



Integrated Primary Care: Practice and Training Implications

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The Affordable Care Act is changing the nature of social work practice in healthcare. One exciting area of innovation is the integration of primary care and behavioral healthcare. Schools of social work should anticipate developing more placements in integrated care settings, such as medical homes, community health centers, and health clinics co-located with mental health clinics. This issue's Conversation addresses the skills and knowledge base necessary for integrated care practice. Do students need a new skillset or are the skills similar to traditional social work practice? Sandra Bailly, M.S.W., Associate Professor of Practice and Assistant Director of the Simmons School of Social

Work Field Department interviews Alexander Blount, Ed.D., Professor of Family Medicine and Psychiatry and Director of The Center for Integrated Primary Care at the University of Massachusetts Medical School. -- Editor's Note



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Sandra Bailly: Based on your experience as the Director of the Center for Integrated Primary Care at the University of Massachusetts Medical School, what are some of the challenges faced by primary care providers and behavioral health clinicians learning to collaborate in integrated care settings?

Alexander Blount: The current challenges faced by primary care providers are very similar to challenges they have always faced; specifically, most mental health issues come to primary care. The vast majority of mental health and substance abuse issues, as well as health behavior issues, present in primary care settings and, in fact, will only ever be treated in primary care.

What primary care providers are now facing and perhaps were not facing before is the expectation that they, as primary care providers, discover and identify their patients' mental health issues through screenings. In the recent past, primary providers were not expected to screen for depression or anxiety. Now, in order to get good pay-for-performance numbers from Blue Cross or other payers, primary care providers must screen for depression, for example. To get PCMH [patient-centered medical home]^[1] certification, depression screening is recommended.

The evidence shows that when primary care providers screen for depression, the number of people identified as depressed doubles. However, it's also important to point out that it's recommended not to screen if there are no services or interventions to offer; that is, if you don't have a treatment to offer, you're not urged to identify patients. So if a PCP screens for depression, they need to offer treatment. That means that primary care providers are now expected to learn to prescribe at least the first level SSRIs [selective serotonin reuptake inhibitors]^[2] in primary care. Many are comfortable with that. Many are not.

About half of people diagnosed with depression prefer to start with medication and half prefer to start with a brief therapy approach. This means that primary care providers need two sorts of assistance. They need psychiatric backup to help them with prescribing patterns. They also need behavioral health colleagues who are part of their team who have psychosocial interviewing and brief therapy skills and can provide brief intervention to address behavioral health needs.

Sandra Bailly: How are the differences between professional cultures addressed in primary care settings? Would you say that the multidisciplinary approach has always been present in primary care?

Alexander Blount: We have to distinguish between what has been called "multidisciplinary" in both the medical and mental health "silos." It was different disciplines within generally the same expertise set. It was levels of medical expertise and levels of mental health or psychosocial expertise, depending on the silo. That is different from what occurs when a behavioral health clinician of whatever sort is added to the primary care team. When a behavioral health clinician is added to a primary care team, you have a whole new expertise set on the team. If there is real team work, there is substantial "expertise transfer." The medical people get better at behavioral health models and techniques and the behavioral health people become much enhanced in their medical knowledge and in medical issues.

Another difference on the primary care team is how patient confidentiality is treated. For people who've trained in the mental health world, this is often a shock. In mental health we were raised with the idea that what goes on between ourselves and the patient is sacrosanct and is kept confidential at all cost. The unit of confidentiality in mental health is between the therapist and the patient, whereas

the unit of confidentiality in primary care, and in medicine generally, is between the patient and the team.

When people first come to primary care from mental health, they almost always struggle with the idea of sharing information. They don't know how to decide what information to share. In fact, in terms of the exchange between the PCP and the patient, it is very rare to have a patient who is at all uneasy about the exchange of information. They think that it's natural and that it should happen, and if it doesn't they're uneasy.

The only people who have ever been—I think it may be one or two people in an 18-year career—who have ever had any unease about my sharing with the PCP are people who have already been in individual therapy and have been socialized to the rules of specialty mental health psychotherapy. Clinicians from specialty mental health settings often don't understand that they need to be the eyes and ears of the medical side of care when they are working with a patient. Communication needs to go both ways. They need to know the person's medical issues as well as communicating about the progress of the behavioral care. When the behavioral health provider meets with the patient, it's just as important that they ask whether the patient is taking their diabetes medication as it is that they ask whether the patient is taking their SSRI medication.

Sandra Bailly: What is the patient experience in integrated care settings? What is it like for the patient when they need to meet with the primary care provider and the behavioral health provider? Do they need to tell their story twice?

Alexander Blount: Yes, telling the story twice is something that happens in medicine everywhere, especially in the inpatient setting. Patients don't like it, but it happens less frequently in primary care. It's more likely that the warm handoff³ will be in front of the patient, and there'll be some discussion of the issues and the reason that the PCP [primary care provider] brought in the behavioral health clinician, in front of the patient.

In fact, it's a more transparent process than many in medicine, and when it's done well, it's a completely transparent process. In my practice, the doctors with whom I have worked for a long time never talk to me in the hall. They save it for when we walk in the room. I walk in the room knowing only that they have a patient they'd like me to help. Once I'm in the room, they explain the situation in a way that allows the patient to see what I know about them, which builds the bonds between the patient and me. There isn't a secret part that was said out in the hall.

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hall.

But in general, most of the people we see are only getting their behavioral health in primary care, and they're completely comfortable with the idea of the exchange of information.

The other thing that people in mental health have to learn in primary care is how much briefer the interaction is and how much more targeted. Most of us were trained in therapy that, to some degree or another, was reflective – that we let the patient go first, and then we help to find patterns and useful ideas in what the patient says and reflect it back to them.

That is not the drill in primary care. In primary care, first of all, there's a good deal of evidence that teaching people about mental health disorders is an effective therapeutic device. There's a lot of teaching about depression, about anxiety, about how it works, about the body and the emotions and the fact that it's one process, just with different names.

There are a lot of teaching skills, of breathing or relaxing or behavioral activation skills. That means that the term "therapy" is rarely used in primary care. I almost never use it. We're helping people learn. We're helping people gain skills.

Sandra Bailly: Let's talk about health information technology as a significant component of the integrated care model. It's used in a variety of ways, including to facilitate communication between primary care and mental health providers. Health information technology and the electronic medical record [EMR] have been part of healthcare for a number of years but are more prominent now with the launch of the Affordable Care Act.

What should we be teaching social work students about healthcare technology?

Alexander Blount: First of all, the social work students probably already know more than the professors.

Sandra Bailly: Absolutely!

Alexander Blount: They're more comfortable with technology, so if you say to a social work student, "We're going to text you with where and when we want you to come to see a patient. Just give us your cell number," they're completely cool with that. I'm assuming their professors wouldn't object, but they might be surprised.

An electronic medical record is a daunting piece of software to interact with. It doesn't do much good, I don't think, to train anybody on a particular EMR, because they're different enough that you'll need

to learn a new system wherever you work. Perhaps learning to document using a computer is a good tool. The skill that is most important is learning to do primary care notes. The “process recording” that is used in training is almost the opposite of what is needed in primary care. These need to be terse, clear summaries of the issues, progress and plans of the session. Students need to learn the difference between “psychotherapy notes” and “progress notes” and learn how to record in the latter and eschew the former.

Now learning the EMR as a software system is part of any placement. It usually is a full day or more of training. In any primary care setting, it’s expected that you communicate with the PCP within the EMR.

Sandra Bailly: Which then raises the question: are there opportunities for schools of social work to teach more about documentation? Documentation has always been emphasized. “If it’s not noted, it didn’t happen” has been the mindset for years in social work. But, is there a teaching opportunity to focus on how to make documentation useful, meaningful, and succinct at the same time?

Alexander Blount: Yes, that would be good. It would also be good if there were someone in the social work school who had already worked in primary care and knew how to do that. If a professor has only worked in specialty mental health, I have my doubts about the usefulness of their teaching in that area. It is a different-enough skill.

The idea that “If it isn’t documented, it didn’t happen” is built around the idea that we have to keep track of everything that occurred in the interaction, and that’s not true, and it’s not useful.

I have a note that I use that has a bunch of checkboxes, and the checkboxes are the things that happened, from the perspective of the payer. It’s got topics, and it’s got intervention types, and it’s got a risk assessment. But by the time I’m done with my checkboxes, I only need about three or four or five sentences to communicate with the PCP to have a note that can be vetted by any payer. The approach to writing it all down is something that you have to get beyond. In the future, that’s going to be even more true, because the payer requires that the notes taken are supporting the practice working cohesively and treating the patient – not billing fee-for service – so that whole area of documentation is headed for transformation.

Sandra Bailly: Let’s shift to talk about the co-occurrence of behavioral health conditions and medical conditions. It’s common. What level of medical knowledge is necessary for social work students working in primary care settings? What’s the best way for them to gain this knowledge?

Alexander Blount: I would say, first of all, I learned most of the medical knowledge that I have on the job.

It is not necessary that everybody know everything. Students do need to know how to access medical information and definitions by, for example, having their smartphone or tablet with them. And when they're in a meeting and someone uses an abbreviation, they just type it into Google, and there it is. There's the answer. You catch up fast.

There are also programs that translate medical abbreviations, and there are programs that have drug translations. They tell you what a drug does and what the interaction issues are. It's more about having it with you and being ready to learn.

What I think social workers should bring is a knowledge of common chronic illnesses and the behavioral health issues and assessment tools associated with those chronic illnesses. That's one of the things we teach in our course here for primary care behavioral health.

The first class is on diabetes. It's taught by a physician, but we also focus on the behavioral health provider's role in diabetes or what it can be, because sometimes social workers and psychologists have said, "that's not what I do." In primary care it is what you do, and people need to be comfortable with that.

It also means that they have to have some strength in what's called "behavioral medicine." Behavioral medicine is the relaxation response technologies – intervening on the body with words – and in using health behavior change interventions like motivational interviewing.

The behavioral health person on the team should be an accomplished expert in this. An example is engaging smokers and applying the stages of change. That is something that the behavioral health person needs to have as a solid skill.

Sandra Bailly: Do you have social work interns in your center? How is the discipline of social work introduced to the primary care providers?

Alexander Blount: We have both psychologists and social workers on the staff in the various primary care practices.

We've had psychologists longer than social workers, because when I got here I was a psychologist, and that was the only profession that I could supervise. We created a post-doctoral fellowship in primary care psychology, a two-year experience.

We've been looking for an opportunity to work with social work schools; the openness of social work to work with us has increased recently. We have an "open call" for trainees, and we pick who's available. We now have a social worker, an LICSW, who's working in the same behavioral health

clinician role as the psychologist in the Barre Family Health Center.

We see social work trainees as an important future workforce for us. We want to develop more behavioral health clinicians to work in other practices in our department. The social worker at the Barre Health Center has been a real test. It is new for the Department to have a behavioral health clinician who is a social worker, but she has been a great fit.

Social workers can get stereotyped by their role on some inpatient units. Physicians sometimes think of social workers as the person who finds beds or who talks to the family or the patient on inpatient units. Physicians don't always have a sense of the range of what social workers are trained to do, and that training is, in fact, a good fit for primary care.

At the Center for Integrated Primary Care we are training social workers for two different roles and jobs. About half the students in the Primary Care Behavioral Health course are social workers, and about half the people who take our Integrated Care Management course are social workers.

Care management in medical settings was formerly almost always a nursing role. When doctors first think about integrated care management, meeting the complex needs of the highest utilizing patients, they think about nursing because it requires managing care for people with complex illnesses. Because only a nurse can change the medication, the thinking is that you need to have a nurse in that role. However, it turns out that for a very high percentage of the most expensive, most complex patients – whatever the complexity of their medical illness – what makes it complex and expensive is usually the behavioral component. This means that having someone who is comfortable dealing with depression and who is good at motivational interviewing, makes a real difference.

The social worker is perfectly capable of calling the PCP and saying, “The person is reporting side effects. Do you want to see them and do you want to consider a med change?” The actual adjusting of medication in these cases is such a small part of what needs to be done that Center for Integrated Primary Care is constantly pushing to make the role of the care manager one that is defined as done by a licensed clinician, whether that is a social worker who is “medically enhanced” or a nurse who is “behaviorally enhanced.”

In the Primary Care Payment Reform program [PCPR]^[4] of Masshealth, I was on the committee that designed that clinical model. I pushed very hard for the care manager role to be a licensed clinician rather than a nurse. We were able to get that changed, so in the PCPR, the care manager can be a social worker or a nurse.

We're finding that, in small practices, the care manager and the behavioral health clinician are often the same person. We all do some care management in the behavioral health role anyway. Sometimes,

as a primary care practice gets bigger, you end up with a care manager as a separate job, but that care manager is also a consultant to the team about the role of care management, not just the person who does all of the care management.

Sandra Bailly: The care management model broadly defined is prevention, and prevention is a huge part of the new integrated care model as well. Can you talk about a focus for student learning in prevention activities in integrated care?

Alexander Blount: When you work in primary care, you are definitely preventing people needing to go to specialty mental health, but that's often because you're doing an intervention so much earlier in the course of their problem or their illness.

It's a behavioral health intervention, but it's at a point where they are starting to have difficulty – they're starting to miss work, they're starting to feel like things aren't going to work out – as opposed to when someone is on disability, or in bad shape.

Also, health behavior change is really prevention. We're doing prevention because we're doing substance abuse interventions, but we're doing it at the point that someone who is diabetic is drinking three beers a night, for example, rather than that they are in more advanced problems.

Also, the work with pediatric obesity is a good example of prevention in a primary care setting with integrated care. Some programs use a protocol for pediatric obesity: every child who is in the top five percent of BMI [Body Mass Index] in the practice gets a behavioral health visit as part of their well childcare. They also received education about healthy eating and activity and about reduction of time in front of screens. There were very strong results in terms of children who improved their healthy eating and were supported by parents to increase their activity.

Those kinds of things are prevention in the sense of, again, early intervention. They didn't prevent them from being in the top five percent of the BMI.

Sandra Bailly: "Prevention" in this context definitely is, "Okay, the chronic condition may have been diagnosed already – or in the obesity case it's already there – but how do we try to intervene in a way to prevent it from worsening?"

Alexander Blount: One example of prevention and assessment in a primary care health center is a program in which every woman who came for a first prenatal visit automatically got a visit with a behavioral health provider. The behavioral health visits were brief. They were 15–25 minutes. There were introductions, an orientation to the role of behavioral health, a check-in and an invitation to return during her pregnancy. That was all well and good.

But in the process, the behavioral health providers identified a subpopulation of women who were at risk for the health of the baby because of substance abuse, homelessness, a history of trauma, or fear of prenatal care. Those women were referred to a high-risk pregnancy clinic, but the high-risk pregnancy clinic was high-psychosocial-risk, not high medical risk. The outcomes were that babies were not born addicted and could go home with their mothers.

Sandra Bailly: How does the current reimbursement system, the payer system as it is today, work with an integrated care model? Does that help or hinder the integration of care?

Alexander Blount: It hinders.

We would have a hard time setting up a system that was worse for integrated care than what we've got.

The things that have been shown to be evidence-based ways of saving money while making people's lives significantly better in many cases aren't billable. For example, a behavioral health provider calling a person with depression, urging them to do something they enjoy every day, checking on their medication side effects, discussing their concerns – it's effective, but it probably isn't billable. I have to say probably because every state is a different health system, with different rules. Health plans all set their own rules and many change them from state to state.

Let's put it this way. The large health systems that have succeeded in integrated care have been systems in which the entity that was paying was also the entity that was hiring the providers – the HMOs, and the federal systems: the Department of Defense, the Veteran's Administration, and the Indian Health Service. All of those are substantially integrated and fully committed to integration.

The other ones that have been successful have been health systems that were the only game in town, particularly for very stressed populations. Where the medical system has had little competition to work with needy populations, the places that did could essentially dictate terms to the payers. A place like Cherokee Health Systems in Tennessee has, in almost every one of its payment contracts, some kind of bundled payment or case rate or something else that allows them to design their program the way they think it should be. They have rewarded the payers by having overall costs that are about 78 percent of those of similar health systems in the region.

Sandra Bailly: As a last question, do you have any final advice for schools of social work that want to prepare the next generation of social workers for the integrated care model?

Alexander Blount: Changes will need to be made to ensure a place for social work in primary care. It may mean that social work students need to be supervised by another profession, so there has to be

flexibility about that. Otherwise you never get a beachhead in the primary care practices you want to serve.

Creating primary care as a track [concentration], and identifying primary care behavioral health as a track [concentration], is important. Also, it's important to have a faculty person who has a substantial amount of work experience in primary care. Experience in health settings is not the same.

Sandra Bailly: Are there other steps?

Alexander Blount: I was at the recent NASW conference, and there were two plenary speakers, one of whom was arguing that social workers have to be “at the table” in Washington to push so that every primary care team has to have a social worker. It was about protecting the discipline. I think that's the wrong approach. The other social worker on the plenary didn't talk a bit about social work as a discipline. She talked about healthcare, primary care, what needs to be done, and how are we going to do the work. It's about the patients. It was about the work. That's the orientation that gets people to the table.

Sandra Bailly: Focusing on the work will allow for building collaborations and relationships across professions in different ways.

Alexander Blount: You don't have to argue that social work is good preparation for working in an integrated care model, because it definitely is good preparation.

Sandra Bailly: I agree.

Alexander Blount: Getting people who are flexible and can do both behavioral interventions and work with the social determinants of health — that combination is a particularly powerful one for primary care.

Sandra Bailly: Thank you so much. This has been a very informative conversation.

[1] The patient-centered medical home is a model for integrating care in primary practices. More details are available on the Agency for Healthcare Research and Quality website: <http://pcmh.ahrq.gov/>.

[2] SSRIs are a class of medications used for serotonin-related mental health issues, including depression and anxiety disorders.

[3] A warm handoff involves the primary care physician personally introducing the patient to a behavioral health specialist or other specialist to create a more direct, face-to-face bond.

[4] The Primary Care Payment Reform Initiative is a MassHealth program aimed at developing alternative payment methodologies for the healthcare system to improve patient outcomes and experiences while integrating behavioral healthcare with primary care. More information is available at the Mass. Health and Human Services website: <http://www.mass.gov/eohhs/gov/newsroom/mass-health/providers/primary-care-payment-reform-initiative.html>.