J Clin Psychol Med Settings
DOI 10.1007/s10880-008-9142-7

Addressing the Workforce Crisis in Integrated Primary Care

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Abstract Training and education in integrated primary care is limited. We see a need for addressing the looming workforce shortage as behavioral health services in primary care become more widely implemented. Bringing mental health clinicians straight from specialty mental health settings into primary care often results in program failure due to poor skills fit, assumptions about services needed, and routines of practice these clinicians bring from their specialty settings. Health psychology graduate programs tend to prepare graduates for specialty research and practice in medical settings rather than preparing them for the pace, culture and broad spectrum of needs in primary care. Family medicine residency programs provide an underutilized resource for training primary care psychologists and family physicians together. Even if comprehensive graduate training programs in integrated primary care were developed, they could not begin to meet the need for behavioral health clinicians in primary care that the present expansion will require. In response to the demand for mental health providers in primary care, new initiatives have emerged which attempt to provide training for the preexisting mental health workforce to enable their successful integration into primary care settings.

Keywords Primary care · Behavioral health · Integrated care · Psychology · Training · Work force

A description of this fellowship appeared first in: Blount, A., DeGirolamo, S., & Mariani, K. (2006). Training the collaborative care practitioners of the future. *Families, Systems and Health*, *24*, 111–119.

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Introduction

Primary care is a critical component of healthcare (Starfield, 2001), and has been touted as the linchpin of the current health care delivery system (Haley et al., 2004). Within the United States, an increase in primary care resources has been associated with better health outcomes and lower health costs (Shi, Starfield, Kennedy, & Kawachi, 1999). The same is true internationally where countries with robust primary care systems have better health outcomes, more equitable distribution of care and lower health care costs than countries with systems more focused on specialty medical services (Starfield, 1998).

The process of integrating mental health services into primary care has been well documented (Blount, 1998; Bray, Frank, McDaniel, & Heldring, 2004; Gatchel & Oordt, 2003). Literature has shown the majority of patients with mental health needs rely solely on their primary care provider (PCP) for treatment (Brody, Khaliq, & Thompson, 1997; Cummings, 1991; Hemmings, 2000). Because the majority of patients using primary care will not seek psychological services outside of their PCPs office (Bridges, Goldberg, Evans, & Sharpe, 1991), primary care has become the de facto mental health system (Reiger et al., 1993).

Besides being able to offer access in primary care for the majority of people with mental health and substance abuse who will not go to specialty settings, there are psychosocial needs that should be addressed in treating chronic illnesses. The skills psychologists use to address mental health needs in primary care, can be used very successfully in the management of chronic disease through behavioral health interventions (e.g., Smith, Kendall, & Keefe, 2002). Complex medical conditions such as cardiovascular disease have several health behaviors linked with their

Published online: 16 January 2009

etiology including smoking, limited exercise, and diet/obesity. Behavioral needs are also central to promoting healthy lifestyles. Five of the leading seven causes of death can be attributed in part to unhealthy lifestyle, health behaviors, and stress (Haley et al., 2004). Addressing these behaviors and promoting change is part of the primary care agenda for preventative care.

Background

Central to psychology practice in primary care is the importance of collaboration with physicians and other biomedical providers (McDaniel, 1995; Tovian, 2006). It is important to note that collaboration within medical settings is not simply with physicians, but often non-physicians such as nurses, medical assistants, social workers, and support staff (Belar & Deardorff, 1995). While collaboration may be a central component within interdisciplinary training, it's presence in graduate psychology training and education is rare. If anything, psychology graduate students are likely to be socialized to a competitive stance with physicians, rather than drilled in the routines of collaboration.

If graduate programs offer training in primary care psychology, they typically embed the training into a health psychology track. Some authors have called for primary care psychology to be placed within the generalist model of training in graduate school so all students can benefit (Talen, Fraser, & Cauley, 2002). This approach would be consistent with moving psychology from specialty mental health care to primary health care (Belar, 2006; Bray, 2004; Levant, 2005) and deconstructing the silo mentality that encompasses much of psychology graduate training. Despite a relative increase in programs offering training in health psychology and primary care, some have argued that specialization, which health psychology is considered to be, should occur during internship and postdoctoral fellowships (Olbrisch, Weiss, Stone, & Schwartz, 1985).

There are a variety of internships and postdoctoral fellowships that offer some level of training in primary care settings. A recent online review of the Association of Postdoctoral and Internships Centers online directory (APPIC) reveals 93 APA accredited internship sites that offer a major rotation in primary care and 16 APA accredited postdoctoral programs that have a specialty area in primary care. It should be noted that just because an internship or fellowship identifies itself as offering training in primary care does not mean they offer an integrated primary care training experience. The definition of integrated health care or collaborative care can be different between each training setting.

The goal of this paper is to discuss two training programs offered through the University of Massachusetts Medical School Department of Family Medicine and Community Health, the postdoctoral fellowship in primary care psychology and the Certificate Program in Primary Care Behavioral Health. The former is designed to train psychologists who can be leaders in integrated primary care settings and faculty in medical training settings. The latter is designed to facilitate the transition from specialty mental health settings to primary care for mental health clinicians of many disciplines.

Primary Care Psychology Fellowship

From one perspective, the description of the fellowship is like that of several other such training opportunities. It is a 2-year full time training and service program sponsored by the Department of Family Medicine and Community Health at the University of Massachusetts Medical School. Fellows spend six half-days located in one of the residency Family Medicine practices and four half-days in training experiences. They receive formal training in family therapy, brief therapy, child development, and in behavioral medicine techniques to teach them how to address the behavioral health problems presenting in primary care. Fellows offer lectures on behavioral science topics as asked and can be involved in practice-based research. They provide clinical services to patients in primary care, both as an unscheduled service supporting primary care by physicians and on an appointed basis for follow-ups.

There were several purposes for designing a fellowship as we did. It provides peer experiences of collaborative care for Family Medicine (FM) residents. The fellows are analogous to second year FM residents when they arrive, having completed a doctorate and a year of internship. They train for two more years, just as residents in that position do and are experienced as peers by residents. The fellowship increases behavioral science teaching capacity by bringing more and different behavioral health skills into the residency health centers.

It is the role of the fellows in the training of Family Medicine residents and vice versa that makes the fellowship currently unique. The Dual Interview requirement in the residency has been the vehicle for this unique interconnection. In the 4 years between the start of the fellowship and the beginning of the Dual Interview program, we got to see how residents interacted with fellows when there was no structure forcing an exchange between them. We found that while all the residents liked having the fellows around, some of them used the fellows actively for consultations while the others used them only as referral destinations. The residents who used the fellows as consultants were enthusiastic about the help they received, but the most common relationship between residents was that

of co-located behavioral health specialist and primary care physician. The Dual Interview program was begun as a way of providing a structure for the development of integrated clinical routines, to give both fellows and residents a regular experience of working in teams in patient care. The program was billed as a longitudinal program for residents that teaches the practical implementation of the skills and concepts taught in the behavioral science curriculum. In fact, it is much more than that.

Dual interviews are meetings between a patient or family, a resident physician and a behavioral health provider. Most of the time that is a fellow in Primary Care Psychology, but it can also be the consulting psychiatrist at the health center or other mental health staff. Residents are required to do 33 dual interviews during the course of 3 years, at a pace that matches the percent of their time they spend in the primary care clinic. In order to meet this challenging total, residents have to learn how to identify patients for whom the addition of a behavioral health clinician's perspective could improve care. Family Medicine residents gradually expand their definition of who could benefit from the most obviously psychiatrically ill patients to the whole array of folks with psychosocial needs in primary care.

Fellows, who commonly have been trained to begin relationships with patients on an appointed basis, learn how to offer brief targeted assistance to a primary care physician, without needing to provide ongoing psychosocial care to every patient. Assessment, problem definition, diagnosis and intervention are all recast when the challenge is to "add value today" in the care of a patient they will probably not work with again. It is a practice that helps the fellows to grow their understanding of how the physician/patient relationship can be psychosocially therapeutic and how they can nurture and support that relationship.

Dual interviews improve care for the complex medical and psychosocial needs of patients who are not likely to accept a referral to behavioral health services. In this way, both residents and fellows get experience in providing more complete care for the difficult situations that present in primary care. It is hard to imagine or promote this sort of care in the future if one has not already seen it in action.

Certificate Program

Background

The movement to bring mental health clinicians into primary care is large and growing. The Bureau of Primary Health Care has mandated that primary care mental health services be part of the core services in every federally qualified health center. Health related foundations in Texas, Kentucky, Colorado, Oregon, California, North Carolina, New Hampshire, Maine, and Rhode Island have funded programs to underwrite the development of integrated primary care.

The current leaders in the movement to integrate behavioral health clinicians into primary care are entities that must address the most socially stressed populations, like the Bureau of Primary Health Care of HRSA or the Veteran's Administration. The "Models that Work" campaign of the Bureau of Primary Health Care of HRSA advocates integrating mental health services into primary care in all Federally Qualified Community Health Centers. The model of the service advocated by the Bureau of Primary Health Care, called the Integrated Primary Care Community Based Health System, can be found at http://aspe.hhs.gov/ezec/issues/primarycare/chart.htm.

The agencies of the Federal government which are responsible for providing healthcare have been working together to move toward integrated care for some time through the Federal Partners Senior Working Group-Mental Health and Primary Care Integration (DoD, HRSA, SAMSHA, OMH, OPHS, AoA, NIMH, AHRQ, ACF, and VA). They produced a report in January of 2008 entitled, "*Compendium of Primary Care and Mental Health Integration Activities across Various Participating Federal Agencies*" which can be found at http://www.samhsa.gov/Matrix/MHST/Compendium_Mental%20Health.pdf.

On July 23, 2008, SAMHSA, HRSA, and CMS released a report proposing strategies to overcome barriers associated with the reimbursement of mental health services provided in primary care settings (http://download.ncadi.samhsa.gov/ken/pdf/SMA08-4324/SMA08-4324.pdf). The report expresses the multi-agency commitment to removing barriers to the teaming of non-medical behavioral health clinicians with primary care physicians in providing care in primary care settings.

Integration has been part of the development of many large health systems in which the system was responsible for the whole cost of care, rather than being paid on an encounter basis. This led to large implementations in such HMOs as Kaiser in California, Group Health of Puget Sound in Washington and Health Partners in Minneapolis/St. Paul. The practice of integrated care has continued in all these systems, though they have retreated from the universality of the implementation, as their systems have returned to a financial model that is much more dominated by fee for service.

The advent of 'pay-for-performance (P4P) schemes and advances in the support of integrated care in some states (e.g., NC Medicaid pays for care management and psychiatric PCPs consultation by phone), and the gradual expansion of payment for the Health and Behavior codes for behavioral medicine services in primary care have brought the financial viability of behavioral health clinicians in primary care closer to being a general reality.

We are Headed for a Workforce Crisis

The growing interest in integrated primary care and the sudden increase in foundation and government support to get programs started and to remove barriers to integrating behavioral health clinicians in primary care are not being met by increases in graduates from programs that train psychologists, clinical social workers or other masters level therapist for work in primary care. Fildes and Cooper (2003), after making the case that social workers are the right discipline to provide the services needed in primary care, admit that current training does not prepare them for this role. They see social workers as having good generalist preparation but as needing to be "life long learners" if they are to gain the behavioral medicine and chronic illness management skills needed in primary care. Similarly, McDaniel, Belar, Schroeder, Hargrove, and Freeman (2002), begin their discussion of the training of psychologists for work in primary care by saying, "At this point, there are few organized sequential experiences that enable psychologists to learn the information and gain the skills necessary for working in primary care settings." There needs to be a rigorous orientation to the skills, routines, and assumptions of primary care behavioral health practice for mental health and substance abuse clinicians if we are to begin to meet the growing need for behavioral health clinicians in primary care.

The Department of Family Medicine and Community Health at the University of Massachusetts Medical School has been training mental health professionals to provide services in primary medical care settings for over 15 years. In January of 2007, the department launched a program designed to train mental health professionals to function successfully as behavioral health clinicians in primary care. The program consists of 36 h of didactic and interactive training. It is beamed by videoconference to sites around the US and Canada. The curriculum described next is designed to embody the specific material that a mental health professional would need to add to their graduate training to succeed in primary care. The content has been discussed informally and generally supported by other leaders in the field of integrated primary care, but it is the construction solely of the faculty in the Department of Family Medicine and Community Health. Most of the workshops are co-led by teams consisting of a psychologist and a physician using distance learning technology.

Workshop 1: Primary Care Culture and Needs

Culture and Language of Primary Medical Care (2 h)

- Primary care's role in health system
- Primary care vs. specialty medical care
- Content and sequence of the basic medical interview
- Recommended preventative care expected of primary care physicians (PCPs)
- Role play primary care interview with associated decision-making

Goal: Feel comfortable and oriented in a primary care setting.

Behavioral Health Needs in Primary Care (1 h)

- Mental health and substance abuse rates
- Behavioral health needs
- Chronic illness mental and behavioral health needs
- "Ambiguous" illnesses
- Cultural impact on illness presentations
- A typical morning in practice
- Example of common "complex" cases

Goal: Conceptualizes how a behavioral health professional (BHP) can help in a wide variety of primary care cases.

Consulting with MDs (3 h)

- Common physician perceptions of role of a BHP
- Ways of impacting those perceptions
- How physicians want to be approached
- Determining what input from BHP is useful to the PCP
- Terms for types of collaborative care
- Co-located patterns of care
- Integrated patterns of care
- Practice dual interview
- Practice talking in front of the patient for a hand off

Goals: Effectively uses the curb-side consultation model to communicate with a physician. Can speak sensitively and with clarity about a patient's situation with a physician in front of the patient.

Workshop 2: Evidence-based Therapies and Substance Abuse in Primary Care

Substance Abuse in Primary Care (3 h)

- Chronic illness vs. failure of will
- Role of SA in common illnesses and health behaviors
- The CAGE and other quick screens
- Physician training in identifying and treating substance abuse
- Chronic pain and the dilemmas of pain medication
- What a BHP can add to the care in each case
- Evidence-based approaches to substance abuse in primary care

Goals: Can identify substance abuse problems of patients presenting medical complaints. Can work collaboratively to help patients with SA problems.

Evidence-based Therapies (3 h)

- Role of "evidence" in making treatments credible
- Types of evidence available for approaches we use
- CBT and the therapies of patient activation
- Family and other multi-person approaches in primary care
- The role of solution focused interviewing in patient and provider change
- Role plays to practice
- Working in brief visits and brief treatments

Goals: Able to briefly assess, engage and intervene with adults with behavioral health needs in primary care, using methods supported by evidence. Able to briefly assess, engage and intervene with children with behavior problems using methods supported by evidence.

Workshop 3: Behavioral Health Care for Chronic Illnesses

Across the Lifespan and Child Development and Collaborative Pediatric Practice

Child Development (1 h)

- The role of "milestones" in organizing pediatric decision-making
- Early developmental milestones and the office assessment of them
- Interaction of experience and biology in developmental problems
- Common developmental disorders

Goal: Able to screen children for developmental problems.

Collaborative Pediatric Practice (2 h)

- The unique nature of pediatrics: doctor/patient relationship is (at least) a triangle.
- Engaging parents in promoting health without making them feel judged
- Difficult situations in normal care: bedtime, toileting, feeding, interface with school and learning.
- Learning problems and ADHD
- Special roles for Behavioral Health in pediatric practice

Goal: Able to guide parents on behavioral issues in a culturally acceptable and effective manner.

Chronic Illnesses Across the Lifespan (3 h)

- Symptoms, mechanisms and treatments of:

  Asthma
  Diabetes
  Heart disease
  Irritable bowel syndrome

- Behavioral health needs and mental health co-morbidities for each illness
- Behavioral treatments in evidence based protocols for chronic illnesses
- Group medical visits

Goal: Able to describe an evidence-based biopsychosocial approach for chronic illnesses in primary care.

Workshop 4: The Toolbox and an Overview of Psychotropic Medication in Primary Care

Screening Instruments for Primary Care (2 h)

- Screening vs. diagnosis vs. outcome
- Pediatrics: The Vanderbilt, the Connors, Pediatric Symptom Checklist.
- Communicating with parents and physicians about screening results
- Multi-illness screens, informal screens, PHQ-9, QIDS, SF-12 and -36, the Duke
- Decision-tree for determining next steps after screening

Goal: To be knowledgeable about one child and one adult screening instrument and able to discuss its use with physicians and patients.

Building a Care Management Program in Primary Care (2 h)

- Adults: The chronic illness care movement
- Organizing a care management program
- Enlisting physicians in screening
- Developing a database and reminder system for patients
- Making patient education part of the program

Goal: To be able to begin a care management program in primary care.

Psychotropic Medication Overview (2 h)

- Getting past the either-or of medications vs. therapy

- Pediatrics: When you might suggest considering medication
- Speaking to parents and children about medication
- Common medications given to children, indications, actions and side effects
- BHP role in assessing side effects and communicating with prescriber
- Talking with adults about medication
- Common medications used in adult primary care, indications, actions and side effects
- The necessary role of psychiatry in primary care: consultation and treatment

Goals: To knowledgeably discuss common psychotropic medications with a patient, including indications, effects and side effects. Able to appropriately recommend initiating medication to a PCP.

Workshop 5: Behavioral Medicine Techniques

Health Behavioral Change Strategies (2 h)

- Building the doctor/patient relationship for better health
- Stages of change model
- Motivational interviewing
- Matching approaches to stages of change
- Health behavior change interviewing practice for smoking and obesity

Goal: Able to conceptualize the stage of change of a patient in relation to a health behavior problem and to match motivational approaches to that stage.

Treating the Somatizing Patient (1 h)

- Is the concept of somatization useful?
- Teamwork in providing care
- Language that engages the patient
- The use of uncertainty in uncertain situations

Goal: Able to discuss bodily symptoms that have no medical findings with patients in a way that promotes curiosity and coping in relation to the illness.

Behavioral Medicine Skills (3 h)

- Role of relaxation response therapies
- Sleep promotion skills
- Progressing relaxation and autogenics
- Hypnotic methods without trance
- Biofeedback

Goal: Able to teach patients techniques to calm their bodies' reactivity.

Workshop 6: Families and Culture in Primary Care

Underserved Populations, Culture and Primary Care (3 h)

- Impact of culture on health practices and health beliefs
- Particular health problems of underserved populations
- Looking for a way to improve cultural "fit" when problems arise
- Promoting cultural curiosity and appreciation
- Using interpreters
- Examples from the Worcester Rainbow: multiple Latino groups, Vietnamese, Albanian, Ghanaian

Goal: Able to adapt the approach to specific patients based on knowledge of cultural factors.

Working with Families in Primary Care (2 h)

- The family's role in health
- The importance of a family perspective in addressing problems in health behavior
- Opportunities in regular care (pediatric and adult) to engage family members
- Critical points in care where family involvement is necessary
- Steps in conducting a medical family meeting

Goal: Able to effectively and sensitively conduct a family medical meeting.

Summary (1 h)

- Questions about implementation and finance
- Other questions and discussion

The curriculum is listed in detail because it is designed as a list of the tools, skills, and attitudes that mental health professionals need to be effective as behavioral health clinicians in primary care. We expect that other authors will design other programs and that the difference in content headings will be an important point of conversation in the field.

The evaluation of this program to date has been a combination of feedback from the participants after each workshop session and a final summary evaluation for the course as a whole. For that purpose, we use a retrospective pre-post format in which participants are asked to rate their skill in the core competencies we are teaching before and after the course. The rating is done after the course, so that the judgment of what they knew before the course is informed by their experience of the course. The validity of this form of evaluation has been supported in a recent summary of studies (D'Eon, Sadownick, Harrison, & Nation, 2008). In our program, the improvement of participants' skills has been assessed as significant to better than .05 level for all of the competencies we ask them to report.

Discussion

There is a growing need for the development of programs to teach physicians and psychologists to work together in teams and a similar need for convenient training to equipmental health professionals to work as behavioral health clinicians in primary care. We have tried to offer descriptions of two training programs, one designed to train psychologists and family medicine residents together and the other to train practicing mental health professionals. We suggest that each offers an outline of an approach worth replicating in other settings.

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