

Chapter 2

A Primer on Primary Care

*“In theory there is no difference between theory and practice.
In practice there is.”*

Yogi Berra

Since the ink dried on the first edition of this book 7 years ago, several factors have accelerated the move toward development of Primary Care Behavioral Health (PCBH) practices throughout the United States (and other countries). Probably the most basic reason has to do with the fact that the PCBH model is more about practice and less about theory. However, there are other factors driving the expansion of PCBH programs.

First is the evolution of PC, as it moves from physician-centric to team-based care, in line with the aspirations of the *Patient-Centered Medical Home* (PCMH) model. Concurrent with this, the empirical and anecdotal evidence for the positive impact of the PCBH approach to integration has grown. Large healthcare systems such as the Department of Defense have led the way in demonstrating the value of PCBH implementation, while in smaller systems the model has grown organically in transforming PC to behaviorally friendly team-based care. Another contributing factor to growth has been the requirement for community health centers to integrate behavioral health providers into PC in order to receive federal funds for expansion. Federal government grant announcements have even referenced the first edition of this book (see Web Link 1). A final influencing factor is the substantial increase in the number of people able to access healthcare services due to implementation of healthcare reform. As the pressure grows on PC to see even more patients, the need grows for the high-volume practice methods of the PCBH model.

In this chapter, we explore these developments in more detail as we describe the mission and function of PC and its fundamental role in the healthcare system.

We also provide a glossary of terms used in today's conversations about healthcare innovation and laws related to the delivery of healthcare services. We conclude with descriptions of the specific roles and practice habits of the Behavioral Health Consultant's (BHC's) teammates in the new PCMH.

The Mission of Primary Care

Everywhere in the United States, people of all ages, cultures, and socioeconomic statuses visit PC; it is the patient's first point of entry into the healthcare system and focal point for future healthcare needs. Thus, of all healthcare settings, PC involves the widest range of services. While there may be variations among PC clinics in mission statements, the Institute of Medicine's definition of PC is clear and stable, having been made originally in 1996 (Institute of Medicine, 1996). It is as follows: "Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community." Note the emphasis on integration, accessibility, and continuous generalist care and the importance of connecting with family and community; the PCBH model was built with these same functions in mind.

Primary care helps patients prevent health problems, address acute health problems, and manage chronic health conditions, through both direct care and coordination of specialty care. It also helps patients access social services and advocate for patients' health needs. Primary care is delivered in diverse settings including solo practice clinics, multiple provider clinics, long-term care units, home care services, day-care programs, and school-based clinics.

As the works of Barbara Starfield and others have shown, primary care is an incredibly important part of any well-functioning healthcare system. Countries with the most robust primary care have the healthiest populations. The benefits of strong PC are better health outcomes, a more equitable distribution of care, and lower healthcare spending. Unfortunately, the United States has for many decades failed to recognize the importance of primary care, instead designing a reimbursement and care delivery system that favors specialty care. This is a major part of what has contributed to ballooning healthcare costs in the United States and the poor ranking of the United States on various key health measures (for more on the above, see Starfield, 2008; Starfield, Shi & Macinko, 2005).

In recognition of the above, the focus of the PCBH model is on strengthening PC, so it can be delivered as intended. In contrast to some other models of integration, the PCBH model is not about bringing specialty MH approaches into PC and does not focus primarily on strengthening ties to the specialty MH system. Integration models that aim to make PC more specialized run the risk of losing sight of the value that true PC can bring (Starfield, 2007). Instead, the PCBH model is about embracing the PC mission and approach and helping PC to work better so it can fulfill its mission and realize its potential.

New Terms in Primary Care

Most BHCs experience new and sometimes challenging circumstances in the PC setting. We both recall the confusion and stress of our early days in PC, as we tried to learn the roles of our new clinic teammates, understand the terms and concepts discussed at meetings, and just figure out how to get a word in with a busy primary care provider (PCP). In addition, the barely controlled chaos of PC, with crying children on vaccination day, masses of people in the waiting area, and constant overhead pages, seemed overwhelming at first. Over time, and after many questions, we relaxed into the busy and noisy hallways, learned how to work in sync with our new team members, and mastered the language of PC. In the rest of this chapter, we hope to give the new BHC a head start on these adjustments by reviewing current PC language and terms (especially those related to recent healthcare innovations) and introduce the PC team members.

The Medical Home Concept

One term commonly encountered in PC today is the PCMH (also referred to as the “patient-centered healthcare home,” “medical home,” or “healthcare home”). The PCMH lists a number of aspirations for how to structure and deliver PC. In 2007, the major PC associations joined together to create and publish the *Joint Principles of the Patient Centered Medical Home*. Since then, the model has evolved to consist of the following five components (Agency for Healthcare Research and Quality, 2014):

1. Comprehensive care: the PCMH must meet the majority of a patient’s physical and MH care needs, including preventive, acute, and chronic care. This is accomplished by building a team of diverse care providers.
2. Patient centered: care is relationship based, involving patients as partners and respecting their culture, values, and preferences.
3. Coordinated care: care provided by specialists, home health care, hospitals, community services, and others should be coordinated by the PCMH.
4. Accessible services: a PCMH should have shorter waiting times, hours that are convenient to the patient, and care team members that are available through a variety of means, including email and phone.
5. Quality and safety: the PCMH should engage in continuous quality improvement and use evidence-based care and population health strategies.

In 2011, the National Committee for Quality Assurance (NCQA), the primary agency responsible for certifying, or “recognizing,” an organization as a PCMH, detailed PCMH program standards. Such recognition is voluntary. The six standards include: (1) patient-centered access to care, (2) team-based care, (3) population health management, (4) care management and support, (5) tracking and coordination of care (e.g., for referrals), and (6) measuring and improving performance. The NCQA will help clinics prepare for recognition, including ensuring that *electronic health record*

(EHR) systems, advanced registries, population health management tools, and other technology-related aspects of care align with PCMH standards (AHRQ, 2014).

Many studies conducted in a variety of settings, and even different countries, have shown that the PCMH can improve quality, lower costs, reduce errors, and improve patient satisfaction (e.g., see Reid et al., 2010; Rosenthal, 2008). At the same time, research has also questioned the results of the PCMH. It is often applied very differently from one system to another, and results have sometimes been less than expected (Hoff, Weller & DePuccio, 2012; Peikes, Zutshi, Genevro, Parchman & Meyers, 2012). One important point about the PCMH is that, as noted by Freeman (2011), behavioral health providers have not typically been considered members of the PCMH team. The joint principles merely recommend that a physician lead the team; other PCMH policy papers rarely discuss behavioral health, other than those written by behavioral health professionals themselves. Seemingly, when conceptualizing the PCMH team, most think only of the usual staff, such as the physician, RN, lab technician, and MA. Freeman concludes that, “Behaviorists...are considered external to the Healthcare Home by the chief architects of the concept.” The American Psychological Association (2009) has also noted this and has lobbied for change. The 2014 revision of the PCMH standards do promote enhanced care for behavioral issues, but unfortunately they still do not require a behavioral health presence be integrated into the team.

This omission is unfortunate, given that so much of what the PCMH is intended to help with involves conditions with a behavioral component. One might imagine that some, if not all, of the goals of the PCMH would be much more easily met if every PCMH team had strong behavioral health support. Indeed, data from a Blue Cross/Blue Shield analysis of care outcomes in the behaviorally enhanced PCMH of Cherokee Health Systems, in Tennessee, found exactly that (Freeman, 2011). Compared to patients of other PC systems in the same region, Cherokee patients used emergency rooms, medical specialists, and hospital care significantly less; and the overall cost of Cherokee’s patients was significantly and substantially lower. Cherokee was an early adopter of the PCBH model, and the only difference between Cherokee and the other PC systems was the presence of a BHC on Cherokee’s PCMH teams (Freeman, 2011).

Thus, while the PCMH holds promise as a model for improving PC, it would likely benefit from a greater emphasis on the role of behavioral health in PC. Given the behavioral nature of so many of the problems seen in PC, the PCMH team that adds a BHC should be well on its way toward meeting the ideals of the PCMH approach. We turn our attention now to other terms closely associated with PCMH, which a BHC will surely encounter.

Triple Aim

In 2008, Berwick, Nolan, and Whittington described the *Triple Aim*, which refers to the three keys to improving the US healthcare system. They noted that despite spending far more than any other country on health care, the United States lags far

behind other countries in results. As an example of the problems the system has, they discuss congestive heart failure, the most common reason for admission of Medicare patients to a hospital. Nearly 40% of patients presenting with congestive heart failure are readmitted within 90 days, even though well-designed demonstration projects have shown for a number of years that proper management of patients can reduce the readmission rate by more than 80%. Thus, owing not to a lack of knowledge or technology, but rather to various deficits and inefficiencies in the current system, these patients are not as healthy or satisfied as they could be and are more costly. Thus, the goals of the Triple Aim are for the healthcare system to (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.

In their seminal 2008 paper, Berwick and colleagues suggested a strategy for achieving the Triple Aim, and most healthcare reform efforts have lined up with the strategy suggested. Note that a key element of the Triple Aim strategy is redesigning PC to be consistent with the goals of the PCMH. Stiefel and Nolan (2012) offer a guide to Triple Aim measurements and we will provide more on this in Chapter 8 as a part of a discussion on measurement and PCBH program evaluation.

Affordable Care Act

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act, commonly called the Affordable Care Act (ACA), or colloquially termed “Obamacare.” It mandates a series of comprehensive health insurance reforms so vast that even a separate book on the topic would fail to do it justice. For the purposes of this book, we will highlight several key aspects of the new law relevant to the PCBH model.

First, the ACA aims to assure that all Americans have access to affordable health insurance options, including millions of people who were previously uninsured. People who have been excluded from healthcare insurability due to preexisting conditions, young adults who previously lost insurance when turning 18, and those people who simply could not afford it, all may now have access to insured health care. Second, the law emphasizes the importance of PC and attempts to strengthen it in various ways, including incentivizing medical students to work in PC, particularly in medically underserved areas. Third, the law aims to move health care away from the episodic, fee-for-service model of care delivery and toward a preventive, coordinated model. For example, it mandates that Medicare pay for a yearly wellness visit, creates a 15 billion dollar fund for prevention and public health, and encourages PCPs to join together in “Accountable Care Organizations” to improve care coordination, which we discuss later in this chapter.

All of these initiatives are likely to produce enormous changes in how PC is organized, provided, and paid for in the years to come. For a BHC, at the time of writing this book, there are two significant ramifications. First, many PC clinics will see an influx of new patients, and many of these new patients will have been without recent health care. This will make the already stressed PC system even more so. It

is estimated that the country will need about 52,000 additional PCPs by 2025 to meet the new demand, and that, of course, will take some time to happen (Pettersen et al., 2012). Second, there will be greater competition for patients among health-care organizations, as the newly insured sort through care options. This is especially likely to affect community health centers, which previously were the only viable option for uninsured patients.

These ramifications will create new challenges in PC, but they will also create new opportunities, especially for an energetic BHC. As discussed throughout this book, the goal of the PCBH model is to help PCPs be more efficient and effective, meaning a strong BHC service could help ease the strain of the PCP shortage. The influx of new patients, many of whom will have chronic problems, means plenty of opportunities should exist for a BHC to help his new PCP colleagues. A recent RAND report suggested that use of the PCMH could cut the expected shortage of PCPs in half (Auerbach et al., 2013), and that is, of course, without considering the additional help that a BHC could provide to the PCMH. In addition, the new competition for patients means clinics will need to be improving and meeting the needs of their population more than ever. For many clinics, especially community health centers, this means building the best team possible to meet the medical, social, and behavioral needs of patients, and that translates to great potential for a BHC service. If nothing else, the emphasis that the ACA puts on PC means the job market for BHCs should be strong and the opportunities plentiful for doing meaningful work. Thus, we encourage BHCs to embrace the challenges of the new care environment. As the saying goes, “In chaos there is also opportunity.”

Accountable Care Organization

Elliott Fisher introduced the term *Accountable Care Organization* (ACO) in 2006, at a meeting of the Medicare Payment Advisory Commission. It was included in the federal Patient Protection and Affordable Care Act and now there are ACOs in every state. While ACOs may vary, all share the following three characteristics.

1. They are provider-led organizations with a strong PC base and are collectively accountable for quality and total per capita costs across the full continuum of care for a population of patients.
2. Payments link to quality improvements that reduce overall costs.
3. Performance is reliably measured.

In order for ACOs to succeed in their mission to foster excellent care while simultaneously saving money, their sponsors will need to create incentives for hospitals, physicians, post-acute care facilities, and ACO staff to work together to strengthen linkage and coordination of care delivery. The devil will surely be in the details on this very good idea, and BHCs will likely to be in a position to play a pivotal role.

Coordinated Care Organization

A Coordinated Care Organization (CCO) is a network of different types of healthcare providers (often medical, addiction, MH, and sometimes dental) who have agreed to work together to better serve the healthcare needs of their community. If you think of the PCMH as a patient's medical home, you can think of the ACO or CCO as the patient's medical neighborhood. In the state of Oregon, 15 CCOs are providing both prevention and chronic care management services to the state's Medicaid recipients. The state's goal is meeting key quality measurements for improved health for clients served while reducing spending growth by 2 percentage points per member over the next 2 years.

Providers and Management in Primary Care

Providing good PC requires not only good physicians but also a whole host of competent staff. For the new BHC coming from the specialty world, understanding the roles of PC staff members is crucial, yet sometimes confusing. To help, we devote the rest of this chapter to introducing these new colleagues. We explain the different types of PCPs and the roles and responsibilities of other staff persons commonly encountered in PC and discuss how each position might interact with a BHC. Bear in mind, however, that clinics differ from each other and some will not have all of the staff described in this chapter, whereas others will have positions not described here.

Primary Care Providers

In this book, the term PCP includes physicians as well as nurse practitioners (ARNPs), physician assistants (PAs), naturopathic physicians, and any other providers who independently oversee all aspects of a patient's PC. In this definition, nutritionists, BHCs, acupuncturists, and some others may be "providers," in the sense that they provide care, but they are not PCPs because they do not govern all aspects of care.

The PCP is a generalist who provides care for any undiagnosed sign, symptom, or health concern (the "undifferentiated" patient), regardless of the patient's age, the problem origin (biological, behavioral, or social), or the organ system involved. The PCP provides the first point of contact for such care and takes continuing responsibility for it, consulting with or referring to other health professionals as needed. The majority of a PCP's practice is devoted to a defined population of patients (her "panel"), who may remain under her care throughout the entire life span. The PCP is also an advocate for the patient in coordinating use of the entire healthcare system to benefit the patient.

Physician Primary Care Providers The term *physician* applies to doctors of medicine (MD) and osteopathy (DO). Primary care physicians have training in one or more PC specialties, including family medicine, general internal medicine, geriatrics, and general pediatrics. Some PC physicians obtain additional certification for practicing obstetrics–gynecology. In 2010, there were approximately 209,000 practicing PC physicians in the United States. Around 80,000 of these were in family medicine, 71,000 in general internal medicine, 45,000 in pediatrics, and 3,000 in geriatrics. Primary care physicians represent slightly less than one-third of practicing physicians in the United States (AHRQ, 2014).

Like other professionals, PC physicians vary in practice style, interests, and specialization areas. Older PC physicians tend to have older patients, while younger doctors tend to attract younger patients (Robinson et al., 1995). Provider panels are typically diverse but may reflect provider interest and skill areas to a degree. Some providers deliver babies and provide care for numerous young families; others provide care to mostly older patients with multiple medical problems. Some providers enjoy treating patients with psychiatric disorders; others have little interest in this area.

As a general rule, family medicine PC physicians manage the greatest variety and highest number of patients, internists manage the most complex adults (often having a smaller panel size as a result), and pediatricians manage the most complex child patients. In reality, however, most PC physician panels are a mix, and family medicine PC physicians manage plenty of complex patients of all ages. The Institute of Medicine of the National Academies (1996) recommends the following competencies for PC physicians:

- Periodic assessment of asymptomatic patients
- Screening and early detection of disease
- Evaluation and management of acute illness
- Evaluation and management (or referral) of patients with more complex problems
- Ongoing management of patients with chronic disease
- Coordination of care among specialists
- Provision of acute hospital and long-term care services

There is little in the literature about how to improve practicing PC physician competence for behavioral strategies. Available research suggests that when PC physicians do use behavioral strategies, they tend toward use of cognitive behavioral therapy (CBT) interventions for treatment of depressed patients (Robinson et al., 1995). Also, the likelihood of a PC physician to use behavioral interventions increases over time when a BHC is a part of the PC team (Katon et al., 1996). Residency training for PC physicians in behavior change strategies is typically anemic. In family medicine, every residency program must have a “behavioral scientist” on faculty, usually a psychologist or social worker. However, the training provided by these behavioral scientists has typically been inadequate and not aligned with the real clinical world. Historically, training has involved didactics regarding diagnosing and therapy interventions, observation of the behavioral scientist in 55-minute family therapy interventions, home visits with the behavioral scientist,

or 55-minute resident visits with patients. In other words, little is typically taught that could actually be applied in the real world of 15-minute visits in PC.

Some innovative residency programs are beginning to change this. In the Central Washington Family Medicine Residency, for example, the behavioral scientists operate as BHCs, and residents work side by side with them during rotations in psychosocial medicine. The residents observe multiple brief BHC visits with patients and, when ready, provide parts of the BHC visit and then the entire visit (with direct BHC supervision). Eventually, residents function as autonomous BHCs, providing brief, functionally oriented visits and only accessing the behavioral scientist BHC as a preceptor when needed. Residents also participate in group medical visits with the BHC. Many other residency programs are also attempting to improve how they prepare the PC physicians of the future for the many behavioral issues frequently encountered in PC. Like MH providers who in the past have tried to integrate PC with traditional therapy, behavioral scientists have begun to realize that what is needed for PC is a vastly different skill set from the traditional therapist approach.

Nonphysician Primary Care Providers Nonphysician PCPs are usually ARNPs or PAs. There are approximately 56,000 ARNPs and 30,000 PAs practicing today as PCPs (Auerbach et al., 2013). Typical PA training involves 18–24 months of graduate work, following a bachelor's degree, whereas an ARNP is usually an RN who also holds a master's degree in advanced practice nursing. In some states, ARNPs can diagnose, treat, and prescribe without physician involvement, which means they function autonomously as a PCP. Considering that they also draw a significantly lower salary than a physician, many organizations are looking to meet an increased patient demand (and work around the PCP shortage) by hiring ARNPs rather than physicians. The number of ARNPs practicing in PC is expected to nearly double by 2025 (Auerbach et al., 2013). The number of PAs in PC is also expected to grow, though the actual percentage of PAs working in PC versus other specialties has been shrinking for a couple of decades (Coplan, Cawley & Stoehr, 2013). Unlike an ARNP, a PA must be supervised by a physician, which probably results in a stronger market for ARNPs. Regardless, both PAs and ARNPs will certainly be called upon to lead many medical home teams (Cooper, 2007).

Naturopathic Physicians At the time of writing this book, 17 states in the United States license naturopathic physicians (NDs) to practice, but scope of practice and prescriptive authority varies state to state. Although NDs emphasize the use of natural healing agents, they are also trained in pharmacology, and in some states such as Washington, Oregon, California, and Arizona, they can prescribe most synthetic drugs. NDs complete 4–5 years of postgraduate training in a naturopathic medical school. They study the same basic and clinical sciences as MDs but also receive considerable training in nutrition, counseling/psychology, and homeopathic and botanical medicine. Additionally, they receive extensive physical medicine training and can provide procedures such as manipulation (similar to osteopathic or chiropractic manipulation). Their training also emphasizes disease prevention and wellness (American Association of Naturopathic Physicians, 2014). If practicing in a state where NDs can be licensed, a BH might find himself working alongside one. Often, NDs are easy partners for a BHC, owing to their interest and training in natural and holistic treatment.

Temporary Primary Care Providers Like everyone, PCPs sometimes need to be away from work for vacation, sickness, continuing education, maternity leave, or some other reason. When this happens, clinics often hire temporary PCPs to substitute for them. *Float providers*, sometimes called just *floats*, are PCPs who fill in for short periods of time, typically on a moment's notice. Typically, clinics have an established pool of floats who they contact for help when needed. Coverage for longer-term absences, such as when a PCP is away on maternity leave or when a departed PCP's position has not yet been filled, is provided by *locum tenens* providers (sometimes called just *locums*). Most locums are hired through an agency that manages their work. A clinic in need of a locum will contract with an agency that supplies them; the clinic may pay the agency, who in turn pays the locum and arranges for his travel to the clinic, lodging, and other expenses. Some PCPs make a career of locums work, traveling the country working in various clinics for a few months at a time.

Because patients with chronic conditions often prefer to see the same PCP consistently, temporary PCPs may end up mostly seeing patients for acute problems. They also sometimes end up seeing fewer patients than a regular PCP, for this same reason. Yet, these temporary PCPs have their own unique set of stressors. Their temporary status shields them from some of the challenges of managing a panel, but also deprives them of the rewarding aspects, such as seeing patients benefit from their guidance and help and forming connections with patients over time. They also experience stress from working constantly with unfamiliar staff in unfamiliar clinics with unfamiliar policies.

An established BHC who knows the clinic's patients and policies well can be a valuable resource to a temporary PCP, offering insights and advice regarding patients the PCP sees. However, a new float or locum may not know about or understand the BHC's role, so taking a few minutes for an introduction and an orientation to the BHC service can be very helpful. Touching base informally with the float/locum throughout the day will also help him to be mindful of the BHC service.

Registered Nurses

Although it varies, most clinics will have one RN for every five or six PCPs. Possessing a bachelor's (BSN) or an associate's degree (ADN), the RN serves several important roles in the clinic. Those RNs with a BSN may have an administrative role, including supervising nursing assistant staff. In many clinics, an RN is also responsible for triaging patients who call or come to the clinic requesting same-day appointments. Most RNs also provide services for chronic disease management (e.g., diabetes education, chronic depression medication adherence), preventive services (e.g., anticipatory guidance during well-child checks), and in some cases lifestyle behavior change (e.g., smoking cessation). Some RNs focus on specific patient groups and are called *disease management RNs* or *care coordination RNs* or *RN facilitator*.

In the context of ACOs and CCOs, select nursing staff may partner with BHCs in specific duties concerning at-risk patient groups, including patients in the community

who do not have a connection with a PCP. These are new jobs for RNs and BHCs, evolving out of the Accountable Care Act and the move toward creation of PCMHs. The mission of RNs and BHCs in these organizations includes helping patients avoid unnecessary use of the emergency department (ED) and unnecessary hospitalizations by assisting them at transition points, such as obtaining timely follow-up care with a PCP after a hospital admission or emergency room visit.

Unlike BHCs, most RNs do not make treatment decisions and so are not usually considered “providers.” However, as is evident from the above, there may be a lot of overlap in BHC and RN activities. To avoid conflicts about “turf” and to maximize the skills of both, a good early activity for a new BHC is to collaborate with RNs on planning a division of work that benefits the maximum number of patients. For example, the RN might prefer that the BHC handle most of the tobacco cessation visits so the RN is freed up to do more diabetes education.

The BHC and RN also need to discuss other ways they can complement each other’s work. For example, an RN facilitator may work primarily through phone calls to assist depressed patients with medication adherence, while the BHC provides skills training in brief clinic visits with the same depressed patients. The RN can also support interventions started by the BHC in phone checks. When the patient is ready to taper from medications, it may be the BHC who develops a relapse prevention plan. The BHC and RN facilitator may also provide group visit services together for select patient groups that need both medical and behavioral expertise (e.g., older patients with limited social support who are demoralized by multiple medical problems). In some ACOs and CCOs, RNs and behavioral health providers also focus on health promotion and prevention activities (e.g., helping patients start exercise activities in community programs).

Given the overlaps in some patient care tasks, and also their role in triage, RNs are often a great source of referrals for BHCs. Like other members of the PCMH team, however, they may need education regarding the various ways a BHC can be of service. Including RNs in discussions about how to refer patients for visits with the BHC on the same day of requested and/or provided medical services and helping them understand how a BHC can help with nonpsychiatric issues (e.g., lifestyle change for chronic diseases or prevention) are a key early activity for the new BHC. Developing a workflow for when to involve the BHC with patients who are in emotional distress during an RN triage visit or call is also helpful. Like PCPs, RNs frequently deliver bad news to patients (e.g., calling a patient about a positive lab result for a sexually transmitted infection) and during triage visits patients are often in emotional distress.

Licensed Practical Nurses, Nursing Assistants, and Medical Assistants

Licensed practical nurses (LPNs), nursing assistants (NAs), and medical assistants (MAs) play important roles on the PCMH team. They typically have completed specialized coursework following graduation from high school. Of the three, LPNs

have the most training, while NAs have the least training. Due to nursing staffing shortages, healthcare clinics are hiring more LPNs and NAs to assume some duties that would otherwise be accomplished by an RN.

Together, nursing staff members coordinate a variety of patient care activities. Given their central role, they often have a finger on the pulse of the clinic and they will often be the ones to go to when you, as a BHC, want to communicate with a PCP. Typically, NAs and MAs bring patients into exam rooms and complete various pre-visit activities with them. They take vitals, clarify the reason for the visit, verify medications, and often ask screening questions about smoking or other problems. They then enter this information into the EHR. These team members are often the ones who administer self-report measures, such as a quality of life scale, prior to the PCP visit. As such, they may need training from the BHC on how to administer and score these measures. They also, by virtue of being the first clinical contact with the patient, might detect patient concerns that could warrant a BHC visit. If empowered to bring such issues to the attention of the PCP or the BHC, they may generate BHC referrals that otherwise would not materialize.

At the end of the patient–PCP encounter, the NA or MA may escort the patient to the next stop, such as the laboratory or front desk. They may also give patients information about resources, patient education pamphlets, etc., as directed by the PCP. For this reason, the BHC should ensure they have access to handouts on behavioral topics and keep them informed about relevant community resources. In this book, we use the term NA consistently but recognize that MAs may perform similar or even more responsibilities, consistent with more extensive training.

Support Staff in Primary Care

For some support staff in PC, such as front desk workers, the roles and responsibilities are similar to their equivalent in an MH clinic. Depending upon the size of the clinic, the front desk worker typically greets the patient, verifies demographic and insurance information, provides the patient with screening or other visit-related forms, and notifies the team of the patient’s arrival. In smaller clinics, the front desk person may also collect payment, answer the phone, and schedule patients by phone or in person for return visits after the medical visit ends. In larger clinics, part of the responsibilities of the front desk person may be shifted to the ward clerk or appointment line worker. There will also be support staff members who provide a range of services related to billing. Their jobs include review of coding information, summarizing data, generating information for billing, and creating reports for leadership. It is important that the BHC develop good relationships with these staff members, so we encourage you to get to know them and keep your communication with them strong.

Front Desk Staff Members These are the first and last people to see most patients. When a patient enters the clinic for any provider, the front desk clerk obtains all

necessary information and generates documentation for the visit. If EHRs are in use, he or she enters information on a computer indicating that the patient has arrived. Whether communicated electronically or in some other way, the front desk clerk makes sure the NA knows when the patient is ready to be called back. (When the front desk is short on staff, patients wait in lines and NAs may not know that their provider's patients are in the clinic.) At the end of a visit, patients may be directed again to the front desk staff to turn in a billing slip, pay, and/or schedule a follow-up appointment.

In many clinics, front desk workers will be the ones to enter *same-day patients* as well as *warm handoffs* into the BHC's schedule. Same-day patients are those who walk in or call the clinic asking for a BHC appointment on the same day, whereas warm handoffs are BHC referrals generated during a PCP visit. Either the BHC or her assistant will need to notify the front desk of the warm handoff so the visit can be appropriately documented, and often this will require some planning to create a process that works smoothly for both all parties involved. This planning should be one of the initial activities for a new BHC. Educating front desk staff about the variety of ways the BHC can be utilized is also very important. They can be a good source of same-day appointments by, for example, offering a BHC appointment when checking in a patient who is coming to see a PCP for smoking cessation.

Front desk staff members have a difficult job and may benefit from assistance from the BHC. They are often the ones who check the insurance status of patients, tell the late-arriving patient that he can't be seen, and keep demographic and billing information Up To Date. Patients often express frustration to them and might view them as an annoying obstacle to care. At the end of a visit, when patients are eager to get home, they often must return to the front desk to pay or wait in line to schedule a follow-up. The BHC can cultivate relationships with front desk staff by suggesting strategies for handling angry patients, offering stress-reduction workshops at lunch, or even just bringing them snacks during holiday times. Simply acknowledging the challenges of their job can go a long way.

Ward Clerks Ward clerks are expert multitaskers who also have difficult jobs. Ward clerks usually work at a computer in the nursing station area wearing a headset while on the phone with patients. At the same time, they usually have a patient at the window with a request or concern and an NA at their side trying to tell them something. As with any staff who are busy, be mindful of their workload before interrupting them. In some clinics, ward clerks create provider schedules and make changes to them, meaning they may be the ones to go to for assistance with the BHC schedule template.

Appointment Line In larger clinics, there may be one or more appointment line workers. Their job is to answer the phone and assist patients with scheduling an appointment. They often schedule patients for multiple services. It is a good idea to talk with them at the start of a new BHC service, so they have a basic understanding of BHC services and what patients may say when requesting a service from a BHC. They are also important players to consult with when planning group visits, because scheduling for groups is often different from individual visits.

In larger clinics where multiple BHCs provide services, the system may have a public service announcement about BHC services on the appointment line recording that patients listen to while waiting to make their request to the appointment line worker. As patient portals become more commonplace, there will be opportunities for email “blasts” targeting specific patient groups for BHC services. Here too, the appointment line clerk will need to know what the BHC is blasting in order to be prepared to schedule the patient correctly.

Billing Specialists These staff members may also be referred to as *medical billing specialists* or *coding specialists*. They record and process patient health records. Their responsibilities include organizing patient files and assuring that visit notes are accurate and accessible. Additionally, they may process payments, including sending out bills and processing insurance claims. When there is confusion about a billing issue or about what services were rendered by a provider, the billing specialist is often the one who works to resolve it.

Interpreters Clinics vary in the way they address the issues related to interpreting. A solo practice might have a less frequent need for interpreters and so may rely on phone interpretation services. Federally qualified health centers, which see a disproportionately high amount of non-English speakers, are required as a condition of funding to provide interpreter services. In places like Hawaii, where patients speak between 10 and 15 different languages, clinics tend to have multiple interpreters on staff. Clinics where many patients speak the same non-English language (usually Spanish in the United States) often try to hire staff members that are fluent in that language. For patients speaking less common languages, interpreters from outside agencies may be scheduled to come for the patient’s visit or to assist in a phone-based or video-based service. In Chapter 10, we provide detailed guidance for working effectively with interpreters in BHC visits.

Administrators

There are a variety of administrators in the PC setting. They provide important services and they will likely be a part of the team that interviews candidates for a BHC position. In larger systems, these administrators work with leaders in other clinics in the health system and with the system-level leaders, including the chief executive officer (CEO) and chief of operations.

Medical Directors This position is typically held by a PCP and involves managing and organizing the rest of the provider staff, implementing clinical policies and practices (e.g., diabetes care guidelines or a new BHC service), and monitoring/improving quality of care (e.g., overseeing use of the EHR and helping PCPs meet quality expectations). They assure the availability of team member support to PCPs consistent with panel size and complexity and assist with provider recruitment.

Support from the medical director is fundamental to the success of a BHC service. Specifically, it is the medical director who will assure that the BHC has operational support and access to clinical and support staff time needed for training in the PCBH model. The BHC may also interface with the medical director when implementing protocols or pathways to improve delivery of evidence-based behavioral health prevention and intervention services. The medical director may even supervise the BHC, with regular reviews of BHC metrics, such as the average number of visits completed per day, average time until next available appointment, and average no-show rate (these are metrics commonly reviewed for PCPs). Having a medical director as the BHC supervisor is often ideal. It helps ensure she understands the full array of services the BHC can provide, establishes a pipeline for good communication between the BHC and leadership, and helps protect the BHC's time from being siphoned away from clinical duties. The importance of having a medical director committed to innovation and quality cannot be overstated.

Nursing Director Small clinics may only have one RN, but larger clinics or those that are part of a larger organization often have more, including a director of nursing. The director supervises charge RNs (i.e., RNs in charge of a particular department, such as internal medicine) throughout the clinic. Each charge RN supervises the LPN, MA, and NA in his area.

Clinic Manager or Director The person in this position may have some medical training, business training, or both. Responsibility for all aspects of clinic operations rests with the clinic manager/director. These responsibilities include overseeing the budget, purchasing supplies, managing the property, and a great deal of personnel work. The manager usually supervises reception staff, billing staff, and maintenance personnel at a minimum. The manager also works closely with clinical leadership, such as the medical director and the director of nursing. In some clinics, this tripartite meets with a “building committee” that considers all issues related to delivery of services. Members of the building committee are usually elected by or selected from the department or area they represent (e.g., laboratory, imaging, billing, etc.).

Other Leaders In larger systems with multiple clinics, other leaders play important roles. The CEO works with a senior management team and a board and is responsible for stating the vision for the organization and defining the strategies used to pursue that vision. The CEO also works on budgets and initiates community partnerships. Another important function of the CEO is to create the culture of the organization. The chief operating officer (COO) makes decisions about production and work policies. She reviews statistics about numerous operations within the clinic(s), considering quality, safety, and efficiency. Using this information, she may work with others to implement policy changes. Overall, the goal of the COO is to maximize the quality of service delivered, assure financial viability, and achieve high customer satisfaction ratings. Of course, developing good relationships with these leaders can be very helpful for a BHC.

The Organization of Primary Care

All PCPs have a panel of patients under their care. The panel is a basic element of clinic organization, as the goal is always to establish an ongoing patient–PCP relationship. Historically, panel sizes have ranged from 1500 to 3000, with adjustments made to account for the types of problems seen by the provider. The average US panel size is 2300 (Alexander, Kurlander & Wynia, 2005). A provider who sees mostly older patients with complex problems may have fewer actual patients under her care than one with a less complex panel. Panels will sometimes be closed to new patients if a provider reaches maximum capacity. Providers cover for each other when on vacation, sick leave, etc., meaning they see patients from the absent provider’s panel.

As noted in Chapter 1, the demands on a PCP to meet all of the preventive, acute, and chronic care needs of a panel are both impossible and growing. In a *traditional practice* model, a PCP would need to work 21.7 hours a day to provide all recommended preventive, acute, and chronic care services to a panel of 2500 (McGlynn et al., 2003; Østbye et al., 2005; Yarnall et al., 2009; Yarnall, Pollack, Østbye, Kraus & Michener, 2003). This situation is giving rise to two other practice models. The *ideal medical practice model* sets the panel size at around 1000; however, without a huge increase in PCPs in the United States, this standard is unattainable. Consistent with the ideals of the PCMH, Scherger (2010) suggests that the *organized team model* is a more viable alternative. In this approach, the PCP is able to have a reasonable workday with patients receiving necessary services. This is accomplished by having the PCP delegate work to nonclinician members of the team (e.g., NAs) and clinical members of the team (e.g., BHCs) or to have select services delivered through the use of health information technology (e.g., patient portals) without requiring direct PCP involvement. Using three assumptions about the degree of task delegation that could be achieved (77, 60, and 50% of preventive care; 47, 30, and 25% of chronic care), Altschuler and colleagues (2012) estimated that a PC team could reasonably care for a panel of 1947, 1523, or 1387. The BHC should inquire about panel size at their work site, attempt to understand the processes in place concerning delegation of preventive and chronic care, and offer to assist in these important areas.

Team-based care goes a long way toward solving the dilemma of excessive panel sizes in the context of a PCP shortage. However, it impacts the culture and structure of PC and successful implementation relies heavily on effective training of PCPs, RNS, BHCs, and nonclinical team members. All team members will need to perform at the top of their skill level. Additionally, PCPs will need to create *standing orders* for BHCs, RNs, and nonclinicians concerning provision of specific services (a “standing order” is a blanket permission/request that a given team member always perform a given clinical task). Thoughtful mapping of workflows are also an important part of assuring reliable and coordinated delivery of services. In order to optimally engage in team-based care, patients, too, will need orientation to this new approach. Lastly, payment will need to be reformed to account for the emerging redesign of PC delivery.

Summary

1. Several factors are promoting the rapid expansion of PCBH services, including research showing positive outcomes for BHC services and a variety of health-care reform initiatives that align with PCBH practices.
2. The mission of PC is to provide the majority of healthcare services to a group of citizens. These services include both intervention and prevention services, and they are, by definition, holistic and community based.
3. Primary care is a crucial part of a well-functioning healthcare system. Countries with the healthiest populations have the most robust PC services. The PCBH model was designed to respect the value of PC and to align with its goals.
4. Despite the clear value of PC, it has historically been largely neglected in the United States, in favor of specialty care. This is now starting to change, which means many opportunities for integration and for improving population health.
5. The goals of Triple Aim include improving population health, improving patient experience, and reducing per capita cost. The goals of the PCBH model align well with the Triple Aim.
6. The ACA aims to help patients access care, and much emphasis is placed on improving primary care access in particular. This and other goals of the ACA, such as the promotion of prevention, may mean more stress on PC in the short term but also more opportunities for integration.
7. The PCMH is widely considered the ideal model for delivery of PC services. However, it has largely excluded behavioral health from the PC team. Outcomes of the PCMH may improve with addition of a BHC.
8. There are various types of PCPs and a host of staff members to support their practice. Particularly for new BHC services, the BHC will need to educate PCPs and staff on the PCBH model and discuss how each can support (and be supported by) the BHC.

Web Links

Web Link 1

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Behavioral Consultation and Primary Care

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2016, XXIII, 347 p. 49 illus., 1 illus. in color. With online files/update., Hardcover

ISBN: 978-3-319-13953-1