Chapter 13

Frequently Asked Questions about PCBH: Asked and Answered

"It's better to know some of the questions than all of the answers."

James Thurber

Abstract

In providing training for many Behavioral Health Consultants (BHCs) working in different clinics, regions, and even countries, we have heard a lot of questions. We haven't always known the answers, but we listen and we appreciate the questions because they make us think. In this chapter, we include a variety of questions. Most of the questions relate to the puzzle pieces of Primary Care Behavioral Health (PCBH), and we do our best to provide thoughtful answers based on what we know at this time. The questions cover the map of PCBH, so to speak, ranging from questions about coding to questions about how BHCs work with trauma. The construction of PCBH is on-going, so we hope you will continue to question and to discuss possible answers with your colleagues. Think through the implications of your answers, as answers can close or open opportunities for realization of improvement to healthcare.

Keywords

BHC staffing ratios, coding, follow-up, depression, implementation, introduction, leadership, management, pathways, PCBH metrics, program evaluation, same-day, trauma, visit length, warm handoff

We authors won't say just how long we have been consulting with systems and training Behavioral Health Consultants (BHCs), but suffice to say it's been a long time! In the course of all of our work in supporting systems with implementation of the Primary Care Behavioral Health (PCBH) model, certain patterns have emerged in the questions and confusion points that BHCs and systems wrestle with. In this chapter, we present the questions and concerns most commonly raised during training, along with the responses we commonly provide. We also reference other sections(s) in the book where more detail is available on each question. We encourage you to find a buddy to review these questions and answers with and to perhaps add the wisdom of your own experience to the answers when you do so.

13.1 My appointments are booked out a few weeks, and patients can't get appointments when they want them. What should I do?

Ensure the template has a sufficient number of slots (usually at least 12 per day) with the right mix of pre-scheduled and same-day slots. Same-day slots make it easier for a BHC to work in patients, but they also limit the availability for scheduled visits. Thus, same-day slots should be kept to a minimum, with the actual number based on the frequency of warm handoffs. Also ensure follow-up is only being planned when both patient and BHC perceive a need for it. Try offering classes for common problems, as some patients will opt for a class over an individual follow-up. Increased staffing of BHCs may be needed if BHCs are regularly completing a high number of visits (e.g., more than eight per day on average).

13.2 What billing codes are used in Primary Care Behavioral Health?

Reimbursement varies by payer, provider credential and other specifics, but commonly used codes are listed in Table 13.1. Coding and billing are discussed in other areas of this book (see Sec. 5.4.19 in Chap. 5 and Sec. 7.7 in Chap. 7). The most commonly used codes are psychiatric codes and health and behavior assessment and intervention (HBAI) codes.

Table 13.1 Codes Commonly Used for PCBH Visits

90791	Psychiatric Diagnostic Evaluation. No minimum time requirement. A thorough assessment must be completed, but many BHCs do this in 20-30 minutes. Despite the name, it can be used by non-psychiatrists.
90832	XXXXX. Typically used in follow-ups, but can be used in an initial visit. Visit length must be 16-37.5 minutes.
96156	HBAI assessment/reassessment (for medical conditions). Can use regardless of appointment length when there is time spent on assessment.
96158	HBAI intervention (for medical conditions). Billed in 30-minute increments. Added to 96156 if the intervention portion of a visit was greater than 15 minutes.
96164	HBAI intervention, group, face-to-face, initial 30 minutes
+ 96165	HBAI intervention, group, face-to-face, each additional 15 minutes

HBAI Health and Behavior Assessment and Intervention

13.3 Why are we called “consultants” rather than “therapists”?

Consultants are different from therapists in two important ways. First, as a consultant the person in charge of the patient’s mental health care is the PCP; the BHC’s role is to help the PCP to help the patient. Therapists, by contrast are solely in charge of their patient’s care. Second, whereas therapists plan to follow patients to remission, consultants only plan to follow patients until they start to improve and have a clear plan in place for continued improvement.

When such occurs, the BHC backs out of planned follow-up (the PCP will continue to follow the patient), but can always be re-engaged if regression or new problems occur. Being a consultant does not limit the topics that can be discussed nor the treatment approach used.

13.4 Can a BHC do couples therapy? Family therapy?

Because BHCs act as consultants rather than therapists, they do not see anyone for therapy (whether individuals, couples or families). However, there are many situations where couples and families may be seen by a BHC. Sometimes the goal of such visits is to improve a relationship; other times the goal is to enlist the spouse/partner or family member(s) in the care of an identified patient in some way. Regardless, the BHC still operates in these visits as a consultant rather than a therapist (see Chap. 1 for a discussion of the consultant role).

13.5. Are there certain topics that a BHC should not discuss with patients?

No topics are “off-limits” for BHCs to discuss with patients. The important consideration is whether the topic is directly relevant to the referral concern. For example, if patients divulge remote history that is not clearly related to the referral concern, they should be gently redirected back to the referral concern. However, if the remote history is possibly a significant contributor to the referral concern, the BHC should gather more information about it in order to inform the development of the most relevant, impactful behavior change to work on.

13.6 A lot of my patients report a history of trauma. Do I need to refer them to specialty mental health?

Trauma of one degree or another is very common in the history of patients seen by a BHC. Referring all such patients to specialty mental health (SMH) is likely to be problematic, for a few reasons. First, many patients will not follow-through on referrals (or will go for one visit but not a full course of specialty care), which merely perpetuates the problem we are in primary care to help solve. Second, many patients with a trauma history do not actually need specialty care; many will improve in response to help from a BHC and PCP. Unfortunately, we can't predict in advance which patients will improve in primary care and which won't, so the best plan is for you to treat them first, monitor their response, and refer for specialty care if not improving (unless there is some other reason for referring immediately to specialty care, as outlined in Sec. 13.12 of this Chap.).

13.7 How can a BHC treat trauma?

BHCs focus on improving functioning, which can be affected by many factors including recent or remote trauma. If a patient divulges trauma (whether recent or remote) that is relevant to the referral concern, it can often be used to inform the development of goals that are SMART (i.e., specific, measurable, attainable, related to values, time-bound). For example, if a traumatic event in a person's past has led to avoidance behaviors that are now contributing to the referral concern, a good SMART goal would likely revolve around reducing the present-day avoidance and building on behaviors that align with the person's values. Similarly, if the traumatic event

has resulted in unhelpful negative thoughts that are contributing to the referral concern, a good SMART goal might focus on challenging those thoughts or defusing from them. Some patients with Post Traumatic Stress Disorder (PTSD) might also be candidates for a specific four-visit protocol developed for BHCs in a randomized controlled trial (Cigrang, Rauch, Mintz, Mitchell, Najera et al., 2017).

13.8 Is PCBH treatment inferior to specialty mental health treatment? Aren't I giving patients less than what they should be getting?

PCBH is not "less than", nor is it "more than", specialty care. It is merely an alternative way for patients to access behavioral help. Without PCBH, patients generally have two options: see a PCP alone or see a specialty therapist. While many patients benefit from a PCP alone, and many benefit from specialty therapists, many other patients fall into a separate category - they do not benefit sufficiently from a PCP alone, but they also do not access or benefit from the specialty care system. For these patients, PCBH represents a third option that may be beneficial. Actually, for many patients, PCBH is "more than" the treatment they would normally receive, in that even one 30-minute visit with a BHC is considerably more time than a PCP can provide (and remember BHCs also have more training than PCPs for working with behavioral issues).

13.9 When should I refer a patient to specialty mental health?

Patients should always be referred to SMH in the following situations: (a) the patient requests referral; (b) the PCP requests a referral; (c) the patient is not improving despite 3-4 BHC visits; (d) the patient needs emergency assistance; (e) the patient needs a service the BHC does not provide (e.g., commander-directed evaluation, inpatient detoxification, neuropsychological assessment, etc.). Referrals can also happen for other reasons; most important is to follow a helpful referral process (see Sec.13.10 of this Chap.).

13.10 What is the best way to refer patients to specialty mental health?

When referring to specialty mental health (SMH), remember that many patients do not follow through with referrals, or may have to wait considerable time before an actual therapy visit (and the first visit is often merely an intake). Thus, when referring to specialty care, a BHC should continue planned follow-up until the patient is clearly engaged in specialty care (or until the patient improves). This is often called *bridging care*. However, during bridging visits the BHC should continue actively intervene (i.e., avoid using visits merely to check on the status of the referral).

If referring because of non-improvement, be sure also to nurture the longitudinal relationship with the patient by avoiding statements or actions that suggest the patient is “too complex” for PC or is “beyond what PC can help with”. Such statements, in addition to being potentially pathologizing, may lead a patient to disengage from PC, or at least from the BHC. Instead, consider messaging that emphasizes the continued support of PC and that shares ownership of the non-improvement. We use statements like the following.

> "Unfortunately we haven't been able to get the results we hoped for just yet. I'd like to see you try a different approach in specialty MH, if you'll agree. Of course, we'll always still be here for future needs or if specialty MH doesn't work out."

13.11 How do I handle patients who don't follow through as planned on a referral to specialty care?

When patients don't access specialty care as planned, the BHC should continue treating the patient (along with the rest of the PCBH team). The structure of the BHC's care (i.e., 30-minute visits and a consultant follow-up structure, as described in Sec. 13.20 of this Chap.) should not change. However, at each visit the BHC should remind the patient of the specialty care recommendation (and document that repeated recommendation).

13.12 Can I see a patient who is being seen in specialty MH?

Patients being seen in specialty MH are commonly still seen by BHCs, just as patients being followed by other specialties are still seen by a PCP. For example, a patient seeing dermatology still comes to PC for other concerns (and maybe even for dermatological concerns, if the concern is new or if the patient is unable to see their dermatologist). Seeing a patient in PC for the same concern that is being cared for by a specialist usually is not recommended; i.e., if a patient is seeing a MH therapist for panic attacks, we do not recommend the BHC also see the patient for panic attacks (unless the patient has an acute need and is not able to see the therapist). However, seeing that same patient for a concern largely unrelated to panic attacks, such as weight management, may be entirely reasonable.

13.13 When do I need to assess depression symptoms?

When a patient has significant problems with mood, assessing for depression may be helpful. However, it should only be done if clarifying a diagnosis will aid treatment planning in a significant way. Mostly, a diagnosis is helpful for making medication decisions, such as whether to start a medication and which type of medication to start (e.g., an antidepressant for a patient with depression versus a mood stabilizer for a patient with bipolar disorder). Thus, consider assessing for a depression diagnosis if that could help the PCP to make medication decisions (see Chap. 1 for a discussion of antidepressant use in PC). Remember also that if assessing for depression, the PHQ-9 may be better than a verbal assessment, as it will allow for measurement-based care and easy communication between team members (and may take less time for some patients).

13.14 What is a "warm handoff"?

The term *warm handoff* (WHO) refers to the process of connecting a patient with the BHC for a same-day visit during the course of a PCP visit. Typically the patient in this scenario is not planning to see the BHC, but rather is worked-in after the PCP identifies a behavioral concern that s/he desires help with. Warm handoff patients are most commonly worked-in by the BHC after the PCP visit has finished, but sometimes it is more helpful for the BHC to see the patient before the PCP. PCPs may also use a WHO to bring in the BHC for help during the PCP visit. Note that on occasion (if the BHC and/or patient have no time for even a very brief visit) a

WHO results not in a same-day visit but rather in the BHC meeting the patient and scheduling them for a later date. This is termed a “meet and greet”.

13.15 How long are same-day visits that come from warm handoffs?

Ideally, the same-day BHC visits resulting from warm handoffs are no different in structure, length or content from pre-scheduled visits. However, because they are by definition not planned in advance, they sometimes must last less than 30 minutes in order to fit the schedule of either the patient or the BHC.

13.16 Do I have to be trained in behavior therapy or cognitive behavior therapy in order to be a BHC?

As described in chapter 1, BHCs use a self-management approach that focuses on helping patients learn skills they can use outside of the BHC visit to better manage their own health. The focus on direct behavior change, goal-setting and skill-building often comes easiest to BHCs with a background in Cognitive Behavior Therapy (CBT), Focused Acceptance and Commitment Therapy (FACT) or some other behavioral approach. However, there is no reason to think that a BHC trained in some other orientation could not adopt a self-management approach.

13.17 Don’t I need more than 30 minutes in visits to establish rapport with patients?

While it might seem surprising, research has shown that patients report a stronger therapeutic alliance with BHCs after just one visit than they do with specialty MHPs after two, three and four visits (Corso, Bryan, Corso, Kanzler, Houghton et al., 2012). To make sense of this, consider that BHCs have some significant advantages over traditional therapists. For example, they are seeing the patient in a familiar setting, after being recommended and perhaps even introduced (via WHO) by a figure the patient probably trusts (the PCP). A BHC also probably has considerably more information about the patient, from the EHR or PCP or both, than a specialty MHP would have, which could influence positively the patient's impression of and trust in the BHC.

13.18 How many patients should a BHC see per day?

In our experience, many systems set a goal of around eight patients per day, but there is no universal productivity goal for BHCs. We advise clinics to mirror with BHCs the expectations of PCPs, in order to keep the BHCs aligned with the clinic culture. For example, if PCPs have mostly 15-minute visits and a goal of 20 patients per day, a BHC with 30-minute visits (i.e., twice as long as PCP visits) could have a goal of 10 patients per day. This approach allows for differences between clinics, which can be considerable. A clinic serving mostly homeless people might only average seven or eight PCP visits per day, partly because of patient complexity and partly because of the relatively small size of the population served; however, a BHC might see almost every patient for 2 or 3 PCPs in such a clinic. Of course, there are many

more ways to measure BHC performance other than visits per day; for a discussion of key metrics, see Sec. 3.3 in chapter 3.

13.19 How many BHCs are needed in a given clinic?

The number of BHCs needed for a given clinic varies. As a general guide, we recommend a 1:2 or 1:3 ratio of BHC:PCP for community health clinics, where the patient population often suffers from multiple behaviorally and emotionally influenced health issues. Other clinics might utilize a 1:3 or 1:4 ratio. However, with so much variation from one clinic to the next, the decision ultimately needs to be metrics-driven. Systems needing to be fiscally cautious might start with a staffing plan that fits the more conservative side of the ratios given here, and then grow their BHC workforce as demand for the BHC grows.

13.20 When should I follow-up with a patient?

When planning follow-up in the PCBH model, the first question is whether to follow-up at all. Many patients feel they get what they need in one visit. Knowing how easy it is to access the BHC may make it even easier for patients to opt out of planning any follow-up, as they can confidently assume that help is standing by if needed. If patients do desire follow-up, then the typical BHC plan is to follow patients just until they are starting to improve and have a good plan in place to continue improving. This is how consultants of all stripes practice; and it is also roughly analogous to how a PCP plans follow-up. If treating a rash, for example, the PCP does not plan weekly follow-up until the skin is completely blemish-free. Instead, once the rash is

improving and the patient is tolerating the treatment, the PCP will likely end planned follow-up (with the advice of returning if the rash does not continue improving). Planning follow-up in this manner helps PCPs – and BHCs – remain accessible.

When follow-up is planned, two weeks is the default follow-up interval. One week is often too little time for patients to have a sense for whether interventions will be helpful; and three or four weeks is often too long to sustain momentum for behavior change. However, various factors such as patient preference, schedule availability, acuity of the patient's condition, and other factors may ultimately result in a shorter or longer follow-up interval.

13.21 How can I boost referrals from PCPs who rarely, if ever, send me patients?

Like all healthcare providers, PCPs differ in their interests, skillsets and practice habits. Some are very interested in, or skilled in, working with behavioral issues and so might not frequently utilize a BHC. Others are the reverse in terms of their interest and skillset, and as such might also not utilize a BHC. Thus, step one of attempting to influence PCP referrals is to accept that the goal of frequent referrals from every PCP is probably not realistic.

At the same time, there are many common causes of low PCP referral rates that can be overcome. A helpful strategy can be to administer the Barriers to Use of BHC Survey (see Fig. 8.11 Barriers to Use of BHC Survey) to the entire PCP group. Summarizing and analyzing the results for the group as a whole may identify barriers affecting multiple PCPs, not only those

with low referral rates. Addressing the barriers with the entire staff may provide a way of indirectly boosting referrals from specific low-referring PCPs (for guidance on addressing identified barriers, see Sec. 8.3.3 in Chap. 8).

Another option is to talk directly with the PCPs who refer the least, to learn what their barriers to referral are. This can be done by the clinic's PCBH Champion, if there is one (see Chap. 3 for a discussion of the Champion role). Or, the BHC can initiate the conversation. This latter option is often difficult for BHCs, especially new BHCs, but it can be fruitful if approached in an open, inquisitive (rather than accusatory) manner. A helpful opening question can be something along the lines of, "Do you have a few minutes? I would love to talk about how I can help you and your patients more." Depending on the PCP, this can lead to a very helpful discussion, or it might merely result in returning to "step one", as identified in the first paragraph.

13.22 I want to start a PCBH pathway but I'm not sure about what – do you have an idea for me?

There are many possible pathways that a simple and appealing to many PCPs and teammates. Here are a few of our favorite examples. The first concerns the PCP making a WHO to a BHC of a patient diagnosed with a chronic condition on the day the diagnosis is made. The BHC would then talk with the patient about the emotional impact of the diagnosis and their interest in perhaps modifying one or more lifestyle behaviors to improve their health. The pathway target would be that of increasing rates of attendance of appointments in the 6 months after the

diagnosis of a chronic condition. A second concerns addressing a health risk behavior such as use of tobacco products. An easy pathway would be to have the Medical Assistant offer a patient screening positive for tobacco use three options: a handout about strategies to reduce use of tobacco products, a WHO to a BHC to discuss ways to not increase their rates of using tobacco products, or an invitation to a monthly workshop lead by the BHC, “Change is Possible: You and Tobacco”. The outcome of interest would be a decrease in the number of positive screens for tobacco use over the course of the next year.

Summary

1. Many puzzling questions come up for new BHCs because the pieces don’t seem to fit together. These questions often relate to completely new ways of working, such as WHOs and working as a consultant rather than a therapist.
2. Other puzzling questions stem from assumptions about how people change. Answers to these questions often require discussion and a closer look at the evidence for commonly held assumptions.
3. Still other questions relate to the need for quick advice so that a BHC can move forward with implementing new ways of working. These include practical questions like codes to use and easy PCBH pathways to start in a clinic.
4. As questions arise, make a note of them. Hopefully, most BHCs will be able to connect to a BHC discussion group for live interactions and/or participate in lists services (such as the PCBH special interest group of Collaborative Family Healthcare Association).

5. It really works best to know some of the questions rather than all of the answers (as Thurber suggested at the beginning of this chapter) because it is the questions that make us ponder the possibilities.

References

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