

Preface

I had seen Ms. Johnson before for a visit or two, though it had been several years. In the years since, she had apparently come to the clinic numerous times for a variety of problems, but always just to see her primary care physician. Today she was returning to me, at the urging of the physician, after just completing a visit with him. Stress was affecting how she was managing her diabetes; she had gained some weight and was depressed. She started our visit by apologizing for not having returned sooner to see me, stating she had often considered it, but never followed through. I reassured her that this happens for many people, and the important thing was that she was here now. We made our way through the visit, catching up on her life and devising a plan for improving her current situation. At the end of this seemingly routine visit, she suddenly broke into tears. “I just want to tell you,” she said, “that I appreciate you being here.” She continued, “Even though I haven’t had a visit with you in many years, I’ve been practicing what we talked about before and it has helped me. When I come in here, I often see you around. It always reminds me of what we talked about and makes me feel so comfortable here. I just want you to know you are making a difference.”

In that simple human interaction, Ms. Johnson managed to capture so much of what this book is about. This book is about making a difference. We can talk about policy, models, cost-offsets, core competencies, quality outcomes, and all the rest, but in the end our goal is to improve people’s lives. And the potential for that to happen in primary care is enormous, if we do it right.

Since the first edition of this book was published in 2007, a lot has changed in the primary care behavioral health integration landscape. Integration has spread, and so has the model described in this book. Whereas the notion of a behavioral health provider seeing a patient for 20 or 30 minutes (or less) was often greeted with a fair dose of skepticism (or even hostility) in 2007, today it is common within integrated practices. Thousands of clinicians around the country now refer to themselves as “behavioral health consultants,” a title that in earlier years was greeted mostly with quizzical looks. Integration is happening, it is happening quickly, and it is moving inexorably toward the model outlined here.

The Primary Care Behavioral Health (PCBH) model has received most of its support from grassroots efforts. This is a model developed by and for clinicians. At the frontlines of the nation's healthcare system, the clinicians in primary care understand what the system needs, and they also understand what it doesn't need. It was their collective wisdom that created this model, and the same collective wisdom has continued to refine it. Thus, while outcome studies of this model have been done, this is not what drives its success. While the billing and financial climate for PCBH has improved, no organization has adopted this model to get rich. The model has spread because it makes a difference. It makes a difference for primary care providers, who are the true heroes of the healthcare system, and it makes a difference for patients, who so desperately need something better.

The PCBH model has evolved some over the years. We have learned how to do even more with even less time. We have discovered new ways that a behavioral health provider may contribute to the primary care team. We have refined what it means to practice this model, and how to spread it throughout organizations large and small. And the language of PCBH, with terms like *warm-handoffs*, *consultants*, *pathways*, and others, has been clarified and more standardized.

As the model has evolved, so have the two of us authors. Both of us have enjoyed diversifying our professional lives, through involvement in a variety of new activities. We both work at the "macro-level" world of policy, training, consulting, writing, and speaking, yet we still enjoy the "micro-level" world of direct patient care. One of us (PR) has focused her work on the macro-level, helping large healthcare organizations to build a workforce for the delivery of PCBH care. The other (JR) has focused more on the micro-level, refining the delivery of the PCBH model in the same community health organization where he runs the integrated care service and still sees patients for 70% of his time. For both of us, our work is a real-world "laboratory" for understanding, testing, and improving the PCBH model.

As time has gone by, the need for a revised edition of this book became apparent. As noted above, the PCBH model has been refined, clarified, and applied in a variety of new ways. Outcome studies have been done and the need has emerged to focus more on certain topics and less on others. Primary care itself is also in flux. The content of this book reflects the current state of these changes. To help primary care physicians and nurses learn the PCBH model, we include a new chapter on competencies for them. Additionally, we include an entire chapter devoted to the problem of prescription drug abuse in primary care. We also detail new developments in primary care, such as the Patient Centered Medical Home. We have refined the tools used for training behavioral health consultants and offer a number of new practice support tools as well. We also present new strategies for making the PCBH model even more of an influence on the efficiency and effectiveness of primary care, and we update the literature on many different topics. In short, there is a lot of new material in this book; more than we imagined there would be when we began. Throughout the book, we reference resources available on the book website, and the URL for the book website is www.behavioralconsultationandprimarycare.com.

As was the case with the first edition of this book, we have many people to thank for helping with this one. Many colleagues reviewed parts of this book and offered

feedback that was invaluable. This list includes, in no particular order: David Bauman, Psy.D., Bridget Beachy, Psy.D., Chris Krumm, N.D., Kim McDermott, M.D., Melissa Baker, Ph.D., Kirk Strosahl, Ph.D., Debra Gould, M.D., and Joanna Robinson, B.A. Sharon Panulla at Springer has believed in us since the 2005 lunchtime meeting where we first pitched the book proposal, and her continued support has helped us publish this book as well. We also thank all of the pioneers and innovators who have taken the first edition of this book and run with it. There are too many of you to mention, but your comments, feedback, ideas, and support for the model over the years have all influenced the writing of this book. This model and this book are truly built on the shoulders of giants.

I (JR) wish to thank the many friends and family who brought me lunch, texted words of encouragement, and just generally tolerated my inaccessibility while hunched down over the keyboard. I also wish to thank my colleagues at HealthPoint, which simply must be the best community health organization ever. From the executive team to the primary care providers to the behavioral health team to the frontline staff, my colleagues never cease to amaze me with their passion, kindness, and skills. What I have gained professionally, and personally, from working with these people simply cannot be measured. I also wish to thank Ms. Johnson and the thousands of patients like her, whom I have seen over the years at HealthPoint. Thank you for humbling and amazing me everyday by your resilience, and for all that you have taught me about courage and acceptance. This book is for you.

I (PR) wish to thank Jeff for saying, “Yes,” to my request to write a second edition of this book and for the countless hours of discussion, writing, and editing that went into completing this work. I can truly say that I’ve learned a lot from Jeff in writing the second edition and I have become a better consultant and trainer. I also want to thank two people who supported this work in a very fundamental way: Joanna Robinson, BA, an amazing editor who brings a sense of wonder and extraordinary attention to detail to her work, and Pamela Rieger, a loving sister who was a daily cheerleader for me. I also want to thank the brilliant and caring people I have worked with in the United States Air Force, the San Francisco Department of Public Health, the Calgary Health District, the University of Texas San Antonio Health Sciences Department, Psychology Partners in Sweden, the Oregon Patient Centered Primary Care Institute, the Saint Louis County Department of Health, the Louisiana Public Health Institute, the University of Arkansas Medical Science Clinics, Trillium Coordinated Care Organization, Multnomah County Public Health Department, Community Health of Central Washington (my home clinic), and other Federally Qualified Health Centers and Family Medicine residency training programs with whom I’ve worked large and small. Watching you help others and seeing your willingness to experiment and evaluate how you do that is my inspiration. This book is for you.

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