The Transition to Behavioral Health Consultant: 
Successes and Missteps 

Joe Schatz, MSN, CRNP, PMHNP-BC 
Behavioral Health Consultant 
ChesPenn Health Services 

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Objectives:

• Define the behavioral health consultant role
• Identify the characteristics that make APRNs a good fit for the behavioral health consultant role
• Articulate “growing pains” associated with an individual’s shift from a patient-centric to a population-focused practice environment
CV:

• 2002 to 2007: STAP
• 2003 to 2012: FLECS
• 2004 to Present: EMS
• 2009 to 2013: WRT
• 2012 to Present: UPenn
• 2013 to Present: PGC
• 2013 to Present: BHC
• 2014 to Present: PICN
Three-step warm-up...

1. “Integrated behavioral care acknowledges the mind’s inextricable connection to the body and fully recognizes that what happens to one profoundly impacts the other.”

2. ...pause to process...

3. Realize that WE ALREADY KNEW THAT! We’re NURSES! DUH!

Integrated Behavioral Health Project
Unfortunately, not everyone thinks the way we do...
“care for the whole person, not just a portion.”
PCBH: Why? ACES!
Why Integrate BH and PC?

- An estimated 25% of people with diabetes and 35% of people with heart failure suffer from mental health conditions, such as depression.
- For those with diabetes, “decapitation” can add as much as 50% to the cost of care.
- Individuals who experience SMI are dying approximately 25 years earlier than the general population.
- A 2010 report by found that people with a combined mental health and substance use disorder are at greatest risk -- Average age of death is 45

BH in PC

- Up to 70% of PC appointments stem from psychosocial issues
- Up to 42% of PC referrals to specialty psychiatry will not follow-through.
- 50% of MH care is provided by PC (92% for elderly)
- 67% psychotropics Rx by PC (80% antidepressants)
- Up to 85% of complaints are often NOT traced to any organic etiology
- Many PC complaints have significant potential for flare-ups with stress—IBS, HA, insomnia, pain...
But really, why? Let’s look at PCMH:

**Comprehensive Care**
- Primary care providers are accountable for meeting the large majority of each patient’s physical and mental health need.

**Patient-Centered Care**
- Relationship-based primary care that meets the individual patient and family’s needs, preferences, and priorities.
But really, why? Let’s look at PCMH:

Quality and Safety

• A commitment to safe, high-quality care through engagement in quality improvement activities and safety monitoring.
And why is it necessary?

- “The focus is shifting now, though, to a pay-for-performance model. Payments will be based in how well you do in caring for the patient. This is measured in decreased ED and hospital visits, stabilizing labs and vital signs, decreased number of missed office visits and patient satisfaction…”
PCBH: Where → What?

Illustration: A family tree of related terms used in behavioral health and primary care integration
See glossary for details and additional definitions

Integrated Care
Tightly integrated, on-site teamwork with unified care plan as a standard approach to care for designated populations. Comprises organizational integration involving social & other services. “Alitudes” of integration: 1) Integrated treatments, 2) integrated program structure, 3) integrated system of programs, and 4) integrated payments. (Based on SAMHSA)

Patient-Centered Care
“The experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one’s person, circumstances, and relationships in health care”—or “nothing about me without me” (Berwick, 2011).

Shared Care
Predominantly Canadian usage—PC & MH professionals (typically psychiatrists) working together in shared system and record, maintaining treatment plan addressing all patient health needs. (Kates et al, 1996; Kelly et al, 2011)

Collaborative Care
A general term for ongoing working relationships between clinicians, rather than a specific product or service (Doherty, McDaniel & Beird, 1996). Provides combine perspectives and skills to understand and identify problems and treatments, continually revising as needed to hit goals, e.g., in collaborative care of depression (Unutzer et al, 2002)

Co-located Care
BH and PC providers (i.e. physicians, NP’s) delivering care in same practice. This denotes shared space to one extent or another, not a specific service or kind of collaboration. (adapted from Bisnati, 2003)

Integrated Primary Care or Primary Care Behavioral Health
Combines medical & BH services for problems patients bring to primary care, including stress-linked physical symptoms, health behaviors, MH or SA disorders. For any problem, they have come to the right place—“no wrong door” (Blount). BH professional used as a consultant to PC colleagues (Sahn & Borus, 2009; Elias & deCruy, 2004; Robinson & Ritter, 2007; Hunter et al, 2009).

Behavioral Health Care
An umbrella term for care that addresses any behavioral problems bearing on health, including MH and SA conditions, stress-linked physical symptoms, patient activation and health behaviors. The job of all kinds of care settings, and done by clinicians and health coaches of various disciplines or training.

Mental Health Care
Care to help people with mental illness (or at risk)—to suffer less emotional pain and disability—and live healthier, longer, more productive lives. Done by a variety of caregivers in diverse public and private settings such as specialty MH, general medical, human services, and voluntary support networks. (Adapted from SAMHSA)

Substance Abuse Care
Services, treatments, and supports to help people with addictions and substance abuse problems suffer less emotional pain, family and vocational disturbance, physical risks—and live healthier, longer, more productive lives. Done in specialty SA, general medical, human services, voluntary support networks, e.g., 12-step programs and peer counselors. (Adapted from SAMHSA)

Primary Care
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. (Institute of Medicine, 1994)

Patient-Centered Medical Home
An approach to comprehensive primary care for children, youth and adults—a setting that facilitates partnerships between patients and their personal physicians, and when appropriate, the patient’s family. Emphasizes care of populations, team care, whole person care—including behavioral health, care coordination, information tools and business models needed to sustain the work. The goal is health, patient experience, and reduced cost. (Joint Principles of PCMH, 2007)

Thanks to Benjamin Miller and Jorgen Unitzer for advice on organizing this illustration
## Where → What?

<table>
<thead>
<tr>
<th>Referral</th>
<th>Co-Located</th>
<th>Integrated</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key Element: Communication</strong></td>
<td><strong>Key Element: Physical Proximity</strong></td>
<td><strong>Key Element: Practice Change</strong></td>
</tr>
<tr>
<td>Minimal Collaboration</td>
<td>Basic Collaboration On-Site</td>
<td>Close Collaboration On-Site with Some System Integration</td>
</tr>
<tr>
<td>Basic Collaboration at a Distance</td>
<td>Close Collaboration On-Site Approaching an Integrated Practice</td>
<td>Full Collaboration in a Transformed/Merged Integrated Practice</td>
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Behavioral health, primary care and other healthcare providers work:

- In separate facilities
- In same facility not necessarily same offices
- In same space within the same facility
- In same space within the same facility (some shared space)
- In same space within the same facility, sharing all practice space + EMR
PCBH: What?

Target Population

- Prevention Education
- Brief BH Consultation
- Referral to MH Specialist Care

Symptoms:
- No Sxs
- Mild Sxs
- Moderate Sxs
- Severe Sxs

Prevention Education

Educa*on

PCBH:	
  What?
### PCBH: What?

**PCBH:**
- Problem-focused/brief
- Focus: Population
- Goal: Functional Restoration
- Timing: Same-day
- Integrated records
- Cost = Less/Free
- Freq: Intermittent
- Stigma: Likely less

**Specialty MH:**
- Comprehensive/50-minute
- Focus: Individual
- Goal: Symptom elimination
- Timing: Delayed Scheduling
- Separate records
- Cost = Potentially more...
- Freq: Intensive, then D/C
- Stigma: Possibly more
PCBH: What?
A day in the life…

- 07:45 to 09:00
- 09:00 to 09:15
- **09:15 to 09:33**
- 09:40 to 10:05
- 10:07 to 10:37
- **10:58 to 11:17**
- 11:20 to 11:52
- 11:52 to 12:00
- **12:00 to 12:08**
- 12:08 to 12:30
- 12:35 to 13:02
- 13:02 to 14:00
- **14:00 to 14:28**
- 14:32 to 15:06
- 15:27 to 15:48
- **16:20 to 16:50**
- 16:52 to 17:06
- **17:10 to 17:35**
- 17:35 to 18:00
- 18:02 to 18:20
- 18:20 to 19:00
- 19:00 → Home
09:15 to 09:33

• 26 ♀, Hispanic, ESL, uninsured
• +LTR, lives in apt with BF and 3 ♀
• Seen today for 3rd Visit
• Originally referred by WHNP for “anxiety”

• Initial visit (35-min): Psychoed + cognitive restructuring
• Second visit (24-min): ACT
• Today: “It’s annoying, but that’s it.”
10:58 to 11:17

- 36♀ referred by CTTS for “stress”
- Seen for f/u visit #3
- Tobacco Use: Onset 16yo, 1.5PPD for past 5yrs
- “Tried to quit...but I can’t...”
- PHQ-9 = 19
- GAD-7 = 17

- Visit 1: Comprehensive assessment of support system and DB
- Visit 2: Minimal improvement... start Citalopram 10 mg
- Visit 3: PHQ-9 = 4, GAD-7 = 10, AND...
12:00 to 12:08

- 42\(\sigma\) referred by shelter, uninsured, released from prison 14-days ago
- Chronic passive SI
- Chronic AH
- Meds: Doxepin 150 mg, Risperidone 6 mg, Citalopram 40 mg
- Curbside Consult
12:08 to 12:30

- 49♂
- Dx: HTN, NIDDM, HL, Morbid Obesity, HIV+, Glaucoma, Gout...
- Metoprolol 50 mg BID, Catapres TTS 0.3 mg, Benazepril, Furosemide 80 mg BID... total meds = 12/day
- Initial BP consistently 220’s/110’s

- Weekly appts x 6wks
- Biweekly appts x 6wks
- Monthly appts ongoing
14:00 to 14:28

- 6♀, uninsured, here with mother, referred by pediatrician for eval + rec for new enuresis
- 5/7 nights/wk for past 6wks
- During our encounter, she also discloses nightmares

- Visit 1: ID problem, assess context
- Visit 2: Created a card
- Visit 3: Encouraged conversation between mother and daughter
- Visit 4: 6-mo later
16:20 to 16:50

- 46♀, chronic pain, xferred to CHC from previous PCP who retired
- Initial urine OK
- 1\textsuperscript{st} f/u appt, overuse ID’d... for the next 12wks, engaged in “ping pong” visits
17:10 to 17:35

• 32 ♀, “migraines”
• “Behind the forehead”
• DAILY!
• Moderate improvement with Excedrin
• Per PCP: “Seems stressed...”
• Patient initially QUITE resistant

• Headache Journal:
  – Time
  – Intensity
  – Preceeding Sx
  – Triggers
  – Med Use
  – Response

• F/U in 2wks: ID’d patterns, planned to break patterns
PCBH: Who?

- Primary Care Team:
  - Front Desk
  - MAs
  - RNs
  - NPs
  - PAs
  - Physicians
  - Interpreters
  - And...BHC

- ...Behavioral Health Consultant (BHC)
  - Psychologist
  - LCSW
  - APRN!!!
Long before the advent of the psych NP role, psych CNS’ had psychiatric consultation-liaison nurses in hospitals and other settings to help non-psychiatric providers address the mental health needs of their patients..., distinguish between primary and secondary psychiatric disorders, address organizational/systems/educational needs... Unfortunately...the emphasis seems to have shifted to responding/reacting to an individual in crisis at the expense of long-term liaison relationships with specific programs and units...”

“I feel that the ‘Nursing’ is being taken out of NP. Psychiatric Nursing is so much more than prescribing, but that is becoming the focus... What makes us different in our profession is our ability to do psych nursing in all of it’s roles.”

“...we are nurses first and foremost! I hear that compliment over and over from my patients and friends who receive care from NPs...”
Why us?

• We already know how to talk the talk
• We’ve already been socialized to the biomedical model
• Pathophysiology: We know it!
• Nurses are educators!

• Team-based care is what we know!
• Value collaborative relationships with patient AND other HCPs
• Excellent time-management/efficient
• We already have the necessary skills!
The APRN-BHC: (excerpts from Member Bridge):

- “long-term liaison relationship”
- Change agent regarding the use of “evidence based practice”
- “educate and train” the primary care team “to better engage their patients”
- Intervention with an “emphasis on health behavior change”
- “…It involves engaging the patient as a member of the health team...[enhancing]... ownership of their... [health]... so they take better care of themselves...”
My working definition:

- The APRN-BHC is an adjunctive (but essential) member of the PC team who provides support via both direct and indirect consultative services. The BHC is a generalist with competence/confidence in addressing psychosocial needs across the lifespan. The goal of any BHC intervention is to decrease functional impairment which requires holistic assessment, identification of barriers, reasonable solution-focused intervention, and partnership with the primary care provider. While an effective APRN-BHC will always value intervention at the patient-level, penetration at the population level is the BHC’s priority.
Things that worked:

- ChesPenn’s Culture
- PICN Support
- Trauma-informed Perspective
- Curbside Consultations
- Warm-handoffs
- Ping-ponging
- Unscheduled Services

- “Interrupt me!”
- Office Location
And... the missteps:

- Documentation Skills
- Axis I-focus
- Save-the-world Complex
- Interpreter Orientation
- “Only four sessions...”
- Phone extension
- Comprehensiveness

- Rx-focus
- PHQ-2
- Initial response to COD
- Poor marketing
Questions?