

The Culture of Working in Primary Care

Scripts by Paul Barry
(in slide note section)



What Does a Behavioral Health Patient Look Like in a Primary Care Setting?

67 yo man recently widowed

43 yo woman drinks "a couple of glasses" of wine daily

19 yo man "horrible stomach pain" when starts college

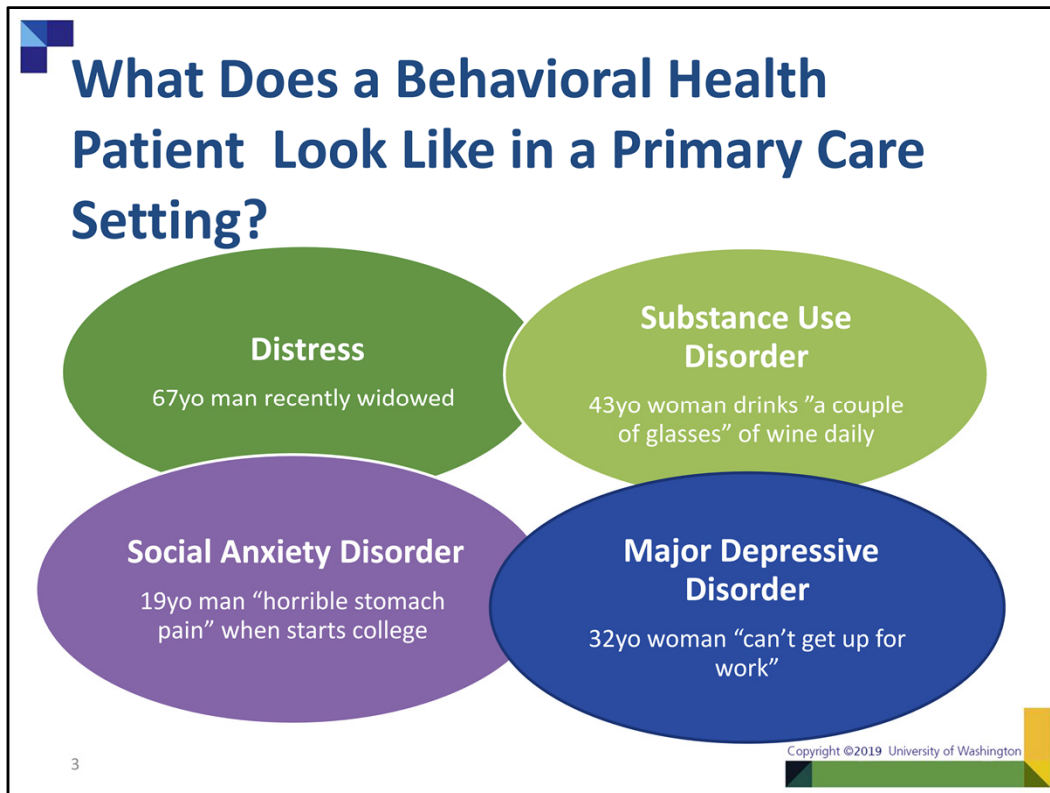
32 yo woman "can't get up for work"

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NARRATION

Let's start with what behavioral health will look like in primary care settings. These bubbles represent typical primary care chief complaints that you will see. If you notice at first pass, most of these presentation are not clearly related to behavioral health conditions.



NARRATION

However, when you actually look at what the patient is ultimately diagnosed with, many of these presentations that start out looking like common physical symptoms will actually represent behavioral health conditions. For example, our recently widowed gentleman actually has distress. A woman who is presently initially drinking a couple of glasses of wine daily may end up having a substance use disorder. And people presenting with physical complaints, such as stomach pain, can end up being diagnosed with anxiety disorders or other common mental health conditions. It will be important for you to help support your team in the assessment of patients to help them differentiate mental health disorders from distress and establish a preliminary diagnosis using team assessment.

Common Behavioral Health Presentations	
Common Outpatient Psychiatry Presentations	Common Primary Care Presentations
<ul style="list-style-type: none"> • Mood disorders • Anxiety disorders • Substance use disorders • Psychotic disorders • Cognitive disorders 	<ul style="list-style-type: none"> • Depression • Anxiety • Unexplained physical symptoms • Somatic presentations & somatoform disorders • Acute and chronic distress • Adjustment disorders • Pain • Challenging patients • Pet patients

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NARRATION

So, The types of presentations you see in the primary care setting will be different from those you may be used to seeing in your patients in MH outpatient settings. Commonly in outpatient settings the patients have already previously been diagnosed with a DSM diagnosis, such as a mood disorder, anxiety disorder, etc. However, in primary care you will have a wide variety of presentations, including unexplained physical symptoms, somatic presentations, and the need to differentiate distress from a true psychiatric disorders.



Culture Clash

- **Primary Care**
 - **Action culture**
 - urgency, pace
 - immediate intervention
 - high access
 - refer to other providers for specialty care
- **Specialty Behavioral Health**
 - **Narrative culture**
 - in-depth assessment
 - deep understanding
 - slower pace

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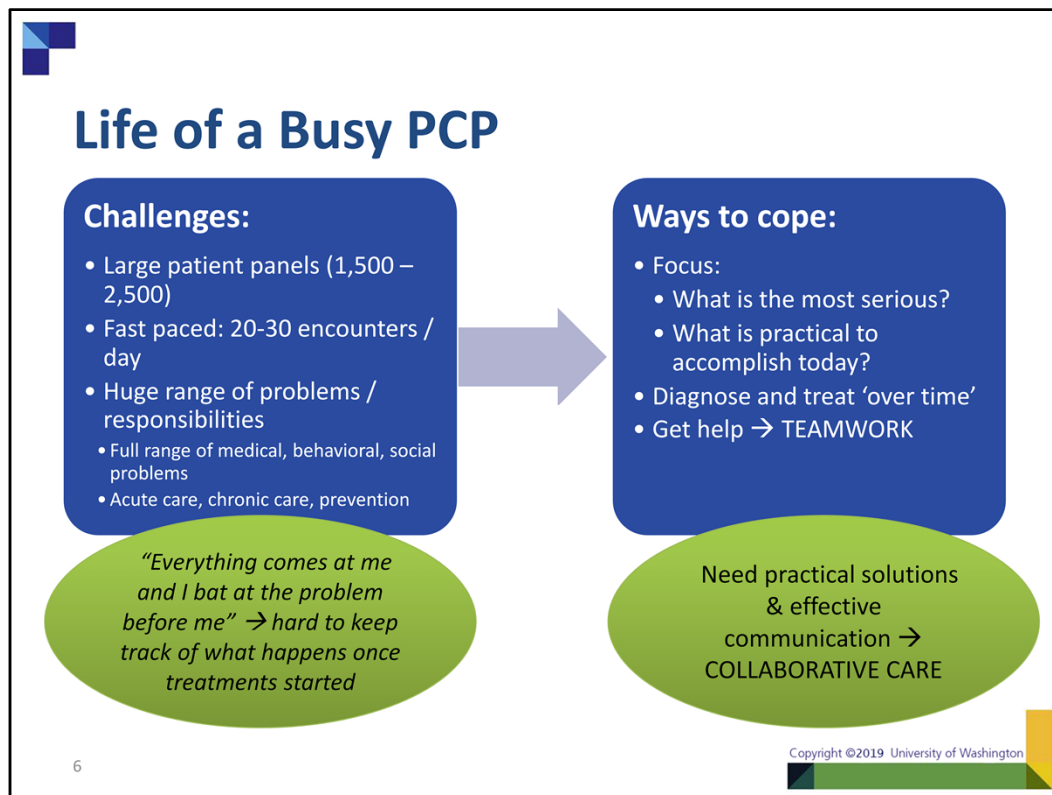
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So you can see there are considerable cultural differences to overcome in “interpreting’ between the two worlds of primary care and behavioral health and it is a crucial part of the care manager’s role to take responsibility for building the bridge between the two.

Let’s start with a consideration of how different the nature of the workday can be in the two cultures. Traditionally one might think of the counselor as having long visits with a small number of clients a day in a quiet individualized private space, in contrast to a primary care provider flying between exam rooms on 12-15 minute visits, under the pressure of meeting tightly controlled productivity goals and seeing tons of people, some new to them and others they have seen for decades.

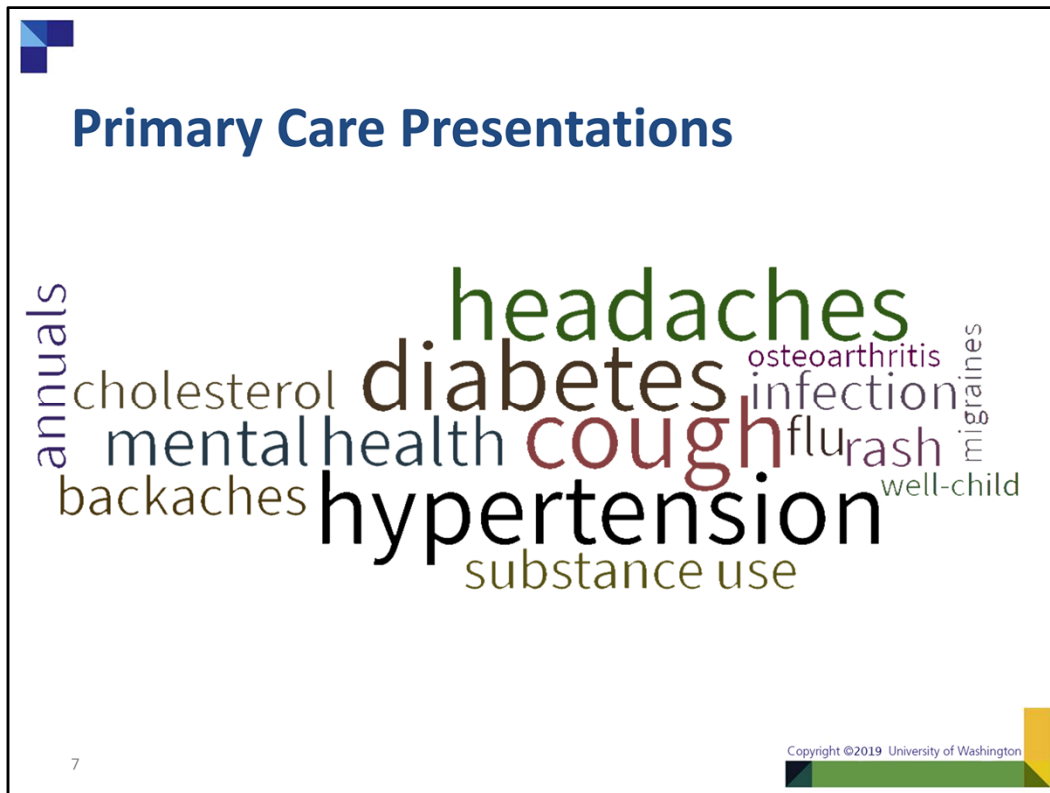
In addition, the primary care provider is used to referring out to specialty care those patients with issues beyond their scope of practice and normally these referrals will be to another practice elsewhere. They will hear back if the referral is successful but may never find out if the patient did not make it to the other provider. It is important for us to understand the PCP’s work in order to build a productive collaboration between these two worlds and two modes of practice.



The size of the patient panel, the vast diversity of complaints and problems, and the fast pace of the day are hallmarks of the lives of primary care providers.

Often they share with behavioral health practitioners an interest in developing relationships with people under their care for the long term, but the sheer busyness of their days and numbers of folks they see creates a tension between relationship and problem solving. It is a common place that many of the people seen in primary care practices have behavioral or emotional issue underlying their physical complaints, but providers may be hard pressed to address these issues appropriately in the brief time allotted to each visit, especially as the more complex issues may come up during the course of the visit, rather than being the original complaint the patient came in for.

This is exactly where collaborative care comes in- to assist providers with the follow up and provision of care for these complicated patients.



Your providers are going to see an enormous amount of people with an enormous variety of complaints. Many of these will be routine but they are also on point for spotting anything out of the ordinary. Effective primary care is widely recognized as being the foundation for good care in the community and there is a ton of pressure on providers both to be productive but also not to miss the slightly unusual presentation that may be indicative of a much more serious medical problem.

In addition to their training and expertise and the strength of their relationships, they really have to rely on the patient's organized presentation of their complaints and the short visits can be a barrier to unearthing complex underlying psychological or social issues.



Range of Problems from Birth to Death

- Annual exams/Well-child visits
- Skin disorders
- Osteoarthritis and joint disorders
- Back problems
- Cholesterol problems
- Upper respiratory conditions, excluding asthma
- **Anxiety, depression, and bipolar disorder**
- Chronic neurologic disorders;
- High blood pressure;
- Headaches and migraines
- Diabetes

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It's really astonishing to think of the complexity of their work and the breadth of knowledge primary providers need. There is a huge range of different conditions they will see in their practices and the emotional and psychological will only be one part of their skill base.

But the work as a generalist also means they see many patient over time and will develop deep bonds with them. In collaborative care we sometimes borrow some of this rapport they have built up with their patients to forge our own relationship with the patient they have referred.

Also of note is that boundaries and relationships may be managed differently in primary care than in behavioral health as they may have insight into the patients they see that we will never have, due to their witnessing more of the patients complete life through attending to the whole family, attending to serious medical crises, births and deaths.



PCP Understanding of Collaborative Care is Critical

- **May not know about Collaborative Care**
- **May not know your role in the team**



As we have seen these are busy people! The success of the collaborative care model in your clinic will be reliant on the care manager being able to recruit the primary care provider into the team and encourage their enthusiastic participation.

They may have been too busy to read the memo that came out explaining the program and your role, so it's your job to elegantly and efficiently explain how you can add value to their practice. It's an exciting connection you will be creating in emphasizing treating the whole person, connecting care of the mind to care of the body.



Why the PCP is important

- **PCP recommendation is powerful**
 - Introduce care manager and team roles
- **Existing relationship as foundation**
- **PCP engages the whole patient**
 - Integrated whole person care plan

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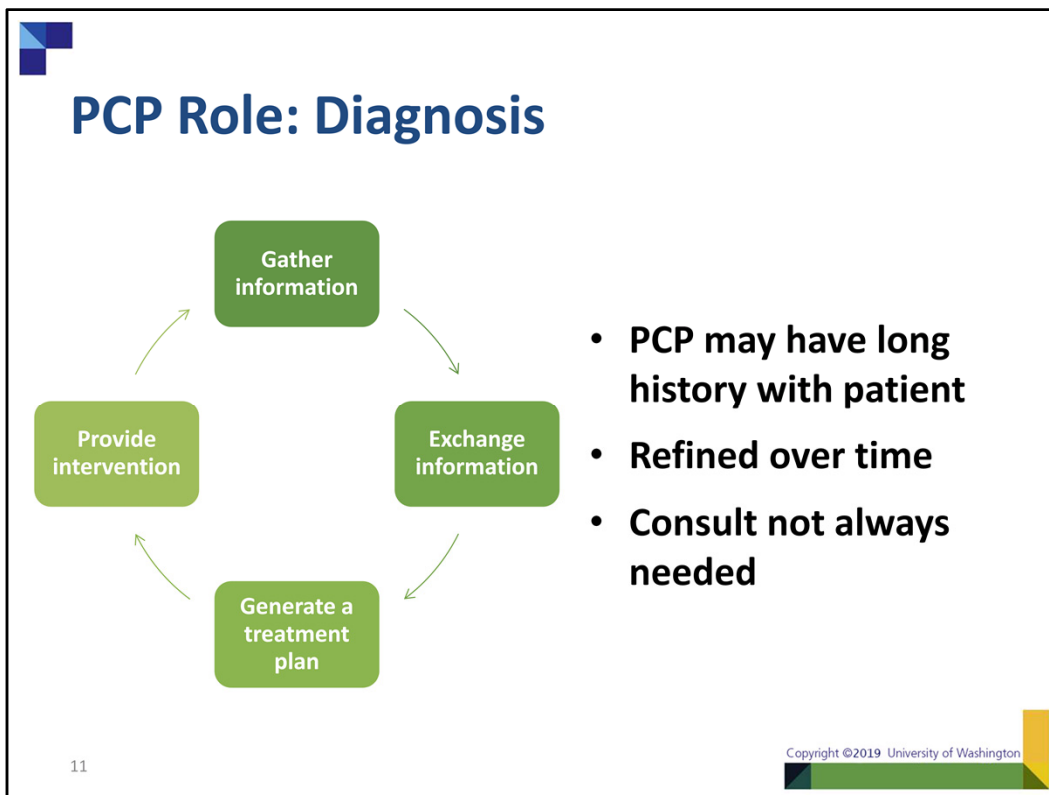
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As we have seen the PCP often has a profound connection to the patient and their family, and often the relationship you will build with the patient will rest on the rapport the provider already has and their willingness to recommend your services.

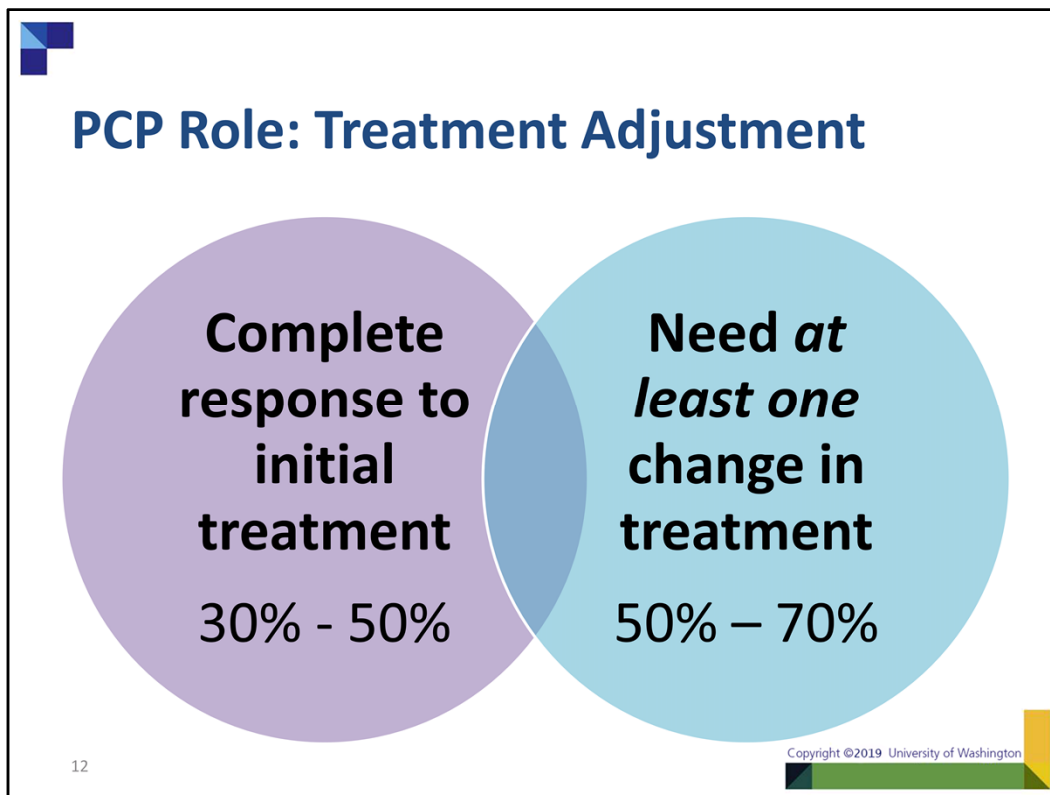
You can additionally see how important this is to access when one considers issues of stigma connected to seeking mental health services, and the difficulty many people have in seeking help- our place on the provider's team really expands access to services in a unique way and helps people access care in a familiar setting.

So it is of paramount importance that the care manager establishes a good relationship with the PCPs in the clinic and helps them understand the role thoroughly in order to elicit appropriate referrals. And you have an important service to provide the PCP also by assisting them in treating the whole patient.



Owing to the close relationship that the provider has with many of their patients it might not always be necessary to have a psychiatric consultation to establish diagnosis. The PCP may have established the diagnosis over many visits and seeing the patient at different stages of their life.

It's very important to respect this aspect of their work and your introduction of collaborative care should not suggest that the team will be preempting this practice wisdom. Our goal is to enhance the PCP's practice by offering additional services where needed and support them in their challenging cases.



We should be clear that collaborative care will not be preempting the PCP's authority as the prescriber. We can't compel cooperation from the provider. You always defer to the PCP, as it is under their license that adjustments to medication treatment, when called for, will be made.

The success of the team rests on the PCP having confidence in the psychiatrist's recommendations and that their patient's condition has been accurately conveyed to the psychiatric consultant, and that the care manager is skilled in communication and assessment. It is very common that treatment needs to be adjusted during a course of care and this is one of the key reasons collaborative care has been proven to be so successful, including as it does measurement of treatment progress and focus on change when needed. It is the PCP who will be writing the prescription for any medication changes, based on the psychiatrist's recommendation so you can see how important it is to manage these relationships effectively.



PCP “Toolkit” to Engage

- **Introductory Package of Materials for PCPs**
 - Key recent research references
 - Descriptions of model and roles from PCP perspective
- **Suggestions for “warm connection” language to introduce care manager, engage patients in care**
- **List of ideas for strategies to work with your PCPs**

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It’s important to consider how you will manage this relationships and what tools you will need for this.

You both need to bring the PCP on board with the collaborative care model and also help facilitate their involvement in it so as to lessen any burden in their busy days. So you might prepare a package of materials on collaborative care to share with them, or offer time to explain the model to them. Be sensitive to what will work best with each provider. You might also create materials for them to share with their patients, a script for them or a hand out for the patient that will assist the provider in developing referrals to you.

It will probably be worth coming together as a team to work out strategies that will work in your clinic and customize these to the needs of each PCP.




Communication with PCPs

- **Need a clear method**
 - Notes in EHR, Copy of a note, other?
- **Communicate significant changes in patient's clinical and functional status or care plan**
 - Prioritize which changes need to be brought to the attention of the PCP
 - Maintain enough contact so that they remember who you are, but not so much that they see you as a pest

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There are big cultural differences between primary care and behavioral health.

Primary care is highly action oriented. They expect to resolve the problem TODAY or, at the very least, initiate a treatment TODAY. They like using measurements (like blood pressure or lab tests) to determine whether there is a problem and to measure progress toward that problem. It is a very fast-paced environment with brief interactions in which assessments and clinical decisions are made very quickly.

Behavioral health is a narrative culture. We want to know the person's story and we want to have a full understanding of the person's life experiences up to this point before making any decisions or recommendations. We can be suspicious of the ability of a measurement to tell us something meaningful about a person. We prefer longer, deeper interactions with fewer people.

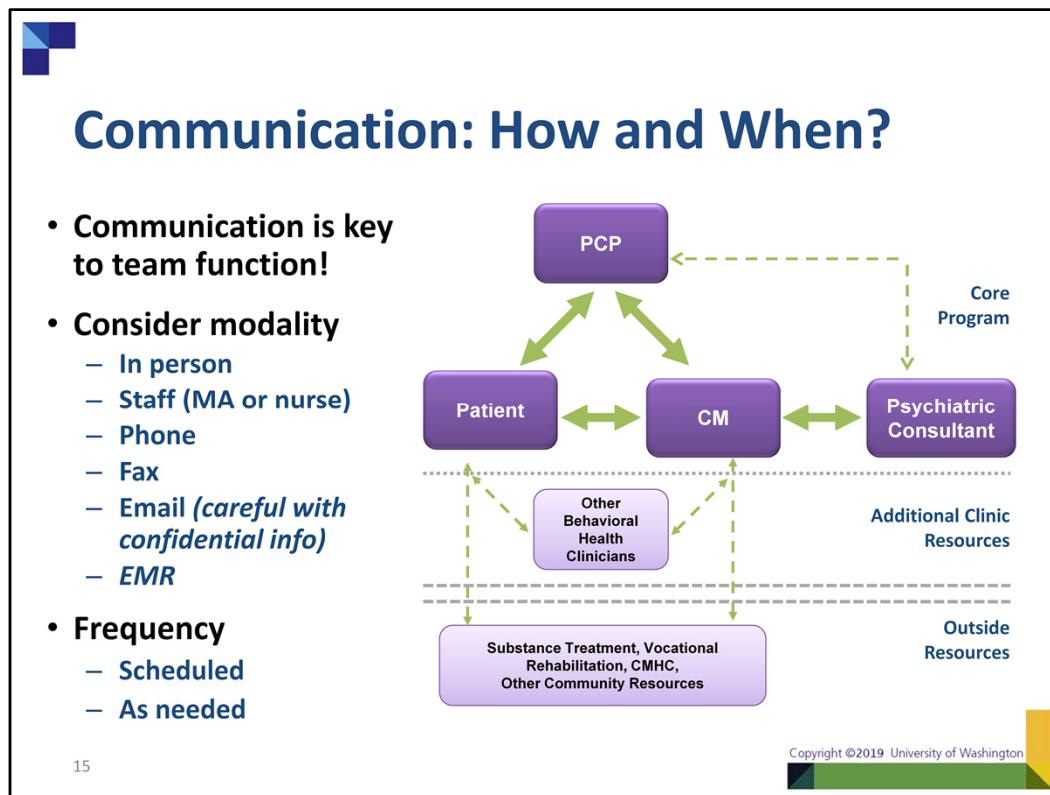
These are broad stereotypes but they are more true than not.

When considering the two cultures, it's easy to see why it can be a challenge for a primary care provider and a behavioral health provider to communicate effectively. The PCP wants numbers, a quick summary and an immediate assessment.

When talking with a PCP about your shared patients:


- use their time as efficiently as possible by prioritizing which patients to discuss and which things to mention about those patients
- but don't be afraid to bring them into the loop and keep them involved

Most PCPs appreciate this contact, when it hits the right balance.



It's not possible to overemphasize the importance of communication when you're working as a team.

Each PCP can be different in terms of the type and amount and method of communication they prefer. I find that it works best to just ask them which method of communication they like best and when/what they want to know. Some providers want to know more and others want to know less. Some prefer a hallway conversation while others prefer a message in the EMR. Asking their preference and using it to organize your communications with them will go a long way toward establishing and maintaining a strong working relationship.




Key Elements to Include When Talking to PCPs

- **Name and ONE sentence psychosocial history**
- **Baseline clinical measures**
 - e.g., PHQ-9 Score
- **Provisional diagnosis; current symptoms**
- **Current treatment(s) and length of time**
 - Symptoms that aren't improving
 - Problematic side effects
 - Psychiatric consultant recommendations (if relevant)
- **Question or purpose of communication**

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There will be a variety of ways you will communicate with your PCP about their patients depending on their style and your needs.

Most importantly you should consider the purpose of the communication and how it moves the patient's care forward. Is it a brief check in requested by the PCPC or a request from you to initiate treatment? Obviously these will be very different communications. A check-in may be brief and purely to satisfy a PCP's concerns or you own questions about a patient who hasn't been showing up perhaps, and can be taken care of in a hallway chat.

Asking for the PCP to initiate treatment or requesting a treatment change may require a more formal request in the EHR perhaps, covering the details shown here. But then again the PCP may already be aware of the need for treatment and just awaiting confirmation from the psychiatric consultant. So you will need to judge what is most efficient and helpful in each case.



Connecting the PCP and Psychiatric Consultant

- **Most of this is through notes and recommendation**
- **Can facilitate direct contacts**

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Something that will be probably be new to your PCPs will be using you as the intermediary between them and their specialty consultant. That is why building trust and confidence in your PCP in the process is so important.

Depending on each clinic setting probably most of the communication between them will be through your notes in the EHR, however you might be able to facilitate in person consults when needed. And this in person contact might be especially important in the beginning of the program as these relationships begin.

A site visit from the psychiatric consultant to a PCP team meeting might be helpful. And going forward you might take the role of scheduling any needed phone calls between the two to help manage the challenges of their busy schedules. This can be very helpful both in establishing trust and in cementing your own usefulness to the team. Remember the psychiatric consultant is a valuable resource that you personally control.



Reality Check



- **We're asking a lot of primary care providers**
 - **Behavior change**
 - **Treatment to target - new way of thinking**
 - **Chronic care management model**
 - **PCP may or may not see value in new model**
 - **Two new team members may be viewed as external, not entirely under PCP control**

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We've spent this time focusing on the integration of collaborative care into the primary care provider's work flow because it is a new way of working for your clinic and relies on a total new approach for most PCPs. It requires them to relate to a specialty resource in a revolutionary new way. They will be communicating through you in contrast to customary practice of sending the patient out for specialty care that would be managed by the specialist colleague who would later fill in the PCP directly. In our model we are asking them to take on the prescribing responsibility based on input from another provider, with whom they have no direct relationship.

In addition, the whole idea of the chronic care management model for behavioral health issues may be completely new for them and their part in it may feel uncomfortable. Working directly with you is also something they will have to learn and it may feel like a burden and extra work at first and seeing you in this care manager role may be very different to how they think of traditional behavioral health roles like psychotherapist or counselor. We asking them to take on a new form of practice at the same time as relinquishing aspects of control.



Effective Integration Requires Practice Change.



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Change is hard for people, and your efforts are going to be key in making this work well in your clinic. So let's turn now to how you will get this done.



Getting Started in Your Primary Care Clinic



- **What's your “elevator speech” for PCPs?**
- **How will you build your working relationship with your PCPs?**
- **How will you share your role with the larger clinic team?**



This is a different way of working for you too! It takes the BH provider out of the therapeutic dyad and requires you to take on the responsibility of developing an effective team and building positive relationships within that team. Partly it is accessing your inner extrovert!

For starters you will need to make an effective communication plan. You will need to find a great way to communicate with your PCPs and the psychiatric consultant but also a way of informing everyone else in the clinic about this new approach, from MAs to the front desk. To be successful you will need to educate everyone the patient comes into contact with about collaborative care in order to gain their support and understanding of this new approach.