Relation of behavioral health to quality health care

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ABSTRACT

Primary health care provided by an integrated treatment team (e.g., physician, nurse, behavioral health specialist) is becoming increasingly common. This article provides background on integrated care, offers a description of the breadth of behavioral health, and notes institutions such as the Veterans Health Administration in which behavioral health is utilized. We also propose that behavioral health contributes to quality health care and is part of best practices, even as it is provided in a practical and cost-effective way within a medical center primary care setting.

KEYWORDS Behavioral health; integrated care; mental health; multidisciplinary treatment; primary care

Behavioral health (BH) is a broad term referring to treatment for substance abuse disorders and mental health issues¹ and in this article refers to treatment for mental and physical health and lifestyle issues (e.g., obesity, smoking, treatment compliance, risk of self-harm, family dysfunction impacting treatment). The need for integration of BH into medical settings such as family medicine and internal medicine has gained attention in recent decades, although implementation of such integration has proven complex.^{1,2} This article describes BH in greater detail, providing examples of integration models¹ and reprising aspects of a position paper from the American College of Physicians.² We then discuss professional settings in which substantial integration between health and mental health has been achieved. Finally, we provide an example of integration in a department of internal medicine.

MODELS OF BEHAVIORAL HEALTH AND MEDICAL SETTING INTEGRATION

Manderscheid and Kathol provided both the reason for and the models of integrated care, noting that “in its simplest form, integration is present when actively communicating medical and BH providers are colocated, care is coordinated, and collaboration in assessing and treating patients for their total health needs is occurring.”¹ Some medical patients do not need (or want) BH care, but many would be helped by it. The failure to address BH needs may strain patients, families, providers, and payers. So what are the current models of integrated medical and BH care as posited by Manderscheid and Kathol?

The prevailing model (model 1) of medical and BH/mental health care is one of separate services in separate sites, with cross-referral of patients. Physicians and other health care providers often refer patients to BH providers (e.g., psychologists, counselors, clinical social workers). BH providers, in turn, refer their clients to medical providers. Often, however, neither patients nor clients ever follow up on a given referral. Despite its flaws, this model has continued because medical and BH services are typically provided in different locations and with different payer systems.

More recently, “targeted integration” (model 2) has developed, often based on grant funding because of the different payer systems used by medical and BH entities. Grant-supported funding is not a practical long-term payment option but, more important, model 2 is based on the assumptions that patients have either medical issues with “some” BH issues or BH issues with “some” medical ones. Manderscheid and Kathol disagreed with model 2 (as well as with model 1). They proposed a third model in which BH services are integrated fully into the primary care health home, such that integrated medical and BH patient care allow for “information access, communication, care coordination, and continuity.”¹ The authors proposed three broad steps necessary for the implementation of model 3.

Much of what Manderscheid and Kathol recommend is congruent with a very detailed American College of Physicians position paper provided in executive summary form by Crowley and Kirschner.² Six recommendations are detailed in the summary. Two primary recommendations concern the integration of BH into primary care and reducing stigma associated

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with BH. These recommendations are the basis of the current article. Recommendations regarding payment issues, gaps in and barriers to insurance coverage, related research, and training for integrative providers are beyond the scope of this article.

INTEGRATION OF BEHAVIORAL HEALTH AND PRIMARY CARE

“The ACP supports the integration of behavioral health care and encourages its members to address behavioral health issues within the limits of their competencies and resources.”²

Although mental health and substance abuse are two major foci of BH integration into primary care, BH providers can address many additional concerns that impact patient health and health care practices. For example, consider a 48-year-old female patient with poorly controlled type 2 diabetes and hypertension who is introduced by her primary care physician to an on-site BH provider (a warm hand-off) for help in improving her overall compliance (and health). The BH provider sits down with the patient, learning that she is widowed, employed full-time, and cares for three school-aged grandchildren who live with her and their father (her son), who is a long-haul truck driver. The patient sleeps poorly, feels heavy responsibility at both work and home, and has little time for herself. The BH provider supports the patient by acknowledging her importance within the family and stressing that her health impacts the whole family’s health. The provider arranges for the primary care physician to prescribe a diabetes medication requiring only two doses per day rather than multiple daily doses required by the patient’s current medication. The provider persuades the patient to accept various kinds of help from family members such as meals and child care respite. A social worker who consults with the team arranges for the children to receive free lunches at their respective schools. Finally, the BH provider promises to call the patient in 2 weeks to check on her progress, especially her sleep. If sleep has not improved, the primary care physician has authorized a prescription for a sleep aid. The patient will be seen again in 2 months, when BH will check with her and also discuss sleep hygiene.

This integrated team approach is what the American College of Physicians is calling for and what has been sought previously as collaborative and, when possible, collocated care for cancer patients and their families.³ The example above speaks not only to Recommendation 1 of the American College of Physicians executive summary but links logically to Recommendation 6, the other recommendation on which we focus.

“The ACP recommends that all relevant stakeholders initiate programs to reduce the stigma associated with behavioral health. These programs need to address negative perceptions held by the general population and by many physicians and other health care professionals.”²

It is our experience that though top-down programs may educate, a bottom-up approach involving BH professionals within the health care team is more effective. For example, a BH provider can show by example that “mental

illness” (including suicide risk) and substance abuse issues are not “entities” but rather “continua” on which patients fall. Some patients are more reachable and teachable, for numerous reasons, including severity and entrenchment of the disorder (e.g., availability of social support from family and/or friends, willingness of patients to at least consider treatment). Seeing just a few patients who make positive changes in their physical/mental self-health care can truly begin to reduce stigma more broadly. In addition, depending on the health care setting, a grand rounds presentation by BH providers can be influential in increasing understanding and reducing stigma toward patients with various issues (e.g., substance abuse, HIV, suicidal risk).

WHAT IS BEHAVIORAL HEALTH?

BH (with roots in behavioral medicine and health psychology) is a rather new and comprehensive designation that can refer to a provider, a profession, or a patient-centered and often strengths-based clinical orientation of a health care team. Although the BH example in this article refers to psychologists-in-training, BH practitioners can come from fields such as social work, mental health counseling, or marriage and family therapy. The common requirement is a background in delivery of health-related services. There is increasing pressure on physicians and allied health providers to meet patients’ needs in a comprehensive fashion. The “biopsychosocial model” proposed by Engel⁴ in 1977 is finally taking hold due to the swell of chronic illness, whether physical, mental, social, or, more likely, a combination of all three. Thus, BH professionals may come from many disciplines but bring a common core of skills and values to the health care team. This comprehensive approach may be somewhat new to most community health care settings, but it has a longer history in the Veterans Health Administration (VHA).

INTEGRATED CARE IN THE VETERANS HEALTH ADMINISTRATION

The VHA served more than 8 million veterans in 2014,⁵ and it likely serves even more at the current time. It has an integrated health care approach modeled on the patient-centered medical home. In the VHA system it is called a patient-aligned care team. This team embeds a mental health professional in each primary care team, working in collaboration and collocation with a primary care physician. Nurses who work as part of the patient-aligned care team may provide care management, often via telephone contact, to monitor patient progress, assess additional needs, and even incorporate motivational interviewing and other strategies to help patients stay “on track.” Care management facilitates consistent care between appointments and can be seen to reflect a mental health perspective of more frequent patient contacts while minimizing health care costs.

Integrating care reduces the stigma that mental health issues may hold, because comprehensive, integrated care

treats the whole person without a mind-body split. An additional benefit for the VHA is that the demystification of mental health for veterans themselves also holds for the non-mental health members of the collaboration team. Thus, stigma is reduced in the minds of providers as well as for their patients.

BEHAVIORAL HEALTH AND PATIENTS WITH COMORBIDITIES

Writing from the perspectives of a psychologist and a physician integrated into the primary care systems in large university health sciences centers, Fisher and Dickinson⁶ noted that a disproportionate share of medical costs in the United States targets people with chronic medical conditions. That is why they emphasize that effective management of a patient's multiple chronic conditions must be integrated. Integrated care, though proposed from various directions, is a different kind of care than has been employed by most primary care entities. It "requires a different model for the provision of behavioral health services, one focused on brief behavioral interventions and new workflows to facilitate 'warm handoffs' of patients among primary care providers, behavioral providers, and staff members."⁶ Although BH providers can fill multiple roles (e.g., mental health screening of patients; providing group programs for weight loss), even just direct care to patients may involve a range of brief interventions, engagement of family members, etc. The needs have been building for some time, but the accelerations of comorbidities and dawning realization that psychosocial issues affect patients' management of their comorbid conditions has accelerated the need for and justification of integrated care involving BH.

It is apparent that integrated care is not only an aspirational goal for medical settings but an attainable one. The VHA, various military branches, large medical centers, and systems such as Kaiser have implemented integrated care through variants of BH. BH is just as important in smaller and/or regional health centers. An example of cost-effective BH care is described in the following section.

BEHAVIORAL HEALTH IN A DEPARTMENT OF INTERNAL MEDICINE

A model for BH integrated with health care was first developed in a comprehensive cancer center affiliated with both a university's health sciences center and a university/county hospital. Placed in a semirural city with a large catchment area, this cancer center had budget limitations that precluded full-time BH services. The center partnered with the university's general academic campus Department of Psychology to provide doctoral-level psychology students with a BH practicum setting. The students worked for practicum credit only. The psychology department provided a faculty supervisor. This partnering continues today.

More recently, this model was implemented in the resident clinics of the Department of Internal Medicine in the

health sciences center referred to earlier. A psychology department faculty member and the medical director of the internal medicine clinic collaborated to initiate BH services. Internal medicine is the largest department in the university's School of Medicine and has an accredited residency program, which involves a number of training experiences, including assignment of residents to see their own patients one afternoon per week in the resident clinics. This was the place where BH assessment and intervention seemed to be most needed. This partnering began with one psychology doctoral student working one afternoon per week for practicum credit. Psychology provided the supervisor for the student, and the supervisor began working in the clinic periodically. Thus, psychology provided the BH personnel and internal medicine provided the practicum setting.

The team has ranged from four to seven students over several years and provides a relatively consistent presence in the resident clinics. Initially, BH was used primarily for depression, anxiety, suicide assessment, and smoking cessation. More recently, chronic pain, medication compliance, trauma, weight loss (particularly for patients with diabetes, coronary artery disease, and chronic kidney disease), and family assessment for caregiver stress have been added to BH work.

The format is flexible. BH personnel may go in with a resident to see a patient or see a patient while the resident is reporting back to his or her attending physician. Sometimes the BH person sits in on the "reporting" and returns with the resident and then stays behind and talks with the patient. When needed, the patient can make an appointment with BH for follow-up. Brief interventions at the time of the initial appointment are most typical, with referrals provided to low-cost or no-cost providers of longer-term psychotherapy. However, given the uncertainty of patient follow-up and provider availability, BH follow-ups are increasing. An important part of the process is BH reporting back to a resident with the clinical impressions and intervention for a given patient. This is still a work in progress, but it is an extremely important aspect of continuity of care. Although relationships with residents and attending physicians are important, also important to BH personnel are positive connections with the nurses and all internal medicine physicians (e.g., pulmonologists) and staff. BH team members are also internal medicine team members.

Progress has been made, but more remains to be accomplished. It is essential to keep talking with the interns, residents, and attending physicians about the always-evolving BH skill set. Implementing and expanding BH patient services within a constantly evolving health care system, payer system, and larger culture is a challenge. However, it can be implemented where partnering opportunities exist between a medical center and a local university or college with appropriate graduate programs (e.g., psychology, social work) that have a BH emphasis. Students receive valuable frontline training, and the health system

receives valuable integrated patient care, increasing quality health care and best practice.

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