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It Takes a Team

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Team-based values, methods, and relationships are now ubiquitous in conversation about primary care. Everyone values "team" and claims to be doing it in one form or another—or having done it all along—"nothing new for me". But what is the substance underlying the slogan? What are the benefits to adding a behavioral health clinician as a long-missing member of the primary care team? How can you deploy behavioral health clinicians to achieve these benefits? What are the properties of different models of integration? How can you be clear enough about this new role to effectively interview and hire for it? In other words, how can this role be truly integrated functionally, not just "anatomically"?

5.1 Introduction

"Team care" is all the rage these days. Primary care doctors are all being urged to adopt it if they haven't already.[1] But who can blame a doctor for thinking, "I've had a team all along. You think I make all the appointments, check people in, put patients in rooms, take their vitals, prepare procedure trays, give shots, change exam rooms, and check people out all by myself?" The question that this doctor has to face is, "With all that help, why is it that you still feel so stressed?" The doctor has been imagining that with one more medical assistant, or with 2 fewer patients a day, it would be comfortable again.

Many of his or her colleagues who have been working in high functioning teams would disagree. They would say that their stress has been reduced because other members of the team are handling elements of a visit that the doctor alone used to handle. Perhaps even more, those doctors would say that now they are giving more complete and effective treatment to patients with behavioral health issues that previously were not adequately addressed. Those patients used to come back more because their care was not addressing their needs. That meant that the patients that the doctors felt least effective in treating gradually took up more and more of their daily schedule.

The same doctors who are practicing in high functioning teams would also tell you that the transition was not easy or quick. Not every member of the group of staff working with each doctor, and for that matter, not every doctor wants to evolve their roles in delivering care to patients. The changes involve more time meeting together and looking at issues like mission and values in addition to workflows and assignments. We will talk about this process in more detail later.

Adding a "behavioral health clinician", a psychologist or clinical social worker or other licensed counselor who is additionally trained to work in primary care, adds more than

[1] I prefer to call PCPs "doctors" because that is usually what their patients call them, whether they are MD, DO, NP, or PA.

one more body to the team. The new staff member, whom I will call a BH clinician, adds a new expertise set, a new way of approaching problems, a way of addressing issues patients face that previously were sources of frustration and failure for the patients and their doctors. One of the first outcomes that has been identified when BH clinicians first join medical practices as team members is that "provider satisfaction" goes up (Blount, 2003). Doctors tend to feel relieved and supported in new ways. They aren't carrying the whole load of knowing what to do in all their most complex cases, and they aren't feeling that they are inadequately serving the many anxious and depressed patients that present every day, usually presenting complaints the patients experience as medical.

5.2 Deploying a BH Clinician

So, for a little while, let's imagine that you solve the issues of funding and you are able to hire a BH clinician for your practice. What do you do with him or her to get this "provider satisfaction" and better patient care? In deciding how to deploy a BH clinician, think about the problem you most want to solve. Would you like to focus on getting treatment to more of your patients? Is there a population of patients in your practice, e.g., people with depression or poorly managed diabetes, that you would like to be the target of your new resource? Finally, in addition to having more of your patients seen, would you like to have your new colleague available for convenient consultation in the flow of care? How you answer these questions will make the difference in whether you decide to pursue a "co-located" arrangement, a Collaborative Care approach or Primary Care Behavioral Health model initially. If you are like most places, you will gradually evolve a hybrid that works best in your setting.

Co-location Model

A first step in many sites is an arrangement called "co-location." This arrangement locates a BH clinician doing therapy, in the primary care office suite, by referral from the doctor or group of doctors who practice in those offices. It requires a little quiet space somewhere in the suite, but nothing more fancy. It will be important to have the BH clinician documenting in the EMR so that the behavioral health diagnoses, observations, and progress made by the patient and BH clinician can be in the front of the doctor's mind when he or she sees the patient next.

This co-location arrangement goes a long way toward solving one problem and may solve a second. It greatly improves the options for referral to some sort of mental health or substance use disorder treatment, because patients will accept care by a professional in a primary care office much more readily than they will go to a separate mental health facility or private practitioner. Your success rate of referrals (meaning the patient has at least one visit with the new resource) will likely change in the general range of from 20-30% for outside referrals to 70-80% or more for inside referrals if your practice is typical of the many I have talked to. Just knowing so many people are now getting seen is a load off your mind.

Coordinating with your BH clinician in providing care, an arrangement in which you prescribe psychotropic medication for depression or anxiety or attention deficit disorder

and the BH clinician maintains closer contact, teaching coping skills, and offering therapy, can be a much more satisfying approach to practice than trying to refer patients to outside resources. Most doctors feel they can be more judicious in the use of medications once they have a BH clinician as part of the team for patients. This puts them more comfortably within the evidence-based recommendations. In the case of depression, for instance, some degree of depression is extremely common and impacts the health and functioning of a great many people. It is only in the case of depression that meets criteria for major depressive disorder that medication is one of the evidence- based choices and only in the case of severe depression that medication is strongly recommended (Kroenke & Spitzer, 2002).

A challenge that you can face in a co-located arrangement is that it tends to make the BH clinician define psychotherapy as their main job. If they have not had sufficient training to know how to move beyond the kinds of therapy they were doing in a mental health facility (we will talk a lot more about training later), they may initiate that kind of therapy in most cases. That means they would engage patients in longer term approaches to therapy, meaning more visits, and each visit would take up an hour, between talking and writing the note. This leads to the BH clinician's schedule filling up. After your initial relief at being able to find care for so many of your patients for whom a referral did not work previously, you can end up with an internal waiting list. It is very frustrating to want care for a patient and have the BH clinician in your office tell you that the patient can be seen in three or four weeks. For co-location to work in a busy practice, the length of each visit will need to be shorter, probably not longer than a half hour, and the mean number of visits in an episode of care will be around 3. This is possible if the BH clinician can make an adaptation from the reflective types of therapy many are taught for mental health specialty work to a more targeted, problem focused approach (Robinson and Reiter, 2016). Treatment focused on a problem creates a different expectation for patients as opposed to treatment that is thought of as "beginning therapy." In that case, treatment only goes as long as patients think they need to come. Patients tend to come until they notice improvement and then they have better things to do with the time and the money (Barkham, M. et. al., 2006). In this model, that is allowed, as is returning when they feel they need a bit more help.

Collaborative Care Model

If you choose to bring on a BH clinician to address the needs of a specific population in your office, you will probably be implementing a Collaborative Care approach. This is an approach with strong evidence for clinical outcomes for patients (Thota, et. al., 2012). It was developed as a variation of the Chronic Care Model (Wagner, et.al, 2001), a variation that targeted depression as the chronic disease. The Collaborative Care approach is built on reliable identification of the group of your patients who make up the population, usually by using a screening tool such as the PHQ-9. Reliable identification, in this approach, leads to the offering to all (or as many as possible) of the members of the population an evidence-based protocol of treatment. Finally, it includes active monitoring of adherence, side effects, and effectiveness throughout the course of treatment, with additional intensity of care offered to patients for whom the initial treatment protocol does not seem to be effective. Since a brief targeted dose of therapy

(4-8 visits in various implementations of the model) is one of the choices in an evidence-based protocol for most patients, your BH clinician will be your provider for this element. A slight majority of patients who have less than severe depression tend to prefer the "counseling" intervention over medication as a first step (Dwight-Johnson, et. al., 2001). The monitoring of adherence, side effects and effectiveness can be done by the BH clinician in addition to providing therapy, though some practices use lesser trained staff, who still need specific training for this role, to ask the questions when patients come for visits and to make telephone calls between visits.

Options for additional intensity of care, or "stepped care," needs to be part of the Collaborative Care Model for the patients who do not respond adequately to the initial protocol (Katon, von Korff, Lin, et. al., 1999). Sometimes this involves a pre-arranged referral arrangement with a nearby mental health facility. More commonly, it involves the possibility of more visits with the BH clinician, on one hand, and a more complex approach to medication, on the other. For this, having access to consultation with a psychiatrist or expert psychiatric nurse practitioner is important. In many cases, doctors don't feel comfortable taking on an approach such as Collaborative Care without regular consultation and discussion with the psychiatrist. Most, but not all of the studies of the Collaborative Care Model, have used psychiatrists to support or guide the process from the beginning. Some used psychologists for the clinical consultation and psychiatrists to consult on prescribing, (Thota, et. al., 2012). Over time, the doctors tend to gain more confidence in their own prescribing expertise and can use the psychiatrist to help with more unusual stepped care cases.

The advantages of the Collaborative Care approach are many. As in other approaches, a lot of patients who otherwise would not get care are given treatment. It is a clearly outlined approach, so the uncertainty about how to implement the new program is reduced. Roles of various team members are clearly prescribed. It fits with the data sought by quality measures commonly used to by government and other payers and with accreditation measures of the National Committee for Quality Assurance (NCQA) and other certifying agencies.

The disadvantages of the Collaborative Care approach are that, without some modification, it tends to keep the doctor and BH clinician on different tracks during the flow of care. The BH clinician is providing prescribed "doses" of therapy or doing monitoring of current patients. It can also be frustrating to doctors and to patients that a behavioral health service is operating in the practice, but the population being addressed is by no means the entire group of patients who need behavioral health intervention. The author visited one community health center in which the provider group had abandoned their formal Collaborative Care program for exactly this reason. The doctors couldn't justify involving a resource for patients with one diagnosis and not being able to offer the resource to patients they judged to be just as disabled by other behavioral health disorders. They developed their own approach that allowed much more "doctor discretion" about which patients were seen by the BH clinicians, while maintaining the screening program, the protocols of brief care, and the monitoring implemented when the Collaborative Care approach was launched. Finally, the Collaborative Care Model has

shown much better results in controlled studies than in broader implementations. In a statewide implementation in Minnesota called the DIAMOND Project supported by specially designed payment models, participating clinics delivered more elements of the model and showed better patient satisfaction than usual care, but depression remission rates were no higher than non-participating clinics (Solberg, et. al., 2015).

Primary Care Behavioral Health Model

The last way of deploying your BH clinician as a resource is called the Primary Care Behavioral Health (PCBH) model. It is also sometimes called the Behavioral Health Consultant (BHC) model. The word "Consultant" is used in the title to remind doctors and BH clinicians that, where possible, the goal of the approach is to maintain the patient's experience that their doctor is in the lead of their care and to help the doctor in the many ways that someone with strong behavioral health expertise can to enhance the care they provide. This can be done through targeted brief interventions and by offering consultation on diagnoses, needs, and possibilities for patients in the flow of the doctor's care.

In this approach, the BH clinician becomes part of the infrastructure of the practice, used for a quick opinion or added to the care of some patients at the doctor's discretion (augmented by screening). Instead of referring patients to the BH clinician for care, or adding them to a pre-set program for a population, the BH clinician is involved in their care for whatever seems needed at the time. As an example, you could ask the BH clinician to speak to the patient in exam room A to see if he or she thinks the patient's obvious dysphoria is part of a picture that warrants further treatment at this time, and if the treatment would be best offered by the doctor, the BH clinician, both, or some other service. You could ask for an opinion in another case about why an obviously intelligent patient has steadfastly failed to adhere to a medical regimen that could prolong his or her life, despite the doctor's best efforts to make the situation clear to him or her. You could ask the BH clinician to teach another patient a technique that allows people to put themselves to sleep more easily, as a first level intervention for insomnia. If you think about all the times in the day when you wish for a quick consult or intervention on psychosocial or behavioral issues, you can think of a lot of ways that a BH clinician in this model could make your life easier. This doesn't have to add a lot of time to your day. The BH clinician can meet with one patient while you go on to another.

The use of your BH clinician as an internal consultant has all the advantages of improved access plus patient and provider satisfaction of the co-located approach. In fact, this is the approach that gets some behavioral health expertise and care added to the overall care of the largest portion of your patients. It would logically follow that if this approach engages a BH clinician with the most patients, no matter how efficiently the engagement is effected, it is also the approach that would require the most BH clinicians for a busy practice. The ratio of BH clinician is variable depending on the acuity of the population, how sophisticated the doctors are at using them in the flow care, and how comfortable the BH clinician is at addressing chronic illnesses and health behavior change needs. If all of these are high (acuity, sophistication, generalism), probably one full time BH clinician could adequately support two to three full time doctors as a start.

The benefits to the doctors and for other medical team members is more support and more teaming in the flow of care. Over time the medical team members gain more behavioral health expertise and tend to practice more "behaviorally enhanced" medicine though they don't begin doing the work of the BH clinician. This approach is also very exciting and interesting to the BH clinicians that choose it. And "choose it" is important here. In programs in which clinicians from a mental health organization have been assigned to work in a primary care setting, they often are very unhappy. A BH clinician has to enjoy the fast pace and the uncertainty of what each patient encounter will bring in primary care. Those for whom that style is a fit, usually in the behavioral health consultant role, become happy and confident team members. They often get assigned other new roles in the organization that need confidence, creativity and flexibility.

The other side of the flexibility coin is that these clinicians have had to make the most adaptation to primary care culture and practice patterns from their original training in specialty mental health therapies. Mental health graduate training is usually built on the idea that medical and behavioral health constitute different worlds of diagnosis and care. The need to make the primary care behavioral health adaptation tends to select for personal flexibility and being able to function confidently within the uncertainties of primary care practice.

The challenges of the PCBH model tend to be those attendant to an approach that is less bound to the prevailing assumptions and practice patterns that are the basis for the "diagnose, treat, bill" sequence in the fee for service payment world. On the other hand, the more a practice goes to bundled payments or shared risk payment model, the more the flexibility of this approach and the people who are schooled in it will stand everyone in good stead when it comes to sustainability.

5.3 Hiring

Your first BH clinician may be the most important hire of your new team. It is probably easiest to say who you don't want. The leaders from the ACT implementation in Colorado (a large multi-site implementation of behavioral health integration; see description in Chap. 1), the researchers who studied behavioral health integration in exemplar practices for the Agency for Healthcare Research and Quality (AHRQ) Integration Academy, and most of the other leaders in the movement to develop the primary care behavioral health workforce agree, you don't want a mental health professional (psychiatrist, psychologists, social worker or counselor) who has only been trained in and only worked in specialty mental health (Hall, et al, 2015). This is a challenge, because very few of the graduate training programs in the U.S. are training clinicians to work in primary care. Most who learn these skills in their degree programs learn them is experiential training placements in primary care. There are some very good programs available online as post-degree transition training, such as the primary care behavioral health training program of the Center for Integrated Primary Care at the University of Massachusetts Medical School, and the guild organizations, such as the American Psychological Association and the American Psychiatric Association have

developed programs and curricula. There are a growing number of primary care health settings that offer practicums, internships or post-doctoral fellowships for behavioral health clinicians in training that help students make the transition to primary care culture and methods. The change offered by an organized training program is as much cultural as it is skill based, so a workshop or two in skills alone tends not to be sufficient. You don't want an "untrained" person if there is an alternative.

If you don't have the option of hiring someone who has worked in primary care or has trained for primary care, hire on the basis of personality. You are looking for someone who is open to learning, who sees working in primary care as a unique opportunity rather than as a less than rigorous mental health delivery setting. You want someone who is comfortable with generalism, who is interested in seeing the full range patients in your practice, someone who makes friends with other staff members easily, who likes the idea of other staff members helping out with the behavioral treatment load in some way rather than a professional who spends energy patrolling disciplinary boundaries and arguing about who is qualified to do what. You want somebody who expecting to do what is necessary for a patient, such as some elements of care management, rather than someone who takes an "it's not my job" approach. When you are interviewing candidates, don't ask them if they work in the way just described. Ask them to tell you a clinical story in which they look good, and look to see which of these qualities you can see in the story. You can ask the same question for an organizational story. Have them tell a story where there was some difficulty or issue in an organization where they worked, and how they kept it from getting worse or contributed to making it better. Push for enough detail so you can visualize the interaction, and if you find it impossible to visualize the patient and their situation that are being described in your candidate's story because of psychological vagueness or jargon, e.g., "I did CBT," you can be confident that you will have a hard time working on a collaborative clinical team with this person. If the patient(s) come across as understandable human beings in the story, and the interventions described make sense to you, e.g., "I worked with her to pick one thing she could do every day that she enjoyed and we tracked those for the next two weeks," that is a very good indication. The more your candidate includes an understanding of the patient's family and other elements of their context, such as their culture, in designing treatment approaches, the more their expertise likely will be understandable and helpful to other team members.

Hiring other members of the team when you need to is probably more familiar. For most of these roles, medical or administrative skills need to be in place. For these roles, the behavioral skills needed in the job are called "people skills." Look for people who find ways to relate positively to patients, who are interested in patients' stories. See if you can find people who have some hope of sharpening their own skills, who want to earn the right to take on increased responsibility appropriate to their training. In the long run you will want everyone to be able to do some motivational interviewing to help patients improve their health by changing their health behaviors. You want someone who could be interested in learning rather than whose first response is "not my job."

5.4 Building Team Culture

Over time a successful team creates a culture that is durable, not dependent only on the attitudes and practice style of the doctor. The addition of the BH clinician to the team begins this process by adding an expertise set to the team that is separate from and additional to the expertise of the doctor. For the first time, the doctor is asking a team member for clinical input, not just for assistance. It is a profound and usually unheralded moment. This begins opening space for the whole team to see how the team can be "smarter" than any one member without losing its coherence or leadership. As the doctor, you might find that some team members have the same degree of challenges to working in this new team as you. They can be a reticent about sharing what they know or what they think because of their experience of doctors who were not interested in their observations and opinions. If they are like many of their peers, they will wait for the doctor to set the agenda, to tell them what to do. Over time, as team members get more comfortable accessing multiple expertise sets, there is one more set of expertise that is available and that can be transformative: the expertise of the patient.

You might want to consider having a "mission talk" that you deliver at your first team meeting after your BH clinician is hired. It is brief statement that expresses the mission of the team. It should be a fairly brief, a conversation you bring up in essentially same form whenever a new member of the team is added. The message can describe the patient as the center of the team's efforts and as a full team member in their own care, whose knowledge and preferences are fundamental to designing their treatment plan. It is sensible every time to highlight the way that behavioral health is "mission critical" to the team. You might want to say something about how team members value each other's special relationships with and therefore special knowledge of patients. It could be worth saying that we watch each other for signs of stress or struggle and show caring when we see them. The talk should encourage each team member being able to articulate the roles of all team members to patients and to other people. And it should support learning from each other, and being able to cover for each other in situation in which the coverage is clearly appropriate and boundaries of licensure are respected. After a few deliveries, you hope that the talk will be so familiar to the team that when a new team member starts on a day when you cannot be at the meeting, other members deliver the talk because they have heard it so many times. This is how you build a culture over time that is self-sustaining.

5.5 Communication in the Team

Ongoing communication within the team is vital for team functioning, both at regular meetings for predictable communication and through brief exchanges of information to keep each other up to date in the flow of care. For regular meetings, some practices have one meeting a week to address a range of matters, other practices have more than one kind of meeting and address different sorts of issues at different times. Some have longer meetings to get it all done, while some have briefer meetings because those are more efficient for them. It is very hard to say what schedule and organization will work for a practice.

It is a fair generalization that primary care practices, and medical services in general, have so much to do that they try to have as little time in meetings as possible. This leads

to a common situation in which a practice avoids meetings and then has barely enough communication to keep things moving. In this situation team members are more likely to feel overwhelmed. The idea that more communication is needed to plan changes in workflows, to evaluate the results, do brief targeted training, or to talk about mission or values, and that the investment in more communication could leave everyone less stressed and help the practice provide better care more efficiently can be a very hard sell. It is also true that time spent in meetings which is not productive or conversations that don't relate to the jobs the team has accomplish will lead to meetings losing the engagement of team members.

Examples of topics for regularly occurring meetings:

1. One or two patients that team members feel the team could engage or manage better: non-adherent patients, scary patients, dissatisfied patients, patients who aren't getting better, patients with complex lives that need to be understood better.
2. How can we improve? The team looks at data, something that is being counted, and sees where the numbers look good and where there might be a place to try something different. Or they remember together one or two specific instances when things didn't go smoothly and think about how those specific situations could be handled better in the future. Before spending too much time looking for a fix, spend some time looking for instances when that same process or task went well. See what various team members did in those instances. Whatever the sequence, it is something they already know how to do and could be the basis for making that success more frequent.
3. Highlight excellence. Take a moment to let team members recite things that other members did that were noticeably helpful, or insightful, or caring, or courageous. Make sure they describe specifically what their teammate did that they appreciated.

It might be good to have a weekly meeting time with rotating topics so that the time is always interesting and useful.

Perhaps the most useful regular meeting is the huddle before each session of patient care. A huddle is a 5-15 minute meeting in which all of the people who will be providing or assisting in patient care during the session exchange information that will help everyone work in a coordinated and efficient way. When you first start to hold huddles there will likely be push back. "We could use this time better to each get ready for our individual role." Don't give in. Once you see how much better the half-day goes, how much less stressed everyone is, and how much less follow-up work there is, they will come around.

If you are using the BH clinician as a consultant in the flow of care, a huddle is the best way to involve her in the care efficiently and effectively. Look at the schedule. Which patients could use a brief check in on how they are doing with their depression or anxiety or drinking? The BH clinician can be called in before or after your contact with the patient. Is there a smoker or two that the BH clinician might look in on before you get to them? It is often possible to help a patient move one stage of change toward health in that time. Then when you come in, the BH clinician and the patient can sum up what

they have discussed and what the patient is going to do in 1-2 minutes, and the BHC can leave. You can start your visit with the patient offering support or congratulations. Think about how much more enjoyable those visits would be. For a good deal more material on building a highly functioning team see the American Medical Association's "Steps Forward" site at https://www.stepsforward.org/modules/team-based-care. For help in building a team that includes a BH clinician, see https://www.integration.samhsa.gov/workforce/team-members.

5.6 Workflows

Adding your BH clinician and the services he or she contributes to the team will inevitably impact workflows. If you are going to address behavioral health issues in any organized way, you will be doing behavioral health screening of some sort. Workflows in a primary care team are modified by the introduction of screening for BH concerns, such as depression (recommended by the United States Preventive Services Task Force for adults and adolescents), alcohol (recommended for adults), other substance use disorders, anxiety, post-traumatic stress disorder (PTSD) or other concerns that might be relevant to your patient population. You and the BH clinician can decide what screens to use and where to start.

Some practices want to use the most brief sorts of screens comparatively often. With these screens, a positive response has to be followed up by administration of a longer screen to help with diagnosis, which is a workflow challenge. A negative screen, however, takes very little time and needs no further discussion. A longer screen, perhaps given annually, with more frequent administrations to higher risk groups, can be followed up for diagnosis and possible intervention directly without a second step, but it takes more time up front.

You might want to use the decision about how to handle behavioral health screens in the workflow as one to which the whole team can contribute. On most teams, multiple members of the team get involved in distributing, scoring, assessing results, interacting with patients about the results and confirming diagnoses. The weekly meeting can be a time to launch and evaluate lots of small workflow adjustments. Having the team in on developing workflows should help with follow through. When everyone is aware of why the new sequence is being tried, that it is being piloted, how it should help or improve some past inefficiency and that they will have a part in evaluating the results, they are more likely to help with carrying it out.

Take some time discussing the words or phrases that team members will use to describe what a screen is for and how it will be used. Small differences in wording can make a difference in how well patients respond and how open they are to some sort of intervention later. You want to normalize the questions and to make the information gained seem to open up the possibility of the team offering more effective care. In several practices the screening sheet, a collection of standard depression, anxiety, PTSD and alcohol screens, was called "The Patient Stress Questionnaire." People found it to be a reasonable and helpful set of questions. One approach to helping team members do

their part in the screening process is to offer scripts for how to introduce a BH screen or respond to a positive screen. When they know what to say, they experience success and the whole area of BH care becomes likely to feel more familiar and related to their work.

The fact that the team has multiple experts in the patients' care means that there probably needs to be more communication about a patient while they are at the practice. Having the conversation about the patient and their care in the exam room with the patient saves time, increases patient engagement and participation, and helps grow the expertise of all the team members.

The practice of having conversations about the patient in the presence of the patient is common in integrated primary care settings, though very few go to the full extent of embracing the patient empowerment slogan: "Nothing about me without me." It tends to start at the "passing of the relationship" when the doctor wants to add the BH clinician to the care. The common practice for this exchange is inefficient. It involves a double exchange of information, as when the doctor and BH clinician exchange information about the patient in the hall and then a social introduction between patient and BH clinician is made in the exam room. It makes starting the new relationship between the BH clinician and the patient somewhat awkward, because the patient doesn't know what the BH clinician has been told about him and the BH clinician has to spend time beginning a conversation and establishing a mutual purpose for the meeting.

When the introduction and exchange of information about the patient are done in the presence of the patient, the existing doctor-patient dyad can be transitioned much more comfortably and effectively into a BH clinician-patient dyad. The "warm handoff" is done in the room with the patient, the BH clinician and the doctor. The doctor leads. It is an introduction that is designed to make working with the BH clinician maximally acceptable to the patient and to orient the BH clinician to the person and the task.

Consider using the mnemonic of SSRI. to organize the passing of the relationship between the doctor and the patient to the patient and the new BH clinician. It is designed to help doctors know how conduct this process smoothly and efficiently.

The first S. is for **Situation.** The doctor says to the patient and the BH clinician what situation in the patient's current care makes him or her want to add the BH clinician to the treatment team.

The second S. is **Skill Set**. The doctor describes to the patient the skill set (as opposed to the discipline) of the BH clinician that makes him or her the person that he or she wants to add to the treatment team.

The R. stands for **Relationship**. At this point the doctor says what relationship the work between the BH clinician and the patient will have to the overall treatment that he or she has been directing. Remember, this isn't a new treatment; it is a new aspect of the patient's current care.

The final I. is for **Indicators**. The doctor says to the BH clinician and the patient what would indicate that the addition of the BH clinician's expertise and intervention had been successful.

Below are three examples of introductions designed to add a BH clinician to the care of a patient in a way that allows the patient and BH clinician to achieve targeted improvement through an efficient and effective interaction. Notice that the doctor doesn't specify what sort of intervention the BH clinician will use nor how many contacts between the BH clinician and the patient will be involved. Those are dependent on the expertise of the BH clinician and the connection that develops between clinician and patient.

In each case there is a social introductory sentence before the SSRI. statements. In the first case it would be, "Ms. Ruiz, this is Dr. Collins. Dr. Collins, this is Ms. Ruiz."

> **Situation:** "Ms Ruiz has terrible headaches. I think they may be related to stress."
>
> **Skill Set:** "Dr. Collins (BH clinician) is an expert at helping people cope with stress."
>
> **Relationship:** "I am hoping that you and Dr. Collins can look into the sources of stress in your life and see what ways of reducing or managing those stresses you two can develop. That would help me decide if it will be possible to avoid an increase in medication that I think it would be safer to do without."
>
> **Indicators:** "Ms. Ruiz was working successfully for quite a while, even though she was coping with headaches. I suspect that if she can get a bit of control, even if it is a small reduction in her frequency or intensity of headaches, she would be able to go back to work. That would make a significant difference for her family financially and would further reduce the stresses she is facing."

In each case, the SSRI. statements can be used to gain the acceptance of the patient to the idea of adding a BH clinician to their care and used again in the face to face introduction that occurs in the exam room. It is tempting to avoid the difficulties of having the BH clinician on call to the doctor for face to face warm handoffs by using the SSRI. statements as a way of getting the patient's assent to be scheduled to see the BH clinician at another time. Sometimes this is unavoidable. It is common experience in practice, particularly with patients who sometimes have difficulty keeping appointments, that the face to face warm handoffs lead to almost doubling the rate that patients keep subsequent appointments with the BH clinicians as when they are scheduled with the BH clinician without a face to face meeting (Apostoleris, et. a., 2005).

> **S:** "Ms. Smith is having a very difficult time helping Brandon (3 year old) settle down for bed at night. It is stressing the entire household."
>
> **S.** "Ms. Johnson is a person with a lot of experience helping parents successfully manage bedtime.
>
> R: "I am hoping that in working with Ms. Johnson you can find a way to reduce the stress of bedtime. Ms. Smith has been having a difficult time managing her diabetes as shown in her very high Hemoglobin A1C (HbA1c) which the stress of bedtime is certainly not helping."
>
> **I:** "Because if Ms. Smith could get Brandon to bed reliably in under an hour, she could return to exercising in the evening. That would be good for her lipids, her HbA1C, and her peace of mind."

Notice that the aspect of the BH clinician's skill set that is most relevant to the patient's situation is what the doctor stresses. In the case above, Ms. Johnson is a skilled BH generalist, experienced at working with the behavioral health needs of adults and children. But it is not her skills with substance abuse care, or depression intervention that makes her someone that Ms. Smith would want to work with, it is her skill at making bedtime easier. That is the skill set that is highlighted. In the early stages of their work together, Ms. Johnson will tell Ms. Smith that she is a licensed clinical social worker, but that will be as context to how she learned the techniques or skills she is teaching Ms. Smith. Ms. Smith is not interested in picking the expertise that is being added to the team for her benefit by discipline. The techniques she will learn could be taught by team members from a number of disciplines, licensed and unlicensed. She wants the person who can best help her get her child to sleep.

S. "Bob reports he is experiencing the early stages of a recurrence of his depression."

S: "Mr. Gonzalez has a lot of experience helping people keep minor recurrences of depression from developing into major episodes."

R: "I am hoping that while working with Mr. Gonzalez, you can get back on track fairly quickly. I would like to get an update from the two of you in 3 weeks so that we can reinstitute medication if that is indicated."

I. "Because if Bob is able to get through a mild recurrence of his depression without losing traction in his work or social life, I think it will give him confidence about planning for his future, something that up to now he hasn't quite been able to do."

On paper this may seem like a complex process, but try reading the examples out loud. You get a complete statement that would require less time than is usually taken for either the hall discussion or the in-room introduction.

When it is possible with schedules, it is also effective to have a "report back" to the doctor by the BH clinician and the patient. It orients the doctor briefly to the specifics of what was useful in their work together. It allows the BH clinician to say complimentary things about the patient and sometimes vice versa. It passes the role of clinician regarding behavioral aspects of the patients care back to the doctor, and enfranchises him or her to remind the patient of the skills that they learned in working with the BH clinician when those skills could be useful in the future.

The SSRI conversation can start the practice of discussing patients' situations between team members with the patient participating on a broader basis. It allows for other members of the team to see examples of what such a conversation looks like. It is much easier to have conversations about the care of patients in their presence than most team members can imagine. No one needs to change the facts that are discussed, though it helps to have a change in some of the types of language in which the facts are couched. **Table 1** offers some examples of ways that usual professional language, which tends to characterize patients in ways that are either passive or negative or both, can be transformed into characterizations that are active and positive.

As a way to build the skills of team members in having conversations in front of patients that engage and activate patients in their own care, have the team practice adding to the list in Table 1. At first they are likely to experience the process as humorous and forced. It is not what they "really think" about the patients. If you imagine or role play using

these terms in clinical practice, the impact begins to come clear. When the experience of the patient is factored into the exercise, and the difference in the behavior that the patient is likely to exhibit begins to become apparent, people begin to see this as an exercise designed to make their work lives much easier. They begin to feel the descriptions take on more authenticity.

As team members get more comfortable in having conversations in the presence of patients, as their characterizations become more active and positive than they have used in the past, they tend to develop greater comfort and skill at speaking with patients generally. This is not something to force, but it is something worth cultivating or nurturing. Some BH clinicians strengthen this skill by reading back their note from the last time to the patient at the start of each subsequent visit. It is regular practice in saying things briefly and in with active and positive characterizations. It is training for the patient to participate in the conceptualization of their care. It is also a way to keep notes simple and clear enough that doctors find them useful and read them regularly as they go in to see the patient.

The discussions of complex or challenging patients in the weekly team meetings, combined with an increase in precision at using language effectively with patients, constitute graduate level course content in behavioral health practice for the whole team. The facility and comfort of team members at bringing each patient into the conversation about their own needs and treatment becomes a central skill set that they share. This allows the team to move from endorsing the patient's participation in their own care team as an aspirational idea, to being able to facilitate this process in day to day practice. This is one of ways that a practice might be said to move from good to great in team-based patient centered primary care.

In many practices in which BH clinicians have been part of the treatment team long enough for the fact of integration not to constitute a new way of working anymore, non-clinical members of the team, such as medical assistants, care managers, and community health workers have begun to take on carefully delineated areas of behavioral health care in the same way that they take on carefully delineated areas of medical care (e.g. Roy-Byrne, Craske, Sullivan, et. al., 2010). With the advent of ways for non-clinical team members to take courses toward master's degrees in counseling or social work, your team may become the source for generating your future BH clinicians.

5.7 Maintaining the Team

If your team is able to develop as you hope, it can bring a few new challenges. One challenge is that team members who become more skilled and who can operate more independently will at some point want to be compensated for what they are able to do that is not able to be done by other people in the same job title. The fact that their work life is more interesting and enjoyable means a great deal, but eventually you may need some avenues for augmentation of payment to reduce the pressure that comparison with their peers brings. Augmenting team member roles and compensation by having them train

new team members is one way to both maintain current team members and to replace the ones who decide to take new opportunities.

The process of onboarding BH clinicians or other roles is important and deserves careful attention. The culture that you have developed can begin to fade if attrition is not used as opportunity to reaffirm and pass on the culture you have developed. (Remember the "mission speech"?) Watching other team members work at the beginning of a new team member's tenure can be worth much more in the long run than quickly filling up their schedule to take the load off their colleagues. New team members should watch all of the rest of the team work, not just members in the same job category, if they are to begin to understand and join the culture and practices that you have worked so hard to develop. Pairing them with team members to help them learn the skills as well as the culture of the team is an important investment for the future of the team. The culture that you have spent so much effort building can gradually dissipate through the addition on non-acculturated team members, if the process of on boarding is short changed.

5.8 Summary

In a very few pages, I have tried to go from the basics of adding behavioral health to your practice all the way to refinements that could help you build a truly great primary care health team. This is a process that is ongoing. I believe that, in addition to the evolution of methods and workflows that are occurring in the "exemplar integrated practices," we are seeing changes in the fundamental ways that medical and behavioral problems are defined and understood in these practices. When all of the patients' disorders, stresses and problems are seen together and in the context of their family, culture and social situation, new patterns emerge that can help us find new approaches to helping. The disappearing of the bright line between physical and behavioral processes that is has been occurring in research in neurology, endocrinology, immunology and psychology is being translated into practice in highly evolved integrated primary care settings. While creating new ways of conceptualizing the problems that our patients bring to primary care is not the goal of anyone at the start of the process of behavioral health integration, it keeps the whole endeavor exciting and rewarding well beyond the initial benefits of better access for patients and greater satisfaction for doctors.

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Table 1 Examples of ways to change your language to engage and activate your patient.

Negative/passive words	**Positive/active words**
Suffers from	Struggles with
Refused to take	Decided against
Didn't keep appointment	Was unable to be here
Was non-compliant with	Had not seen the value of
Arrived late	Was determined not to miss