Behavioural Health Consultancy
Application and Evidence

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Behavioral Health Consultancy (BHC)

- Offers strategies for a new model of primary care – an evolved service informed by behavioral science
- Grew out of problematic circumstances in the US (medical access, mental health access, stressed practitioners, high costs, difficulties with patient engagement and clinical outcomes, health disparities)
- Known as the Primary Care Behavioral Health (PCBH) Model in the US
- Growing evidence that PCBH is a helpful addition to health care

Problematic circumstances: Difficult to make EBTs available to people with mental health and substance abuse problems ***and***

- Problems with unnecessary medical visits

. . . patients with psych disorder use 50% more physical health services

- Problems with unnecessary testing and procedures

. . . only 16% of the 14 most commonly reported problems in PC had an organic etiology

- The importance of addressing psychosocial

. . . drivers for majority of visits among all patients

. . . and the need to have behavioral science informing care for other common problems in PC – long term conditions, milder problems ***and preventive efforts***

- Chronic disease management
- Lifestyle problems
- Stress / burnout / fatigue
- Sub-threshold problems (relationships, parenting, work, finance, demoralization in older adults)
- Preventive health services—mental and medical—giving people the skills to ***flourish***

The PCBH model

A group of strategies designed for PC

Brings new provider . . . HIP or Health Improvement Practitioner

Goals

1) Improve efficiency
2) Improve effectiveness

HIP must work in consultant role

Methods

1) Be Different
2) Be Helpful

HIP must be a fully integrated team member

HIP services must be routine

The Primary Care Behavioral Health (PCBH) Approach

- **G**eneralist
- **A**ccessible
- **T**eam-based
- **H**igh Productivity
- **E**ducator
- **R**outine care component

HIPs Provide 2 Services

BRIEF INTERVENTIONS

- Referral based
- Preferred same-day
- Follow-up as indicated (also same-day preferred)
- Individuals, couples, families
- Groups, workshops

PATHWAY SERVICES

- Agreed path that identifies patients for specific HIP services (smokers, chronic pain)
- Often uses registry

The Behavioral Health Consultant (HIP)

Dimension	Consultant	Therapist
Primary consumer	GP	Patient/Client
Care context	Team-based	Autonomous
Accessibility	On-demand	Scheduled
Ownership of care	GP	Therapist
Referral generation	Results-based	Independent of outcome
Productivity	High	Low
Care intensity	Low	High
Problem scope	Wide	Narrow/Specialized
Termination of care	Pt progressing toward goals (no termination)	Pt has met goals

Requires retraining and operational changes

- Close with practice leadership
- Hiring good candidates for the BHC role
- Core competency training for MH staff, GPs, and nursing staff
- On-going evaluation and refinement

Phase 1 training (classroom based)

Phase 2 training (in the clinic)

Phase 3

- On-going up-skilling
- Evolution to more complete integration

Evidence

A recent review of 29 studies on the PCBH model found that it shows promise as an effective population health approach to behavioral health service delivery and that it is associated with positive clinical and system level outcomes (Hunter et al., 2017).

Clinical Outcomes

- Patients receiving 2-4 visits show broad improvement in symptoms, functioning, well-being (Angantyr, 2015. Bryan, et al, 2009, 2012; Burt, et al.., 2014; Cigrang, 2006; Corso, et al., 2012; McFeature & Pierce, 2011; Ray-Sannerud, et al, 2012)
- Effective for both mild and severe presentations
  - More severely impaired may improve faster (Bryan, et al., 20112)
- Changes are robust and stable at 2 years (Ray-Sannerud, 2012)
- Patients report stronger connection to the HIP than to traditional, specialty therapists (Corso, 2012)

System Outcomes

- Large reductions in specialty mental health referral rate (Brawer, et al., 2010; Serrano & Moden, 2010)
- Improved adherence to evidence-based guideline (Serrano, & Moden, 2010)
- More appropriate antidepressant prescribing ((Brawer, et al., 2010; Serrano, & Moden, 2010)
- Improved GP willingness to engage with behavioral issues (Brawer, 2010, Torrence, et al., 2014)
- Improved detection (and treatment) of suicidal ideation (Bryan, et al., 2008) High patient and GP satisfaction (Brawer, et al., 2010, Torrence, et al., 2014, Angantyr, et al., 2015)
- More appropriate utilization of GP (McFeature & Pierce, 2010; Serrano & Moden, 2010)
- Improved prevention (completion of anticipatory guidance in well-child checks (Burt, et al., 2014)

Impact on medical services Polaha, 2016

- Rural, stand-alone private pediatric primary care practice
- Data included: time stamps of patient direct care, providers' direct reports of problems raised, and a review of medical and administrative records including billing codes and reimbursement.

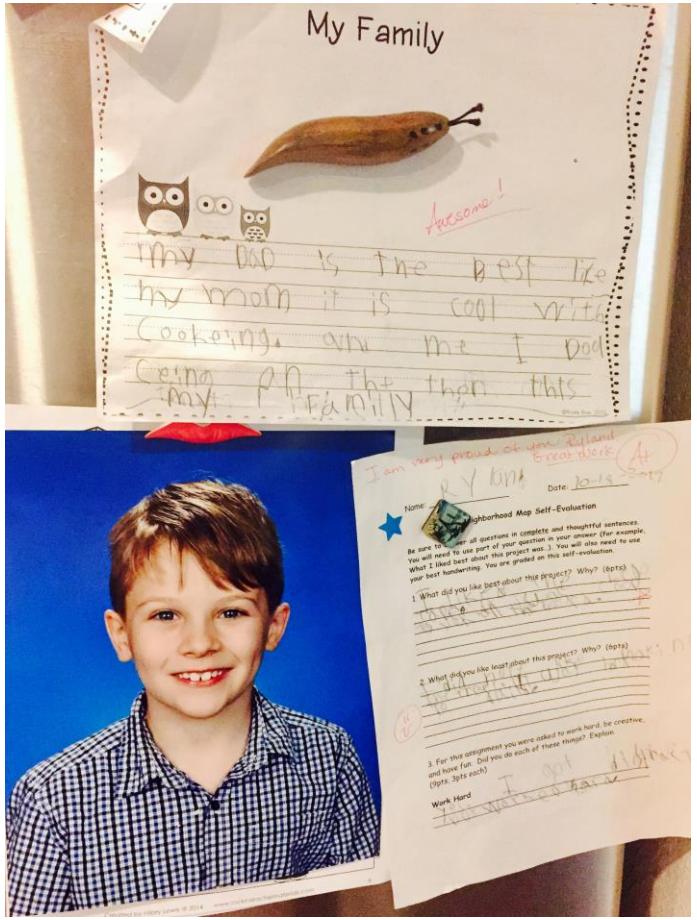
On days when a Health Improvement Practitioner was present, medical providers:

1) spent 2 fewer minutes on average for every patient seen
2) saw 42% more patients
3) collected $1,142 more revenue than on days when no HIP was present

Polaha, 2016

Youth and health disparities

- As many as 80% of youth needing mental health services do not receive them (Kataoka et al., 2002)
- This problem is exacerbated in cultural and linguistic minorities (Satcher, 2001)
- BHC services in clinic /Medicaid insured (68%) or uninsured (29%)
  - 2 visits
  - Clinically significant and reliable decrease in global distress scores
  - High satisfaction



Shifting MH Access Point to PC

Supply and demand mismatch in USAF

- 32% increase of beneficiaries receiving MH care from ‘04-’13
- In 2015 MH conditions were the largest healthcare burden for 0 – 44 year old beneficiary categories
- Insufficient mental health personnel to meet demand
- Access to specialty MH care is difficult

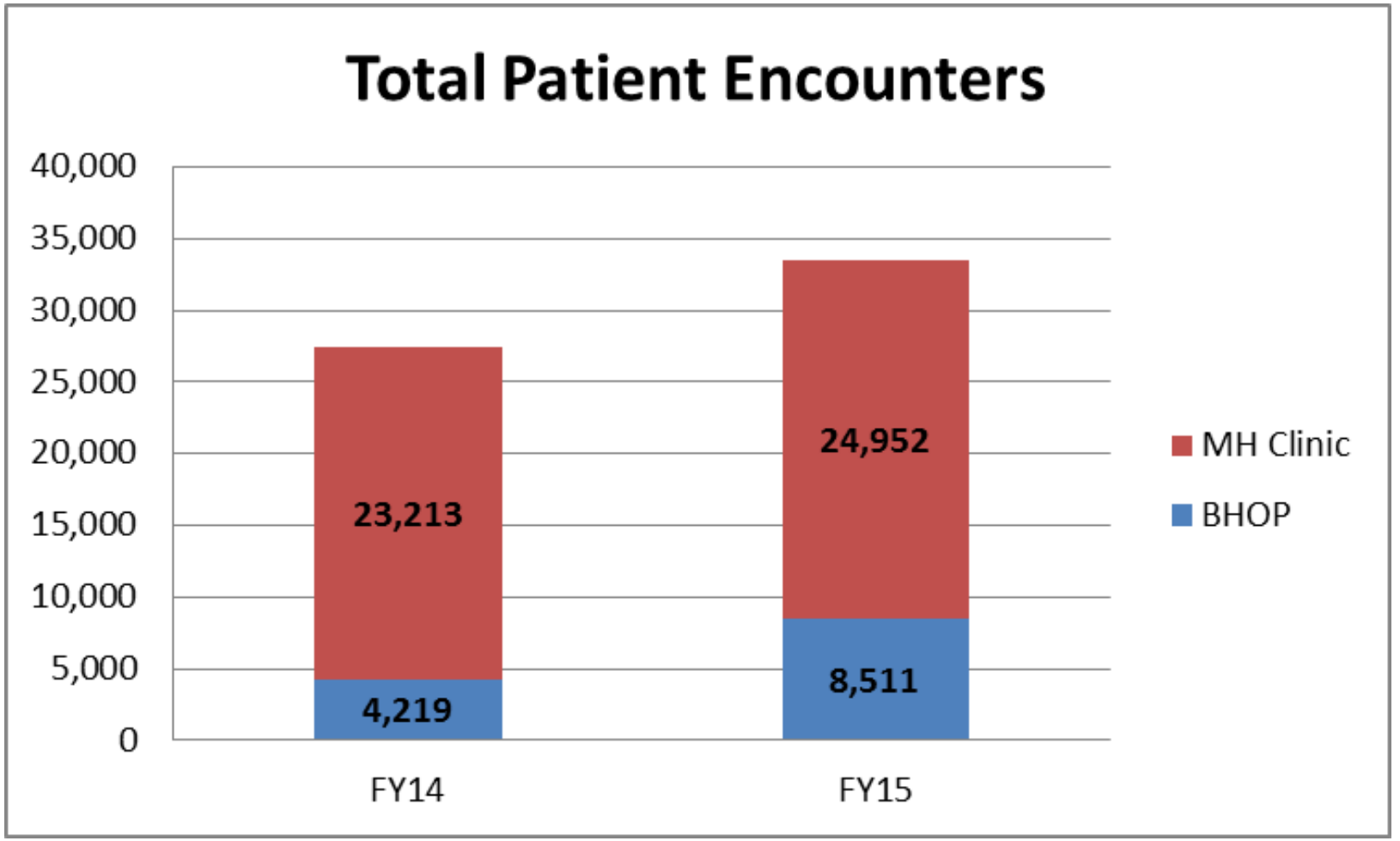
Pilot

- All MH services start in PC
- Moved some mental health staff into PC to join BHCs already in PC

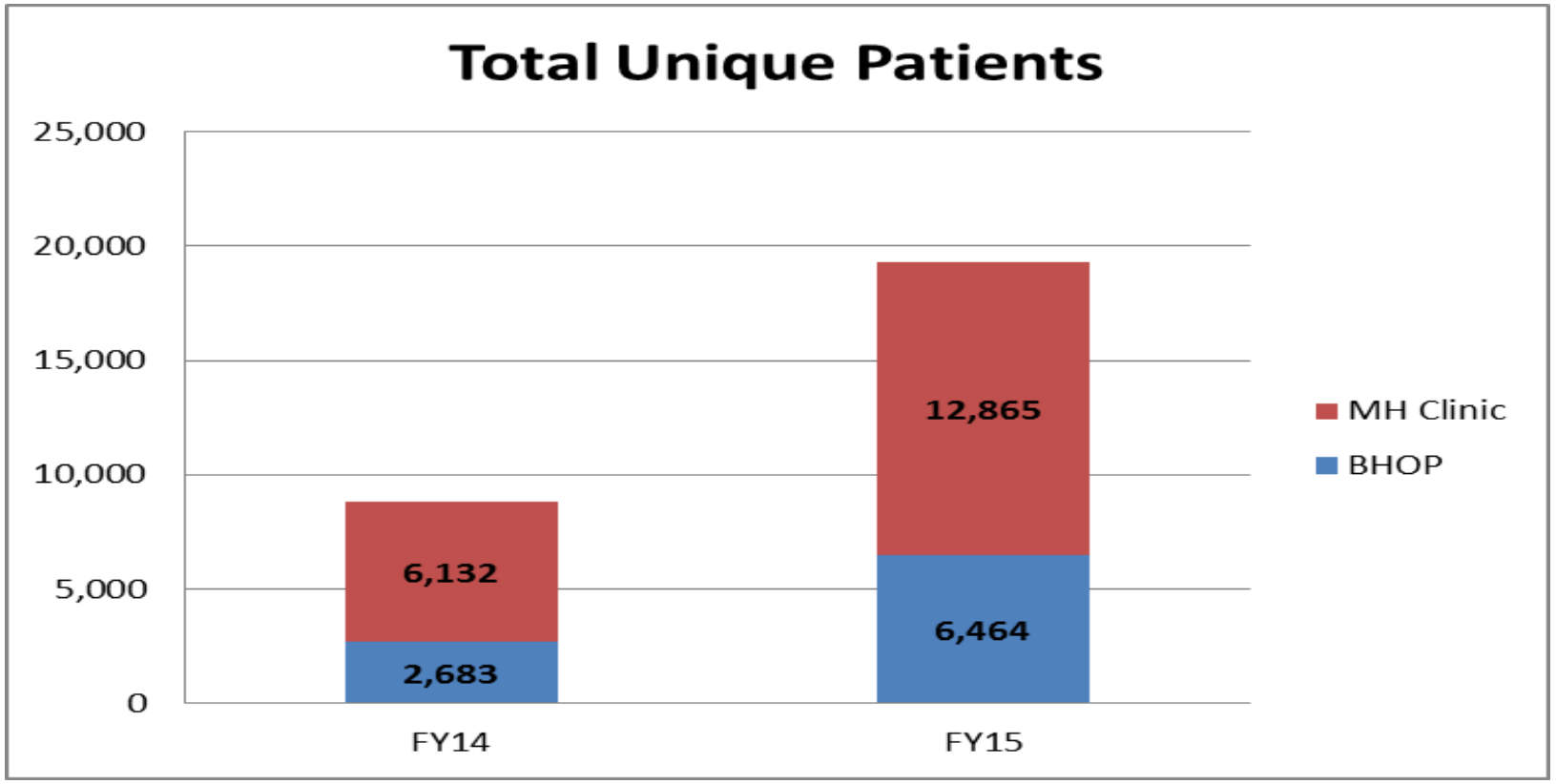
Zero Sum

Small, medium and large clinics in 1 year pilot, after 1 year baseline

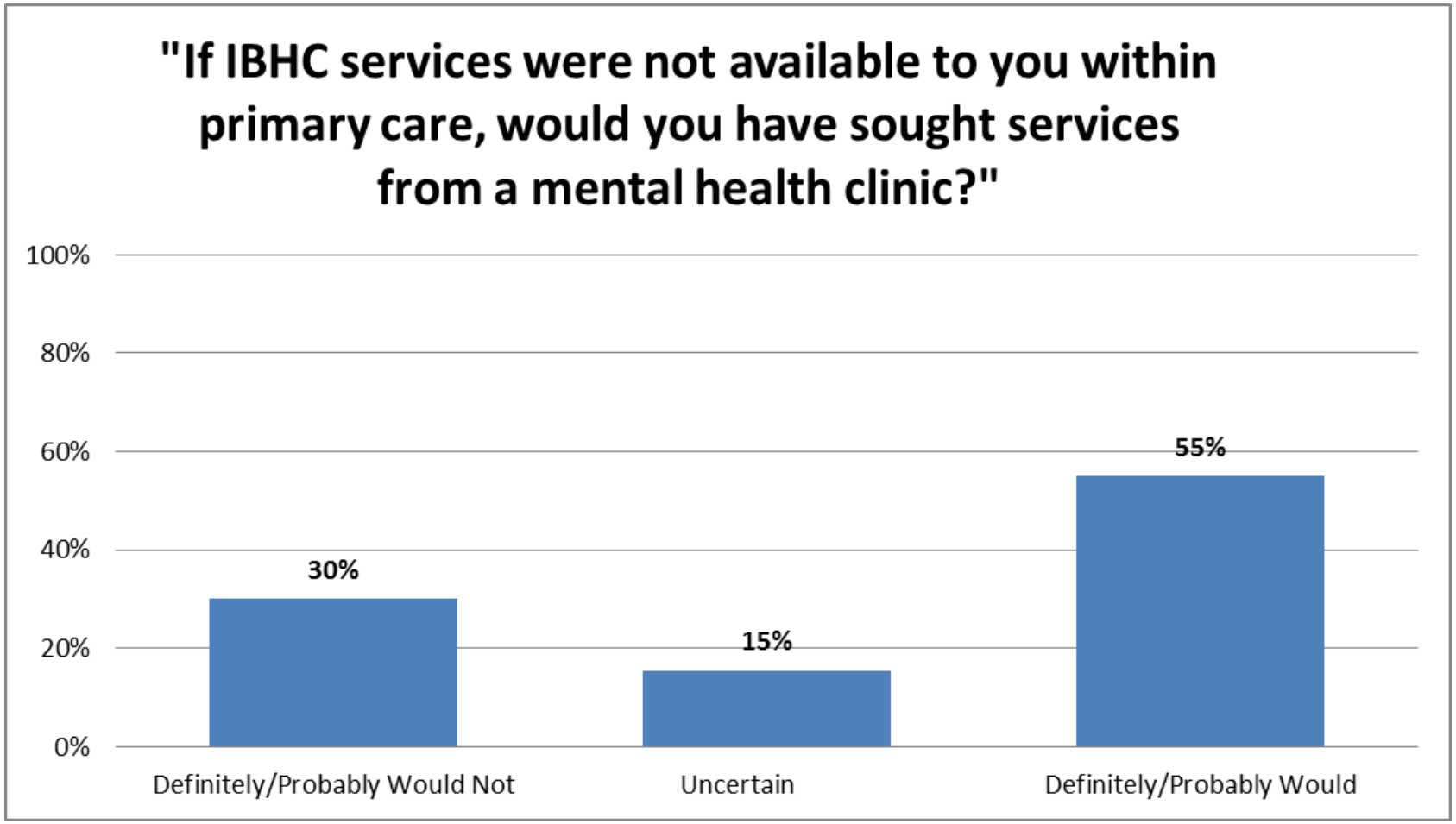
The Results


Total Patient Encounters
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
23,213
4,219
24,952
8,511
FY14
FY15
MH Clinic
BHOP

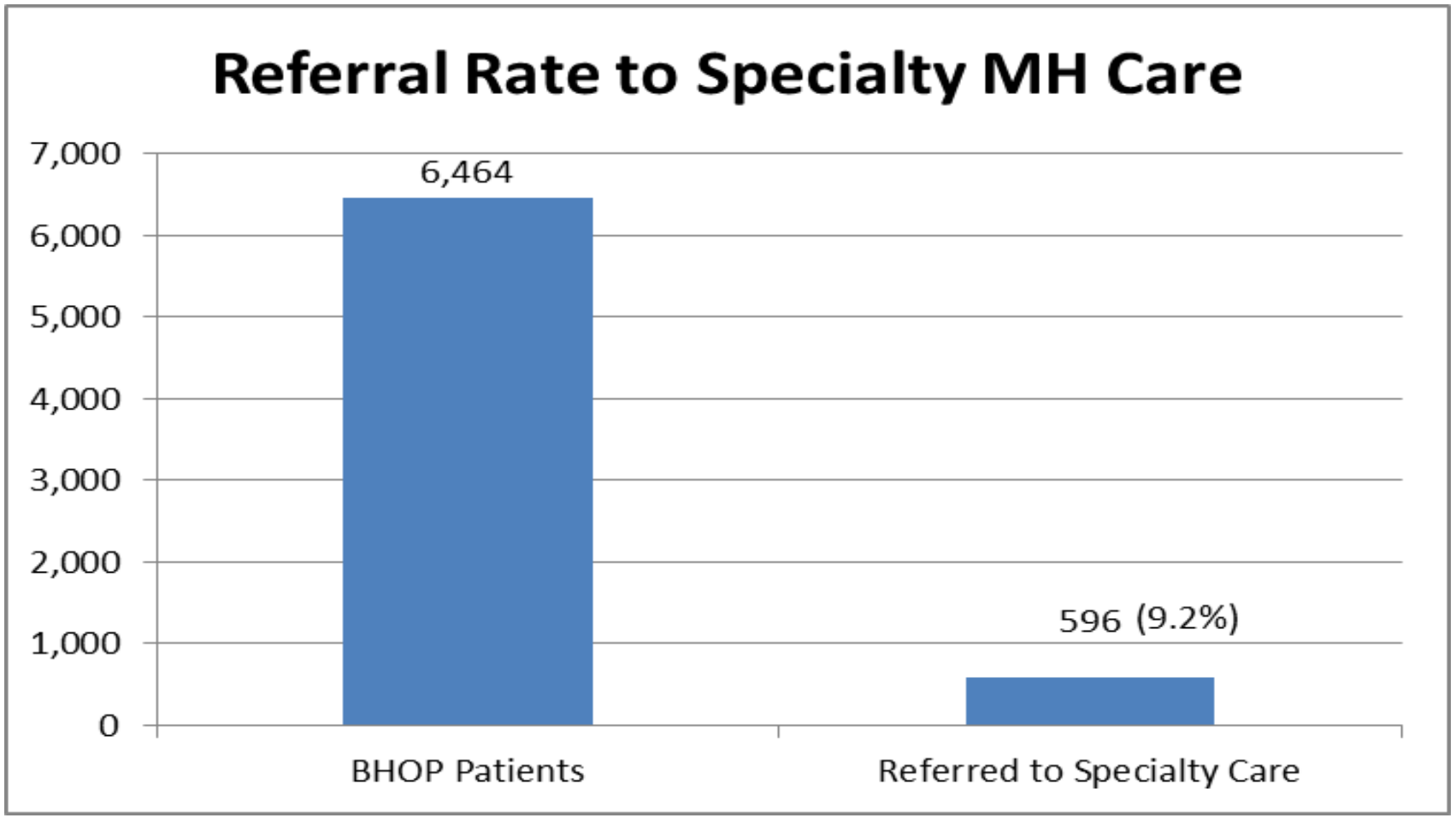
The Results


Total Unique Patients
25,000
20,000
15,000
10,000
5,000
0
6,132
2,683
12,865
6,464
FY14
FY15
MH Clinic
BHOP

The Reach


"If IBHC services were not available to you within primary care, would you have sought services from a mental health clinic?"
100%
80%
60%
40%
20%
0%
30%
15%
55%
Definitely/Probably Would Not
Uncertain
Definitely/Probably Would

The Results


Referral Rate to Specialty MH Care
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
6,464
596 (9.2%)
BHOP Patients
Referred to Specialty Care

Concluding Thoughts

- Primary care is deluged with behavioral health needs and is ill-equipped to handle them
- Integration can help, but it must mirror the goals of primary care and work via the GP
- PCBH is a consultative model uniquely designed for primary care, with the goals of improving GP efficiency and effectiveness
- HIPs provide 2 services: brief interventions, pathway services
- Transformation to PCBH requires all team members to learn new skills and for operations to adjust to support the services of the new PC team

GO Kiwis!