in particular as an opportunity for social workers to respond to that call. **HSW**

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