Chapter 1

The Primary Care Behavioral Health Model: The "Why Now?" and "How?" (Updated!)

"I'm in favor of progress; it's change I don't like."

Mark Twain

Abstract

This chapter details the challenges our healthcare system is facing in both the primary care (PC) and mental health (MH) sectors, in order to develop the rationale for integrating primary care using the Primary Care Behavioral Health (PCBH) model. The model is also outlined, using the GATHER acronym, and its population health framework is explained. The chapter also reviews important related movements and innovations in healthcare that have influenced development of the PCBH model.

Keywords

Access, antidepressants, behavior change, barriers to mental health care, , history, mental health gap, economic angle, mental health providers, on-demand access, pediatric services, primary care behavioral health model, specialty mental health, model for integrating behavioral health, lifestyle, sub-threshold conditions, prevention services

Both of us authors still remember when we worked in traditional specialty mental health (SMH). Like most mental health providers (MHPs), we worked hard, kept up on clinical

innovations and had the best interests of our clients at heart. We had clients who progressed and many who appreciated our assistance. However, we could not help but wonder what happened to clients who failed to show. On a typical day, we might have seven clients scheduled, of which two or three would not show. What happened to them? Why didn't our follow-ups return? If first time clients failed to show, we rationalized that the client was not ready for change; but was that really the case? Further, we felt frustrated that, by the end of the day, we might have only seen a handful of clients, many of whom were weekly regulars. This begged the question: How many people were we really helping?

Meanwhile, as we eventually learned, primary care providers (PCPs) were having a very different experience treating MH concerns. They were asking questions as well, such as: Why do so few patients referred to MH follow through on the referral? Why are so many "psych" patients coming here when a system already exists to tend to their needs? How can we get patients with chronic conditions like diabetes to manage their condition better? How can a PCP be expected to meet all of the "mental and physical" health needs of every patient with a 15-minute visit?

What we learned, and what is still true today, is that the MH system in this country simply does not meet the needs of the population, and PC has been left to pick up the slack. The pandemic years, rife with isolation, stress, and disruption in all areas of life, exacerbated and spotlighted this problem. Mental health problems surged far beyond the capacity of the MH system, leading more and more people to look for help from a PCP

(or to simply go without help). But even before the pandemic, PC had challenges treating behavioral issues. Overwhelmed by the demand for care, underprepared and under-resourced for many of the problems seen, and often unable to access timely specialty help, PC is a busy and stressed system. All of this has led to the question: Is there a better way?

This book aims to help provide a better way. The chapters that follow are a guide for changing how PC is delivered, to both make PC better and get help to more people whose health is compromised by behavior. The focus of the book is on the Primary Care Behavioral Health (PCBH) model, an approach to integrating MHPs into PC settings that changes how MHPs practice, how PCPs practice, and how they work together for the health of the population. As noted by Strosahl (1998), an early developer and proponent of PCBH, this model is best considered a new way of providing health care (specifically primary care) rather than MH care. The model involves a team approach to the care of behavioral issues, with MHPs functioning as regular members of the PC team and practicing in ways that synchronize with the goals and practices of PC. As the name indicates, it is behavioral health practiced like PC.

The general rationale for integrating PC and MH has been discussed thoroughly in other texts, starting in the late 1990s (e.g., Belar & Deardorff, 2009; Blount, 1998; DiTomasso, Golden, & Morris, 2009; Frank, McDaniel, Bray, & Heldring, 2004; James & Folen, 2005; James & O'Donohue, 2009; Patterson, Peek, Heinrich, Bischoff, & Scherger, 2002). Thus, the bulk of this book focuses on *how to* integrate. Specifically, this book

explains how to implement and sustain integration using the PCBH model. This is first and foremost a pragmatic book written with frontline clinicians in mind.

We begin this chapter by outlining the problems that our healthcare system faces in both the PC and MH sectors. Understanding the problems with the current system is essential preparation for taking a fundamentally different approach. One by one, the problems help us not only understand the need for integration, but also the need for the specific type of integration the PCBH model provides. Following that discussion, we introduce the PCBH model.

1.1 Stressed Patients in a Stressed System

At the time of this writing, the population of the United States of America is 336 million. Around 32% of these American adults have a diagnosable substance use and/or psychiatric disorder (Substance Abuse and Mental Health Services Administration, 2022) and 50% will experience a diagnosable disorder at some point in life (Kessler, Berglund, Demler, Jin, & Merikangas, 2005). Among children, 16.5% have a diagnosable MH disorder (Whitney & Petersen, 2019). Reflect for a moment on this - that is a lot of people! What happens to all of these people?

Information about the trends and factors related to MH care utilization in America is lacking, but a few data points are eyebrow-raising. For one, around 55% of adults with a

psychiatric disorder report receiving no care (Reinert, Fritze & Nguyen, 2022) and 94% of people with a substance use disorder receive no treatment (SAMHSA, 2022). The picture is no better with youth, as half of the children with treatable MH problems receive no care from a MHP (Whitney & Peterson, 2019). Thus, we can unfortunately say that most people with MH and substance use problems do not receive treatment.

When people do receive treatment, there's a very good chance they get it not on a therapist's couch but from a PCP's exam room. Only 5% of the U.S. population will see a therapist during a given year and 3.6% a psychiatrist (Johansen & Sticker, 2022). Instead, about 76% of all outpatient MH treatment in the U.S. is delivered by PCPs (Olfson, Wang, Wall, Marcus & Blanco, 2019). Half of pediatrician visits, and 25% of visits with other PCPs, involve behavioral, developmental, emotional, educational and/or psychosocial concerns (Martini, Hilt, Marx, Chenven, Naylor et al., 2012) and 16% of adult PC visits are for treatment of a MH concern (Rotenstein, Edwards & Landon, 2023). The number of PCP visits for anxiety, depression and other MH conditions, and the number of psychotropic prescriptions from PCPs, have consistently far outnumbered those of other physician specialties, including psychiatrists (Jetty, Petterson, Westfall & Jabbarpour, 2021). Even severe persistent mental illness (SPMI) is commonly treated in PC. Almost a third of SPMI care is done by PCPs (Jetty et al., 2021).

These basic statistics upend the notion many have about where and how MH problems are treated in this country. Generally speaking, a person with a MH and/or substance use

concern will most likely either go untreated or will receive care from a PCP. Primary care (PC) treats the full spectrum of psychiatric disorders, from depression to substance abuse to psychosis. They regularly handle chronic psychiatric problems as well as acute flare-ups (e.g., a suicidal patient). Because they provide care across the lifespan, PCPs treat child behavior problems in addition to the problems of adults and older adults. Of course, they must do all of this while also tending to the medical needs of their patients. A PCP must truly be a generalist! For all of these reasons, PC long ago earned the label of the country's "de facto mental health care system" (Regier et al., 1993), and it is a label that still fits today.

Box start

Takeaway: Integrated care must be designed for a high patient volume.

Box stop

Thus, one reason to integrate MH services into PC is to help meet the demand for care there. Another reason lies with the large number of people who receive no care. More than 70% of adults and 85% of children in the US have a regular PCP (Jabbarpour, Jetty, Byun, Siddiqi, Petterson et al., 2024). Visits with PCPs comprise about half of the nation's 1 billion healthcare visits each year (Santo & King, 2019). It stands to reason then that many if not most of the people going without MH care will enter the PC system at some point for some issue. They might only seek help for a sore throat or a work physical, rather than for psychiatric or substance abuse problems, but the point is that they do enter PC.

Much of the time, these patients pass in and out of the clinic without the psychiatric problem being detected. For this reason, screening in PC is commonly recommended for a whole host of behavioral concerns. The United States Preventive Services Task Force (USPSTF), whose recommendations are typically followed closely by PC clinics, recommends screening both youth and adults for depression, anxiety, alcohol use, drug use and many other problems. However, many clinics struggle to do this. For example, only 3% of adults are screened for depression in PC (Bhattacharjee, Goldstone, Vadiei, Lee & Burke, 2018) and screening for substance use "rarely" occurs (McNeely, Kumar, Rieckmann, Sedlander, Farkas, et al., 2018).

An additional challenge is that screening alone is insufficient. Most screening recommendations for behavioral issues come with the caveat that screening needs to lead to an intervention for any patient screening positive, but that is not feasible for most PCPs to do on their own. However, adding an accessible MHP to the team could help to both refine screening practices and ensure the availability of an intervention. Thus, a second reason to integrate is to increase a clinic's ability to identify and provide care to patients who would otherwise slip through the cracks of a broken system.

Box starts

Takeaway: Integration must improve identification of unidentified problems.

Box ends

Yet, improving care for psychiatric problems is not the only reason to integrate a clinic. Behavior interferes with health in many ways, and the consequences show up in PC patients in many ways. To illustrate this, we often have new behavioral health consultant (BHC; we explain this term later in the chapter) trainees review the daily patient schedule of a PCP, with the goal of finding possible behavioral components to the problems patients are presenting with that day. For example, the patient seeing the PCP for headaches might be stressed or skipping meals; the patient presenting with stomach pain might be drinking alcohol to excess; the patient complaining of dizziness might be having panic attacks. There is even a behavioral component to the common cold, in that frequent hand washing helps prevent it! The point is that health and behavior are so intertwined that it can be difficult to find any medical visit that does not involve behavior in some way. A behavioral influence is most notable in four types of patient concerns: 1) lifestyle-based somatic complaints, 2) sub-threshold syndromes, 3) preventive care, and 4) chronic disease management.

Somatoform disorders and medically unexplained symptoms are more common than generally assumed and require a lot of time in PC (Haller, Cramer, Lauche, & Dobos, G. (2015). Lifestyle-influenced somatic complaints include concerns such as irritable bowel syndrome, tension headaches, insomnia, and chronic pain. In a classic study of these complaints, researchers demonstrated that, of the 14 most common complaints in a PC clinic, 84% had no clear organic etiology over a 3-year follow-up period (Kroenke & Mangelsdorff, 1989). In other words, these symptoms were likely the result of stress

and/or lifestyle. Because these conditions are experienced as physical symptoms, patients often view them as medical problems and thus seek help from a PCP rather than a MHP. Obesity is another lifestyle-influenced somatic issue that PCPs confront almost hourly, especially in the new era of weight-loss medications. Adult patients increasingly ask PCPs for these medications, and on the pediatric front new guidelines for obesity impel PCPs to aggressively manage weight issues in children starting at age two (Hampl, Hassink, Skinner, Armstrong, Barlow et al., 2023).

The second category of sub-threshold syndromes includes marital conflict, intimate partner violence, bereavement and other life stressors. These are problems that do not meet the "threshold" of a DSM diagnosis, but are nonetheless problems that may take a significant expenditure of PCP time and energy. For example, conservative estimates indicate 12 to 23% of patients in family medicine have experienced intimate partner violence in the last year (Cronholm, Fogarty, Ambuel, & Harrison, 2011), and such patients utilize 1.3 to 2.6 times as much health care (Ulrich et al., 2003).

Preventive care is another area where PCPs spend a lot of time and energy, mostly involving counseling patients on healthy behavior change. Genetic factors clearly influence one's risk of developing cancer, stroke, diabetes and myriad other health conditions, but lifestyle also plays a role. Thus, PCPs end up regularly helping patients make healthy lifestyle changes. They educate, support, counsel and sometimes prescribe to help patients quit tobacco, eat healthy, get regular physical activity, and minimize or

stop alcohol and drug use. They also teach younger patients to use seat belts, bike helmets and contraceptives and help them avoid high-risk sexual behavior. Unfortunately, though, PCPs commonly report feeling under-trained for this part of their work (Horwitz, Storfer-Isser, Kerker, Szilagyi, Garner et al., 2015) and they also would need 14 hours per day to do all the prevention that is recommended (Porter, Boyd, Skandari & Laiteerapong, 2023)!

Behavioral issues also arise in patients with chronic diseases, the major causes of morbidity and mortality in the world (Reynolds, Dennis, Hasan, Slewa, Chen et al., 2018). Primary care originally focused mostly on treating acute problems, but over the last few decades, care for chronic conditions has fallen more than ever to PC. This change is due to several factors, including an aging population, an increased incidence of conditions such as diabetes and lipid disorders, and medical advances that allow people to live longer with diseases that would have been fatal in earlier years. The rise in chronic conditions means that PCPs must spend more time help patients learn to manage them. They must regularly educate patients about chronic condition care, help them implement self-care routines like checking blood glucose or using an inhaler, and also support patients in making lifestyle changes to get conditions under control. As with preventive counseling, though, PCPs tend to feel under-prepared for helping patients make such changes (Horwitz et al., 2015) and they would need over seven hours per day just to do all of the chronic care activities that are recommended (Porter et al., 2023).

Box start

Takeaway: Integration must help with any health condition affected by behavior.

Box ends

The challenge of responding to all of these behavioral issues in PC may be reason enough to integrate services. Yet, there are other reasons why integration is so crucial. For one, PCPs simply cannot go it alone. Primary care is a very busy place, and a very stressed system.

Imagine you are a PCP seeing a patient who is brand new to your clinic. The patient reports having diabetes, hypertension, high cholesterol, depression, sleep apnea, and chronic pain. The patient also tells you he has been off all of his medications for a few months, and can't recall the names of most, nor the dosages. He is coming in now because he has not been feeling "right" and thinks his blood sugar is "off." You call an endocrinologist the patient saw a year earlier (the patient recalled the name, but you had to find the phone number), but after 20 minutes the endocrinologist still has not called you back. You were 30 minutes behind at the start of the visit, and need to see three more patients in the next hour before lunchtime.

If this scenario sounds unrealistic, it is not; if it sounds unworkable, it very nearly is. The reality is that scenarios like this play out every day on the schedule of most any PCP. With an average visit length of 18 minutes (Neprash, Everhart, McAlpine, Smith, Sheridan & Cross, 2021), many PCPs see 20 or more patients a day, and many of those patients present with multiple and/or complex problems. A multitude of administrative

tasks also fall to PCPs. Believe it or not, PCPs spend more time on administrative tasks than they do in patient visits (Tai-Seale, Olson, Li, Chan, Morikawa et al., 2017)! Such tasks include reviewing labs, refilling medications, returning phone calls to patients or other providers, reading consult reports, and many others. Primary care is a very busy place, and quite often there is little time for anything but the most urgent concerns.

The entire PC team also experiences challenges like these. Medical assistants (MAs), RNs and lab technicians also operate under a time crunch and in some cases they bear the brunt of complaints from disgruntled patients who may be reluctant to complain to the PCP. Similarly, receptionists and other administrative staff must often interact with patients displaying psychotic, anxious otherwise difficult behavior; and referral coordinators must try, often in vain, to locate accessible specialty services. We often have new BHCs spend 30 minutes in the waiting room of the clinic, observing the patients and patient interactions with front desk staff, to give them insight into the challenges staff manage. Almost inevitably, there will be a disagreement over a bill, frustration with a lengthy wait, and questions beyond the realm of what the staff are able to answer. Such scenarios can be taxing and they place additional strain on a PC system that is already taking on more than it can handle.

Like it or not, it’s also true that when patients present to PC for treatment of a MH problem, it can add to the stress level. Visits for MH concerns take twice as long as visits for other acute or chronic concerns (and longer if the MH concern emerged spontaneously during a visit; Cooper, Valleley, Polaha, Begeny & Evans, 2006), which

can make it difficult for a PCP to stay on time for subsequent visits. If patients with complicated MH problems reliably accessed the specialty care system, perhaps the situation would be improved. Primary care is supposed to be the entry point for treatment of any non-urgent problem, with the specialty care system standing by to accept those who fail to improve. This is the intended plan for all manner of health issues, including MH problems. Unfortunately, as noted earlier, PCPs all too commonly find that patients either cannot or do not access specialty MH.

Adding insult to injury, PCPs have also not been compensated as well as their specialist colleagues. They are consistently among the lowest paid of all physicians (Bureau of Labor Statistics, 2023). In comparison to their peers, PCPs are a classic example of "overworked and underpaid." Perhaps not surprisingly, all of this has resulted in a shortage of PCPs nationwide. Medical students have been avoiding entering PC, and seasoned PCPs are retraining or retiring early (Jabbarpour et al., 2024). There are challenges in PC that are going to take a while to fix.

The important point from this discussion is that any attempt at integration must aim to reduce the burden on the PC system. Integration efforts that add more work to the overflowing plates of PCPs and other team members are doomed to fail (Bowman, Seehusen & Neale, 2018). Behavioral health providers who practice in PC without understanding the system's stresses, or who choose to ignore them, risk being viewed as irrelevant at best and a nuisance at worst. Integration must help not only patients, but also the PC system, to function better.

Box starts

Takeaway: Integration must subtract from, not add to, the workload of PCPs.

Box ends

In addition to a lack of time, PCPs also report feeling underprepared for managing many behaviorally influenced problems. In a typical 3-year family medicine residency, the "psychiatry" rotation lasts just one month. Many residents assume they will rarely need to manage complex behavioral issues and that they will be able to reliably refer to therapists and psychologists, only to learn after residency that much of what they must help patients with involves behavior and that specialists are largely unavailable.

Not only is the quantity of training insufficient, but the quality often is also (Horwitz et al, 2015). Almost every PCP, when working with a patient's behavioral issues, has at some point uttered, "My training never prepared me for this!" A large percentage of family medicine residents report a "lack of self-perceived competency in cognitive behavior therapy, psychopharmacology beyond basic antidepressants, and application of basic counseling skills" (Zubatsky, Brieler & Jacobs, 2017). Worth noting as well is that the typical training of other team members (e.g., RNs, MAs) and of non-physician PCPs such as nurse practitioners is similarly lacking in behavioral training, if not more so.

Box starts

Takeaway: Integration must help PCPs improve behavior change skills.

Box ends

At the risk of stating the obvious, we must note that patients are also often not well-served by the current system. As indicated earlier, many if not most psychiatric problems go undetected in PC. When one is detected, treatment often does not follow recommended guidelines and results in subpar outcomes (Maund, Moore, Dowrick, Geraghty, Dawson et al., 2019; Olfson, 2016). Tellingly, a recent large-scale survey found that 87% of patients who received MH or substance abuse care from a PCP alone felt they needed additional help from a specialist (Sky, Wells, Yuhas, Raines, Bowman & Harbin, 2023).

Common problems in PC include poor follow-up and tracking of care, inappropriate prescribing, over reliance on medication treatment, under-use of medication, and a lack of communication with outside providers (Colaiaco, Roth, Ganz, Hanson, Smith et al., 2018; Maund et al., 2019). To be clear, these findings are not indictments of PCPs; they are, instead, the results of a system that is broken for both patients and PCPs.

Box starts

Takeaway: Integration must improve care outcomes in PC.

Box ends

One aspect of PC worth a closer look is its heavy reliance on psychotropic medications. For several reasons, patients seeking help in PC for emotional or behavioral concerns are

highly likely to walk out the clinic door with a prescription. Patients often specifically request medication, PCPs short on time may find prescribing an efficient means of helping, and clinical guidelines commonly encourage medication treatment. However, it's debatable whether all of that prescribing has actually improved population health and it may even contribute to the stresses in PC.

The case of antidepressants provides a good example. A 400% increase in antidepressant use occurred from the mid-1990s to the early 2000s in the U.S., making antidepressants the third most prescribed class of drugs at that time. Around 10% of the population aged 12 or older were using an antidepressant in 2008 (Larura, Debra & Gu, 2011). Fast forward to today, and more than 13% of American adults now use an antidepressant (Brody & Gu, 2020). The vast majority of increased antidepressant use is attributable to increases in prescribing by PCPs that started with the introduction of SSRIs in the 1980's (Wang et al., 2005). The lower side-effect profile of the SSRI's allowed them to be more easily utilized by PCPs.

Yet, despite the popularity of antidepressants, some highly credible large-scale reviews have drawn the conclusion that they are no or only minimally more effective than placebo (Kirsch, Deacon, Huedo-Medina, Scoboria, Moore et al., 2008; Levkovitz, Tedeschini & Papakostas, 2011). Similarly, the vast expansion of antidepressant use has not shown clear gains at a population level. The prevalence of mood disorders and symptoms has not decreased in industrialized countries, despite substantial increases in the use of antidepressants (Jorm, Patten, Brugha & Mojtabai, 2017). Suicide rates in the US have

risen by about 35% since 2000 (Centers for Disease Control and Prevention, 2024). Even polling shows Americans' self-reported MH is at a new low, with just 31% saying their MH is "excellent" (down from 43% two decades earlier; Gallup, 2022). On a positive note, a recent large study showed that serious psychological distress has declined in the U.S. since the early 2000s; however, the decline has actually been smaller among adults receiving MH treatment compared to those not receiving treatment (Olfson et al., 2019). The use of mood stabilizers has also increased significantly (Olfson et al, 2019), a point which seems relevant because when a patient doesn't improve on an antidepressant, a mood stabilizer is often added.

A reasonable alternative to the heavy use of antidepressants would be a strong dose of behavioral interventions, but as noted earlier, most PCPs have neither the time nor the training to provide detailed behavioral guidance and specialty MHPs are hard to come by. Recall that just 5% of the US population receives therapy in a given year (Johansen & Sicker, 2022) even though 32% have a diagnosable substance use and/or psychiatric disorder (Substance Abuse and Mental Health Services Administration, 2022)

This discussion is relevant to integrated care for a few reasons. First, all of this prescribing takes considerable time, and time is not something PC has a lot of. As noted earlier, visits for MH concerns in PC last twice as long as other visits, and multiple follow-up visits are common in order to titrate dosage, manage side effects, monitor for adverse effects and track treatment response. If non-medication interventions were instead available and utilized, the time saved for the PCP could be used for other health

concerns or other patients. Second, if outcomes with medication-only treatment are in fact insufficient, using non-medication evidence-based behavioral interventions (either in addition to or instead of medication) might boost outcomes. Improved outcomes could, in turn, reduce overall use of services. In order to have a chance of reaching these goals, though, a new team member will be needed who can offer readily available help to either augment or replace the medication option for a large volume of patients.

Box starts

Takeaway: Integration must offer an efficient,

high-volume alternative and/or augmentation to medication.

Box ends

1.2 The Economic Angle

We've focused so far on outlining the clinical and workforce drivers of integration, but there is another powerful driver: economics. The problems of untreated and under-treated behavioral concerns, as described above, are costly to the system. An analysis of 21 million insured lives in the U.S. found that the most expensive 6% of individuals with behavioral conditions accounted for 44% of all healthcare costs (physical and mental healthcare costs combined). That's rather remarkable. Annual healthcare costs in this group averaged $45,782. However, the even more remarkable statistic is that half of these individuals had less than $95 per year of total spending on MH treatment (Davenport, Gray, Melek, 2020).

Data like this, which are similar to other earlier reports (e.g., Davenport, Matthews, Melek, Norris & Weaver, 2018), beg the question of whether getting more MH care to patients could bring down total healthcare costs. At the individual level this plays out on a regular basis in clinic. An example is the patient with poorly controlled diabetes whose frequent PCP and specialist visits decline considerably when a previously unidentified problem with depression is identified and treated successfully.

If integrated care can improve the identification and treatment of MH conditions in PC, it can reduce costs by 9-17% (Davenport et al., 2018). That would be a win for patients and it also makes integrated care very attractive to payers and healthcare administrators. The catch: integration needs to be done in a way that actually does improve identification and treatment of problems. If integration results only in more MH care for people who likely would have accessed it anyway (i.e., motivated, resourced, health-literate patients who seek out MH care), or if the integrated MH care is not effective, then integration likely will not live up to its economic potential.

Box starts

Takeaway: Integration may lower costs if it gets effective care to more people.

Box ends

1.3 The Challenges in Mental Health: Barriers, Barriers, and More Barriers

A big question looming over the above discussion is, “Why don’t more people simply go to MH?” When we authors ask audiences for their answers to this question, the most frequent answer we get is that there is a shortage of MHPs. Many experts do believe there is a shortage of MHPs (Health Resources & Services Administration, 2024; Hoffmann, Attridge, Carroll, Simon, Beck et al., 2023) and various initiatives are in the works at the time of writing to remedy this.

However, integrators will be well served by a more nuanced understanding of the many barriers to MH care utilization because the reality is that many factors that inhibit or prevent patients from utilizing MH actually stem from the way MH is practiced. Thus, if MHPs enter PC and practice the same way they always have, then they are likely to get the same results they always have – that is, they will not meet the need.

One of the biggest obstacles to MH care utilization is that, as noted earlier, most patients with diagnosable problems do not actually seek care anywhere. Research shows that those with less serious problems often do not see a need for MH care, or perceive a stigma to MH care, or believe that treatment will not help (sometimes based on past experience). They also often expect that problems will improve without care. More severely impaired patients are often deterred by structural barriers; they anticipate difficulty obtaining appointments, trouble getting to appointments, uncertainty about where to go for care, problems paying for care, or a belief that treatment will take too long and be inconvenient (Mojtabai et al., 2011; Cunningham, 2009).

But given that, as mentioned earlier, so much of the population visits PC during a given year, we can fairly assume that regular opportunities exist in PC for reaching many people who otherwise would not seek MH help. If a behavioral issue is identified, though, these patients are not likely to keep a scheduled visit at a later date with a specialty MHP or even a BHC. The typical process of referring a patient who must then wait for an intake (and complete the intake) before starting care will be a major barrier for many of these patients who, after all, were not even seeking MH care in the first place. However, such patients might agree to be seen if a visit can be arranged efficiently and easily during or immediately after a PCP visit (Ogbeide, Landoll, Nielsen, Kanzler, 2018).

Box starts

Takeaway: To maximize reach, integrated care must prioritize on-demand access.

Box stops

In cases where a patient does seek care for MH problems, as noted earlier, most of the time such care is sought in PC. Many patients are reluctant to trust anyone other than their PCP, and as such will resist any referrals to specialty MH (Olfson, Kroenke, Wang & Blanco, 2014). Sometimes referrals even cause problems in the relationship between the PCP and patient because the patient interprets it as a sign the PCP has given up or does not want to deal with the patient's emotional health (Patterson et al., 2002). Older patients (i.e., over age 60) are particularly unlikely to accept a referral to specialty MH

(Byers, Arean & Yaffe, 2012). Other patients who seek care in PC do so not for the MH problem per se. Instead, they seek relief from the physical manifestations of stress, such as headaches, fatigue or insomnia, but not the stress itself. Such patients may simply not see any reason for a MH referral (Dong, Salamanca, Medina, Firpo-Greenwood, Carter et al., 2020).

For these patients, the more different a visit with a BHC looks and feels from a PCP visit, the less likely they may be to engage with the BHC. For example, visits conducted outside of the usual exam room area, requiring extensive paperwork before being seen, or documented separately from other care run the risk of appearing different and raising resistance to care.

Box starts

Takeaway: Integrated care should look and feel like PC rather than MH.

Box stops

Other patients are in fact motivated for specialty MH care and have the resources for making that care happen. But even these patients run into access barriers, as they often find waitlists for care measured in weeks rather than days. As noted earlier, some will blame this on a shortage of MHPs, but there is no doubt that the structure of MH care also plays a role. The one-size-fits-all approach taken by most MH clinics (wherein hour-long appointments are utilized for all patients), and treatment plans that last for months or even years, results in rapidly booked schedules with long waits for new patients. In many

systems, initial appointments – once they do arrive – often involve merely an intake assessment, perhaps conducted by a technician who then schedules yet another appointment a few weeks off with a therapist or prescriber, if needed.

This lack of timely access to MH care ironically flies in the face of what most MHPs know about the process of change; namely, that readiness to change can occur quickly and unpredictably. When faced with a problem health behavior, many people linger for months or years in a contemplative or pre-contemplative stage of change before something rather suddenly boosts them to preparation and/or action (Rollnick, Miller, & Butler, 2007). Providers in PC witness this regularly, such as when a longtime smoker suddenly expresses a desire to quit cigarettes after developing bronchitis. Patients are most likely to seek help during a crisis or when anxiety about a problem is heightened and are less likely to return for care when distress lessens (Brown & Jones, 2005). A system that forces patients to wait weeks for an initial appointment will often miss opportunities to help.

Box starts

Takeaway: Long visits and protracted follow-up must be avoided to enable access.

Box stops

Of course, some patients do manage to access the specialty MH system. Yet, for these patients too, utilization often runs into barriers. Although most therapists and patients (and referring clinicians) anticipate that engaging MH means completing a long-term

course of therapy, the reverse is more likely to be the result. It has long been known that the modal number of therapy visits in specialty MH is just one (Brown & Jones, 2005). The mean number of therapy visits per patient, about eight in the last large-scale study we could find of this, is also less than one might expect (Olfson & Marcus, 2010).

There are many reasons why patients often complete less care than planned. In some cases, patients feel like they get what they need in fewer visits than expected. In other cases, the barriers cited earlier might be factors (i.e., transportation barriers, lack of time, etc.). For other patients, though, practices considered essential to developing a healthy therapeutic relationship can actually drive patients away. For example, patients who arrive late for a therapy appointment are commonly denied a visit, in order to punish the bad behavior and reinforce the importance of the therapy hour (and/or because of a belief that visits less than an hour cannot be productive). Patients who repeatedly miss appointments might be terminated from care, the thinking being that they are not ready for change and the therapist's time would be better spent with someone more ready (perhaps also with the thinking that terminating therapy will be a "wake up call" that jolts the patient into change). For similar reasons, patients may be terminated if they fail repeatedly to follow-through on the MHP's recommendations.

But while these may be helpful practices for patients who are highly invested in therapy, they can be an obstacle to care utilization by other patients. The "punishment" of a therapy visit being withheld for bad behavior is only meaningful if the patient values the therapy visit to begin with. Such practice behaviors may not cause obvious problems in

specialty MH because MHPs can typically select the patients they want to help. Demand is strong for their services, so if patients are terminated or driven away by the punishment of denied visits, there will be others to fill the therapist's schedule. But if a goal is to reach patients who otherwise would not access care, practices such as these can be counterproductive. (In addition, PC is a safety net for patients and is built around long-term patient-provider relationships, so terminating care for any reason is rare; see Chap. 2 for more on this).

Box starts

Takeaway: Integrated care must be wary of

the rigid boundaries/rules established for motivated therapy patients.

Box stops

Given all of the challenges of accessing and continuing in MH care, who exactly does engage in specialty MH care? Ideally, it would be those with the most need; that is the way healthcare is intended to operate. Primary care is intended to be the first stop for care of most problems, with the specialty care system reserved for patients PC is not able to help. When a patient has a rash, for example, the first stop for treatment is not usually a dermatologist; it is usually a PCP, who can refer to dermatology if the rash does not improve with their care. This is why there are about 300,000 PC physicians and only 13,000 dermatologists (American Medical Association, 2021) in the U.S. Most rashes can be treated in PC, so dermatologists are not needed in large numbers.

This "stepped care approach" (detailed later in this chapter) wherein PC is the first step and patients are stepped up to specialty care when needed is used not only with dermatology, but with all other specialties – except for MH. Historically, MH has operated in a silo, set apart from the rest of the healthcare system in virtually every way, and as a result it does not fit neatly into the stepped care approach used for other specialties. The MH system is frankly less of an organized "system" and more of the wild, wild West, with people accessing it in any number of ways (often outside of a third-party payer), little if any quality oversight, and communication with other healthcare providers a rarity (Matthews, 2021; Pincus, Scholle, Spaeth-Rublee, Hepner & Brown, 2016).

Thus, it probably comes as no surprise that MH care is commonly used by the most functional and the most advantaged groups. Patients who have generous insurance (or can pay out-of-pocket), reliable transportation, and better support such as childcare or flexible work hours, are often the ones obtaining MH care (American Psychological Association, 2018; Bishop, Press, Keyhani & Pincus, 2014). One large, classic study showed that one-third of patients receiving specialty MH care have no diagnosable disorder (Wang et al., 2005)! More recently, a 2019 study showed that while the use of MH care increased over the previous 14 years, the increase was almost completely the result of outpatient MH care by persons with less serious or no psychological distress (Olfson et al., 2019). Rather than serving those with the most need, as would happen in a stepped care approach, the specialty MH system commonly serves those with the least need while those with the most need end up in PC (or get no care at all).

Reflecting back to the beginning of this chapter, we noted that the goal of the PCBH model is to change how PC is delivered, in order to both make PC better and get help to more people whose health is compromised by behavior. Hopefully by this point the rationale for these goals is becoming clear. There is a need to get more behavioral care to more people, but we cannot count on the specialty MH system to do that. Primary care does far better with reaching people, but it is saddled with other challenges and needs help. Thus, integrating a MHP into PC makes sense as a starting point for reaching the goals we have laid out. However, even in PC a MHP can end up seeing only the most functional patients, or those from the most favored groups, if they continue to practice the same way they would in specialty MH. Merely being located in PC is not enough for a MHP to avoid re-creating the many access barriers of the MH system.

Clearly, a better way is needed; a better way for PC to operate and a better way for MHPs to practice. We believe the PCBH model, a model designed with all of the above "Takeaways" in mind, offers just that.

1.4 The Primary Care Behavioral Health (PCBH) Model

This book provides a highly detailed description of the PCBH model, implementation and training materials for it, strategies for expanding and evaluating it and guidance on how to address implementation challenges. To get things started, the remainder of this chapter gives a broad overview of the model. After a brief history, we will define the model,

describe its population health foundation, then outline its basic features using the “” acronym which was first introduced by us in the second edition of this book. We then round out the chapter with a discussion of the movements, models and strategies that have influenced the development and implementation of PCBH.

1.4.1 A Brief History of Primary Care Behavioral Health

Early descriptions of the PCBH model come mostly from the work of Kirk Strosahl and Patricia Robinson, based on work they spearheaded at Group Health Cooperative and the University of Washington (Katon, Robinson, Von Korff, Lin, Bush, et al., 1996; Katon, Von Korff, Lin, Walker, Simon, et al., 1995; Robinson, 1995; Robinson, Afari, & Ludman, 1995; Robinson, Bush, Von Korff, Katon, Lin, et al., 1995; Robinson, Wischman, & Del Vento, 1996; Strosahl, 1998; 1997; 1996a; 1996b). Subsequent writings continued to grow awareness of the model from various corners (e.g., Freeman, 2011; Gatchel & Oordt, 2003; Hunter, Goodie, Oordt & Dobmeyer, 2017; Robinson, Gould, & Strosahl, 2010; Robinson & Reiter, 2007, 2016; Serrano, 2015), then in 2018 a special edition of the *Journal of Clinical Psychology in Medical Settings* (JCPMS) was dedicated to the model to help consolidate thinking (Hunter, Dobmeyer & Reiter, 2018). More recently, the model has also been highlighted in major industry reports (Kearney, Zeiss, McCabe, Thistlethwaite, Chana et al., 2020; Westfall, Jabbarpour, Jetty, Kuwahara, Olaisen et al., 2022; Sky, Wells, Yuhas, Raines, Bowman et al., 2023) and specifically recommended for use by PC and MH entities (Mental Health Liaison Group, 2023; Schrager, 2021).

On the implementation side, the model has been used in large healthcare systems such as the U.S. Military Healthcare System (Hunter, Goodie, Dobmeyer & Dorrance, 2014) and the U.S. Veterans Health Administration (Kearney, Post, Pomerantz & Zeiss, 2014); in community health organizations such as Cherokee Health Systems (Freeman, 2011) and in various other settings, such as family medicine residency programs (Hill, 2015), university health centers (e.g., Funderburk, Fielder, DeMartini, & Flynn, 2012; Sadock, Auerbach, Rybarczyk, & Aggarwal, 2014), and homeless clinics (Ogbeide, Buck, & Reiter, 2014). The model has also been the subject of numerous research publications (Hunter, Funderburk, Polaha, Bauman, Goodie et al., 2017) and training initiatives (e.g., Dobmeyer et al., 2016; Ogbeide & Bayles, 2023).

1.4.2 Defining Primary Care Behavioral Health

The special edition of JCPMS mentioned above was important for a number of reasons. For one, it provided for the first time a concise definition of the PCBH model. The special edition brought together as contributors 30 top PCBH experts who combined to write eight articles, but before completing the articles the experts came to consensus on a definition of the model. That definition was then used in each of the eight articles.

The definition, which we embrace in this book, is as follows.

> "The PCBH model is a team-based primary care approach to managing behavioral health problems and biopsychosocially influenced health conditions. The model's main goal is to enhance the primary care team's ability to manage and treat such

> problems/conditions, with resulting improvements in primary care services for the entire clinic population. The model incorporates into the primary care team a behavioral health consultant (BHC), sometimes referred to as a behavioral health clinician, to extend and support the primary care provider (PCP) and team. The BHC works as a generalist and an educator who provides high volume services that are accessible, team-based, and a routine part of primary care. Specifically, the BHC assists in the care of patients of any age and with any health condition (Generalist); strives to intervene with all patients on the day they are referred (Accessible); shares clinic space and resources and assists the team in various ways (Team-based); engages with a large percentage of the clinic population (High volume); helps improve the team's biopsychosocial assessment and intervention skills and processes (Educator); and is a routine part of biopsychosocial care (Routine). To accomplish these goals, BHCs use focused (15–30 min) visits to assist with specific symptoms or functional improvement. Follow-up is based in a consultant approach in which patients are followed by the BHC and PCP until functioning or symptoms begin improving; at that point, the PCP resumes sole oversight of care but re-engages the BHC at any time, as needed. Patients not improving are referred to a higher intensity of care, though if that is not possible, the BHC may continue to assist until improvements are noted. This consultant approach also aims to improve the PCP's biopsychosocial management of health conditions in general." (Reiter, Dobmeyer & Hunter, 2017, p. 112).

Admittedly, the wording is a bit lengthy for a definition labeled "concise" by its authors. However, the definition is important because no one previously had provided such a coherent conceptualization of the model. Additionally, the definition contains a great deal of important foundational material. Everything written in this book connects with this model definition in one way or another.

1.4.3 Primary Care Behavioral Health as a Population Health Approach

Central to this definition is the model's grounding in population health goals and strategies (just like PC itself). The population health approach is evident in the goal cited in the definition of improving PC for the entire clinic population. That is, the goal is to make PC better for patients seen and not seen by the BHC; for those who have significant behavioral issues as well as those who do not. This population health approach distinguishes PCBH from specialty MH and from other integration approaches and is how PCBH counters the challenges laid out in earlier parts of this chapter.

In a population health approach, the goal is to raise the health of individuals by raising the health of the population. By contrast, the traditional MH approach focuses on improving outcomes for individual patients. Using a population health approach does not mean the care of a given individual is discounted or unimportant; rather, it is a different approach to improving health outcomes (Peterson, Raj & Lancaster, 2014).

In PCBH, two main strategies are used to reach the goal of improving population health: 1) strengthen PC in general; 2) reach large numbers of patients. Both strategies are also goals in their own right, with numerous strategies used to achieve them. They also are related, though are distinct enough to warrant separate discussion here.

The first strategy of strengthening PC in general involves using tactics to, for example, improve access to PCPs; deliver more preventive care in the clinic; increase PCP

completion of chronic disease management activities; increase PCP job satisfaction; decrease PCP turnover; and improve PCP comfort and skills for working with the behavioral issues patients present with. To the extent that a BHC can help their clinic function better, patients benefit even if they do not see the BHC (and even if they do not have a significant behavioral concern). This book is filled with strategies BHCs can use to help their clinic function more efficiently and effectively.

The second strategy, reaching large numbers of patients, is rooted in the idea that lower intensity interventions delivered to a large number of people can equal or surpass the benefits of high intensity interventions delivered to a small number of people (Peterson et al., 2014). The traditional MH system, with long and frequent visits planned for an extended period of time with a relatively small number of patients, takes the latter approach; PCBH (like PC itself) takes the former. Hence, PCBH is about access. All throughout this book are strategies for breaking down or avoiding barriers to patients accessing care from a BHC.

Why does PCBH focus on improving PC for the whole population? Simply put, PC has been shown to have high value to society when it is done well. The well-known research of Starfield and her colleagues showed countries with the most robust PC have better health outcomes, lower healthcare costs, and fewer healthcare disparities (Starfield, 1991, 1994; Starfield, Shi, & Macinko, 2005). Unfortunately, however, the U.S. has not historically been one of these countries (Starfield, 2000). As detailed earlier, PC is a

stressed system, filled with clinical, operational, financial and workforce challenges; the typical PC clinic is a very busy place.

There are many factors contributing to the challenges of PC, but much of what taxes PC actually has to do with patient behavior. As discussed above, PC is where most MH concerns are treated and that care takes longer than care for regular acute and chronic care visits. Long visits with one patient mean less time for another patient. Similarly, when un(der)treated MH issues increase the use of PC for medical issues (which, as noted earlier, happens commonly), PCP visits are harder for other patients to access.

Even patients without significant MH problems can strain PC with behaviors that work against efficient and effective PC service delivery. Patients might, for example, talk excessively during visits, arrive late (and demand to be seen), and ask for more problems to be handled during a routine visit than is feasible (Bodenheimer & Sinsky, 2014). Challenges such as these affect all members of the PC team and make it difficult for PC to function optimally. Not only do team members have little time for managing such issues, they also as noted earlier have little training for doing so. When, as a result, workflows are disrupted and team members are stressed, the ripple effect can detract from the care of multiple other patients.

As such, improving PC's ability to work effectively and efficiently with challenging patient behaviors is likely a key to improving population health. A busy BHC who sees a high patient volume can be part of the fix, but even the busiest BHC will not be able to

help with every behavioral issue that patients present with. The vast majority of patients will be seen by PCPs rather than BHCs on any given day; and the influence of behavior on health is so ubiquitous that PCPs could never handoff every behavioral concern to a BHC. Thus, the PCBH model is about ways BHCs can contribute to better population health, both by reaching a large number of patients and helping their PC team to function optimally.

1.4.4 GATHER: The Essentials of Primary Care Behavioral Health

To bring the population health concept to life for BHCs, we introduced in the last edition of this book the “” acronym. Subsequently, this acronym was used to build the PCBH model definition published in JCPMS. The acronym references the key components of PCBH. The “G” is for a “Generalist approach”; “A” is for “Accessibility”; “T” is for “Team-based”; “H” is for “High productivity” (or “High impact”); “E” is for “Educator”; and “R” is for Routine. The components are not distinct from each other either conceptually or in practice; rather, they work synergistically, each enabling the other.

The GATHER components align BHC practice with the goals and strategies of PC. As the name implies, PCBH is essentially behavioral health (BH) practiced like primary care and outlines for BHCs how to do that. A BHC whose practice aligns with the PC team is well positioned to help the team, whereas one who practices more like a specialist, largely segregated from the team, will have fewer opportunities to help. The GATHER components also are intended to position the BHC for reaching a large patient volume.

Each component is designed to counter the access and utilization barriers outlined earlier in this chapter. Thus, a BHC whose practice matches the components has the best chance of helping PC function optimally and of reaching large numbers of patients – the population health strategies of PCBH.

The following paragraphs review each of the components. Much of the detail presented here is from an article in the JCPMS special edition that gives an overview of the model (Reiter et al., 2017). Readers looking for more detail on each component can find it in that article.

The "G" in GATHER, standing for "Generalist", means a BHC engages with patients of any age and with any health condition influenced by behavior. In contrast with specialty MHPs who commonly limit the scope of problems or ages seen, BHCs work with any patient whose health is compromised by behavior, just as their PCP teammates do. Not only does this align BHCs with the goals and functions of PC, but it also removes a practice that in the specialty MH world is a common barrier to patients accessing care.

To implement a generalist approach, PCBH uses a stepped-care approach. That is, patients are typically treated first in PC, with referrals to specialty care reserved mostly for patients who are not improving. This approach helps ensure that the specialty care system is reserved for the patients who most need it.

The “A” in GATHER, which stands for “Accessibility”, reflects the unique practices BHCs adopt in order to reach more patients and be more available for helping their PCP colleagues. Most BHCs use 30-minute visits, rather than the 60 minutes used commonly by specialty MHPs; and they plan to follow patients just until the referral concern is starting to improve and there is a good plan in place for continued improvement (rather than the typical access-limiting MHP practice of planning to follow patients until concerns are completely resolved).

Patient visits with a BHC are also commonly interrupted by PCPs looking to coordinate a same-day visit with another patient; and the length, planned start and planned stop times of BHC visits all can vary to best meet the needs of patients. In short, BHCs practice very flexibly, and they do so with the goal of being easily accessed. They aim to reach not only those motivated for change but also the many who otherwise would not likely access any MH care.

The ”T” in GATHER refers to the “Team-based” component of the BHC role. Importantly, BHCs do not practice in a silo. They are a part of the clinic eco-system, using the same Electronic Health Record (EHR), schedulers and reception staff as PCPs, and working out of exam rooms and shared team spaces where possible. The main reason for this aspect of BHC work stems from the PCBH definition noted earlier, which states that a primary goal of PCBH is to maximize the effectiveness of the PC team for the whole clinic population. Being embedded in the team creates numerous opportunities for this.

A BHC also contributes to the team in various ways, such as developing patient education materials and clinical resources, participating in quality improvement projects, and helping the team with behavioral needs that arise with patients (e.g., helping the triage nurse manage a phone call with a distressed patient). Care plans are developed in close collaboration with PCPs and perhaps others on the team, and the BHC helps facilitate adherence to the PCP's plan just as the PCP hopefully does for the BHC's plan. In many instances, BHCs act as a PCP "extender" (Robertson, 2004), completing certain clinical care functions, instead of the PCP, to help optimize the PCP's panel management.

The "H" in GATHER represents the BHC's aim of being "Highly productive", which derives from the population health goal (discussed earlier) of reaching a large number of patients or having a high impact. Accordingly, productivity is most commonly measured by patient volume (Martin, Bridges & Cos, 2021), though there is no universal patient volume goal for BHCs. Instead, we recommend that a given BHC's patient volume goal mirror that of the PCPs in the same clinic. For example, if a PCP uses 15-minute appointments and is expected to average 20 patients per day, a BHC using 30-minute appointments might be expected to average 10 patients per day. This approach can help ensure goals fit the culture of the clinic.

Note also that the aim is not only for BHCs to complete a large number of patient visits but also for those visits to include many different patients. An approach in which the same patients are seen for numerous follow-ups would be more typical of a specialty MH

approach that impedes access. There is also no universal goal for the number of unique patients a BHC should reach, because some clinics might have less need for a BHC than others (depending on the health of the patient population, the skillsets and interests of the PCPs, and other factors).

The ”E” in GATHER stands for “Educator”. As noted earlier, PCPs and other team members typically receive little if any training for working with behavioral issues, yet they manage patient behavior all day long and see a large patient volume. Thus, as the sole team member with significant training in behavior change strategies, a BHC’s impact can be boosted exponentially by helping team members be more skilled, comfortable and efficient when working with behavioral issues.

Education done by BHCs may be informal, via spontaneous curbside consultations or when giving feedback to a PCP about a patient after a BHC visit. It also may be delivered more formally, through PCP and team didactics during lunchtime or team meetings. Formal trainings may be only a few minutes in length, or much longer. Developing patient education handouts and materials for use in the clinic is another way a BHC can grow the team’s awareness and understanding for behavior change issues.

The last part of GATHER, the “R”, refers to practices for making the BHC a “Routine” part of care. Being a routine part of care is important for both practical and perceptual reasons. On the practical side, being routinely included in care is how the BHC can achieve the population-level goals laid out earlier in the chapter. It affords a BHC more

opportunities to help the team and of course helps the BHC reach a large number of patients.

On the perception side, being a routine part of care may help avoid the self-stigma that inhibits some patients from engaging in behavioral care (Phelan, Salinas, Pankey, Cummings, Allen et al., 2023). If a BHC operates too differently from the rest of the care team, resembling a traditional MH therapist more than a PC team member, the risk of the patient feeling stigmatized by a BHC visit may rise. Many people seem to feel less stigmatized discussing emotional or behavioral concerns in PC (Ogbeide et al., 2018; Olfson et al., 2014). Thus, a BHC who is perceived as a routine PC team member might have better luck reaching patients who otherwise would avoid MH care because of self-stigma.

Various practices and strategies can promote the perception and reality of the BHC as a routine part of care. Development of a PC behavioral health pathway use is one strategies; many BHCs help lead development of PCBH pathways that include a warm handoff to the BHC for every patient with a certain condition (e.g., depression, tobacco use) (see Chap. 10 for more information on pathways). Practicing like other team members can also help. When a BHC sees patients in exam rooms, works patients in on demand (with no special referral paperwork requirements), and documents in the same EHR as other team members, the difference from a traditional MHP is readily apparent to both patients and team members. Some BHCs even wear scrubs.

1.4.5 Movements and Approaches Influencing Primary Care Behavioral Health

What hopefully is becoming clear by now is that PCBH is both a different way of providing PC and a different way of providing MH services to patients. It is more than merely plopping MHPs down in PC and having them practice the way they always have. But of course the PCBH model was not developed in a silo. Many important movements and approaches from healthcare, including from SMH, have influenced the development of PCBH as a model and the practices of effective BHCs.

In this final section of the chapter, we highlight prominent influences on the development and practice of PCBH. Most are mentioned at various points throughout the book, so to help ensure those references make sense we offer below a brief summary of each. We encourage readers to do additional reading about each of the movements and approaches. Note also that what are described here are influences on the model itself – its goals and structure – more than the specific clinical interventions used by BHCs in visits. Chapter 9 provides examples of clinical assessments and interventions.

1.4.6 The Consultant Approach

A hallmark of the PCBH model is its foundation in a consultant approach (Strosahl, 2005). Behavioral health providers in this model are commonly called “behavioral health consultants (BHC)”. There are several key differences between a consultant approach and a traditional therapy approach. One difference lies in the primary consumer of services.

In a traditional therapy approach, the primary consumer is the client; but, in a consultant approach, it is the PCP. The BHC's goal is to help PCPs to help their patients. Relatedly, ownership of care is different. Therapists own the care of clients; they are the MHP for the client. In a consultant approach, however, the PCP owns the patient's care and the BHC is part of a team led by the PCP.

Follow-up is also different in a consultant approach. Consultants do not plan to follow patients until problems are completely resolved (as therapists do). Psychiatry consultants, for example, typically start patients on medication that the PCP then continues refilling once the patient is improving. A consultant approach is commonly used by providers who are scarcely resourced because planning follow-up in this manner helps keep them available for seeing new patients. For this same reason, BHCs follow this consultant approach to planning follow-up. Once a patient is starting to improve and has a good plan in place for continued improvement, the BHC may back out of planned follow-up and the PCP may continue reinforcing the behavior change plan.

Using a consultant approach helps a BHC achieve the A, T, H and E of The consultant approach to follow-up keeps the BHC "Accessible" and enables "High Productivity", while the BHC's goal of helping the PCP who owns care promotes "Team-based care". The "Educator" role is achieved when PCPs learn basic behavioral strategies through their continuing reinforcement of BHC interventions and discussions of care with BHCs.

1.4.7 Stepped Care Approach

We mentioned stepped care earlier in this chapter. Using a stepped care approach is one way a BHC can function as a "Generalist" and as a "Routine" part of PC (the G and R in). Stepped care is a framework for healthcare delivery that helps disseminate care to large numbers of people. In this approach, patients are first given less time-intensive interventions that are more accessible; if not improving, the patient is then "stepped up" to more time-intensive or specialized care (Richards, Bower, Pagel, Weaver, Utley et al., 2012).

Using a stepped care approach is especially reasonable for MH concerns because a patient's response to any given therapeutic intervention is impossible to predict. Many patients, even those with complicated or chronic problems, will improve in response to less intensive interventions (Strosahl & Robinson, 2018). Thus, starting every patient with highly time intensive care is a poor use of resources.

To implement stepped care, BHCs use 30-minute (or less) visits, which of course are less time intensive than the typical 60-minute therapy visits. They engage with any health concern affected by behavior and if there is no improvement after several visits then SMH may be recommended. (Of course, many patients do not follow-through on SMH referrals (see Sec. 13.11 for a discussion of how to handle such situations.)

Thus, a stepped care approach helps BHCs operate as generalists. It also helps BHCs achieve the R in , because it syncs the BHC's approach with that of PCPs'. As noted

earlier, PC is intended to be the first stop for care of most health concerns, and PCPs also use a stepped care approach. Hence a BHC operating in this same way can more regularly be brought into care and also looks like a "Routine" part of PC.

1.4.8 Self-management Approach

As noted earlier in this chapter, PC teams commonly treat patients for chronic health conditions such as diabetes, hypertension and many others; and commonly help patients make healthy lifestyle choices to prevent disease. When helping patients in these ways, PCPs, nurses and others on the team use a self-management approach (Reynolds et al., 2018).

A self-management approach is rooted in a few key notions (Lorig & Holman, 2003). The first is that we all manage our health every day. The choices we make about diet, relationships, sleep, substance use, etc., all can affect health, in either positive or negative ways. Consistently making healthy choices can prevent disease and improve outcomes of chronic conditions, but this is difficult to achieve. A second key notion is that self-management of health is a lifetime endeavor. Everyone has periods in life when lifestyle choices may lead into unhealthy territory and other times when choices are more beneficial to health. The third key notion is that healthcare providers can guide and assist patients in making healthy choices, but ultimately patients must rely largely on themselves. There is no quick fix for diabetes that a PCP can provide in an exam room.

The approach to care used by a BHC, with an emphasis on teaching skills that can be practiced in the patient's daily life and planning follow-up only until improvement starts, is essentially a self-management approach. It is very different from a traditional therapy approach. The latter views the therapeutic interaction as the healing agent and the therapist as the healer. "Processing" in the therapy visit is assumed to be key to success, rather than changes and skills the patient practices outside of the BHC visit. Therapy involves frequent visits, planned to continue until the presenting problem is largely eliminated, whereas self-management involves episodic guidance over the life course and assumes the problem can be managed successfully but never eliminated.

A self-management approach can help providers remain "Accessible" (the A in), which is a primary reason BHC visits align with this approach. It also helps BHCs achieve the R in , looking like a "Routine" part of PC, because it is the same approach used by the rest of the PC team. Importantly, a self-management approach has also been shown to be effective for MH and other concerns (Brahim, Lambert, Feeley, Coumoundouros, Schaffler et al., 2021; Reynolds et al., 2018).

1.4.9 Single-session Therapy

We noted earlier, in the discussion of barriers to MH care, that researchers learned long ago that most commonly people seeking therapy in SMH complete only one visit (Brown & Jones, 2005). This finding holds across settings and countries (Hoyt & Talmon, 2014), and led to the development of an approach to therapy called *single-session therapy* (SST).

In a nutshell, SST uses strategies to optimize the value of each visit, starting with the first visit, given that so commonly patients do not follow-up as planned.

Not surprisingly, research on PCBH has also shown that most commonly patients have just one visit with a BHC (Wilfong, Goodie, Curry, Hunter & Kroke, 2022). Patients treated in PC for MH concerns may be even less likely to follow-up compared to those seen in specialty MH. A classic study from 2003 showed that patients treated in PC for depression were less likely, compared to those seeking help from specialty MHPs, to perceive a need for care and were less accepting of evidence-based treatments (Voorhees, Cooper, Rost, Rubenstein, Meredith et al. 2003).

Almost by definition, patients seeking help in specialty MH must be motivated for care. Not only must they have the insight and courage to recognize and face difficult issues, they also typically must have the patience, persistence and resources to find a MHP and wait for care to start. Patients seen by a BHC, by contrast, often are not seeking any sort of counseling. They might not even be aware that a behavioral or emotional issue is affecting their health. They might reach the BHC due to screening positive for a mood problem during a physical exam; or when their PCP determines that stress is causing the headaches they are seeking help for; or when they ask for sleep medication from their PCP.

Thus, while the typical patient seeking therapy in SMH understands there is a problem, believes therapy could help and is ready to engage, patients seen in PC often are very different. For these reasons, the strategies of SST can be very helpful for a BHC to utilize. Rather than planning multiple visits that the patient very possibly will not keep, BHCs will use SST strategies to make the most of each visit. Taking an SST approach can also help the BHC achieve the A and H of ("Accessible" and "Highly productive"), because follow-up is planned one visit at a time or might not be planned at all, which helps keep the BHC accessible for seeing more patients. Some of the first BHCs (Kirk Strosahl and Patti Robinson) worked to evolve assessment and intervention techniques that promote single-session benefit and then packaged the approach and named it "Focused Acceptance and Commitment Therapy" (FACT, see Sec. 9.3).

1.5 The Patient-Centered Medical Home

The Patient-Centered Medical Home (PCMH) was first proposed in 2002 as a means of transforming PC (American Academy of Pediatrics, 2002). The goal was to move PC away from a reactive mode built around one physician (best for acute problems) into team-based care that is proactive and coordinated (better for preventive and chronic conditions). In 2007, the PCMH idea took on steam when major PC associations joined together to create and publish the Joint Principles of the Patient-Centered Medical Home, and then in 2014 the concept was revised to its current form, which emphasizes team-based care, access, continuity, and knowing one's patients (Agency for Healthcare Research and Quality, 2022).

Some literature suggests implementing the PCMH produces at least modest improvements on a number of important fronts (Phillips, Sullivan, Mayo-Smith, 2020), and many PC clinics/systems today aim to be recognized as a PCMH, especially community health centers. To gain recognition, a clinic/system must show they are providing the components of the PCMH. Note that the National Committee for Quality Assurance, NCQA, is an independent non-profit that is the primary agency responsible for granting such recognition. Recognition is presumed to be a mark of quality and is incentivized by payers. However, the value of the PCMH is difficult to measure and some have begun to question its effectiveness and call for de-emphasizing it (Bodenheimer, 2022).

Regardless of the fate of PCMH, the point of mentioning it here is that the idea of adding a MHP to PC was emerging just as the PCMH was moving PC toward more team-based care. Thus, the PCMH movement helped open the door to integrated care (though behavioral health integration has not historically been an emphasis of the PCMH concept). The idea of team-based care is also central to the PCBH model, as indicated by the “T” in GATHER.

1.6 Quintuple Aim

In 2008, just as the PCMH was coming into its own, another influential concept emerged: the Triple Aim. By focusing the healthcare system on three key goals, the Triple Aim

became a North Star of sorts for anyone trying to improve healthcare. The three key goals are: 1) improve the patient experience of care, including quality and satisfaction; 2) improve the health of populations; and 3) reduce the per capita cost of health care (Berwick, Nolan & Whittington, 2008). The idea is that each of these is crucial for improving the system, and they must all be pursued simultaneously.

The Triple Aim helped shape a great deal of healthcare reform, but after several years it became apparent that a fourth goal was needed. A crisis was emerging of burnout among healthcare providers, and without reversing that the Triple Aim could not likely be achieved. Thus was born the Quadruple Aim, the proposal that to improve healthcare we must achieve the Triple Aim while simultaneously alleviating stresses on providers (Bodenheimer & Sinsky, 2014).

Fast forward to 2022, with the heightened awareness of structural inequities affecting health, the Quintuple Aim emerged (Nundy, Cooper & Mate, 2022). The Quintuple Aim proposes that achieving health equity is also a crucial strategy for improving healthcare broadly; without it, the other four aims cannot be achieved.

The Triple, Quadruple and Quintuple Aims all greatly shape the practice of PCBH, because they shape the practice of PC. Primary care will play a uniquely important role in achieving the Quintuple Aim because it is the entryway into the healthcare system and the one part of healthcare where the vast majority of us will go throughout our lives. The Quintuple Aim plays a role in how systems are designed, but it also serves as a North Star

for BHCs in their daily clinic lives. In countless ways throughout the course of any given day, a BHC has opportunities to help PC reach the Quintuple Aim. As you read through this book, you will also see countless examples of the alignment of PCBH with these Aims.

Summary

1. While many people have substance abuse and mental health problems, most receive no help with them. If they do, it is more likely to be from a PCP than a MHP.
2. PCPs are under-paid, under-resourced and not adequately prepared to address the needs patients with MH problems and have little to no time to address lifestyle problems that might prevent chronic conditions or improve outcomes for those struggling with self-management of chronic disease
3. While PCPs may refer to specialty MH, there are many barriers to patients accessing and utilizing that system. People that receive MH care tend to have more resources and less severe conditions than those identified for MH care in PC.
4. PCPs report job dissatisfaction, and there is a shortage of PCPs.
5. Significant reductions in healthcare spending could be achieved by delivery of integrated care services that reach patients who otherwise would not receive help with MH issues.

6. The Primary Care Behavioral Health approach to integration aims to improve PC by providing assistance to the PC team and by providing highly accessible, brief services to as many people as possible.
7. The PCBH brings a new provider to the team, the Behavioral Health Consultant (BHC), who engages in practices that are distinctly different from traditional MHPs.
8. BHC services are designed to improve the overall functioning of PC and to help the team attain better outcomes for the population.
9. The PCBH approach is defined by the acronym, , where the “G” is for Generalist, the “A” is for Accessible, the “T” is for Team-based, the “H” is for High productivity, the “E” is for Educator and the “R” is for Routine.
10. Development and implementation of the PCBH model has been influenced by a number of other approaches and movements in healthcare, including the PCMH initiative and the Quintuple Aim.

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