The Philadelphia Primary Care Behavioral Health Network: Integrating Care, Practice, Workforce and Advocacy

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At the simplest level, integrated behavioral and physical health care occurs when behavioral health and primary care providers work together to address the physical and mental health needs of their patients (Agency for Healthcare Research and Quality, 2008). This level of collaboration, however, demands the development of a certain skill set, which is uncommon and not taught (Gawande, 2011). In contrast to a collaborative style of practice, for centuries the practice of Western medicine has favored mind-body dualism over unity, resulting in the silo-ing of physical and mental health care. Nevertheless, in the United States, most individuals view primary care as their first stop for physical health and mental health concerns, so much so that primary care has been referred to as the "de facto mental health system" (Kessler, & Stafford, 2008). Primary care as the first stop makes sense; many medical problems are accompanied by psychological distress, and many psychological problems present with medical symptoms. Despite this, during their

training, most primary care providers are only minimally exposed to caring for psychiatric conditions, and most mental health professionals are trained as specialists working outside of the medical care system. Neither profession receives adequate training in working as a team and collaboratively managing care.

Within the last few decades, there has been a movement within the medical and mental health communities to change this. The mental health profession has taken the lead, and, for the first time in over a century, a new level of mental health care has been developed, that of primary behavioral health (Strosahl, 1996). Integrating behavioral health into primary care has been spreading across the nation and is gaining momentum as more and more practitioners, advocates and policy makers recognize the benefits and simple logic of whole person care. In greater Philadelphia, at present, there are 29 health care sites and 37 behavioral health consultants implementing primary care behavioral health and participating in a regional learning community through the Health Federation of Philadelphia, making this the largest unified, multi-organizational, regional learning network in the country. The prospects for this network include further growth and expansion within southeastern Pennsylvania. Building this capacity took time, resources, collaborative effort and persistence.

Early Innovation: Seven years ago, the Health Federation of Philadelphia (HFP) was approached by the Department

of Behavioral Health and Intellectual Disability Services and Community Behavioral Health (CBH) to explore whether federally qualified health centers (FQHCs) could provide greater access to behavioral health services, particularly for children. Our response was, “Of course!” However, while behavioral health is within the scope of FQHC services, we had long since learned that co-location of specialty mental health treatment in a primary care site is neither financially sustainable nor effective in expanding access. So we started on a journey of redesign. Our innovation was not in the development of the clinical model itself, which had already been in practice in other parts of the county, but rather in the process we undertook to build capacity for adapting, implementing and spreading a model; securing payment and policy changes; and preparing the workforce through training while also establishing and maintaining a stable structure to support ongoing program and professional development.

HFP began this process by engaging FQHCs providers who already had some experience in offering behavioral health care. We listened to their assessments of the barriers and challenges to the effective delivery and sustainability of services and pragmatic ideas for improvement. All along the path, we engaged with CBH as partners. Through a collaborative and iterative process, ultimately, we landed on the behavioral health consultation (BHC) model, a fully integrated, population-

based approach to primary care behavioral health. In brief, behavioral health consultation reflects the principles of team-based care. Licensed behavioral health practitioners are part of the primary care team and provide empirically based, problem-focused interventions for patients who need behavioral support to cope effectively with their mental health, substance misuse, life stress and health self-management challenges. While referrals are made to specialty mental health services when needed, most patients prefer to receive all their care from the primary provider, and all patients continue to receive the support of the full health care team as long as they continue to access primary care.

Fortunately, funding was identified to support planning and start-up implementation efforts. With the help of expert consultants, we began by orienting five early adopter FQHC sites to the BHC model. Based on defining the role of a behavioral health consultant, we developed a strategy for preparing the workforce through training and coaching. In order to promote fidelity to the behavioral health consultation model and to workforce competencies, HFP established a training program and an ongoing community of practice. Through this network structure, we have been effective in providing orientation, professional development and technical assistance that have resulted in efficient replication and spread of the model and rapid deployment of behavioral health staff ready to work in primary care. Further, the ongoing

collaborative structure provides peer support, group supervision, leadership development, ongoing program development and a collective voice for advocacy. Throughout this process, in collaborative fashion, we kept CBH fully apprised of our progress and advocated for appropriate credentialing and payment standards to support the model. Over time, we have sustained and expanded our capacity to support practice, advocacy, replication and quality improvement and now reflect a unique regional network model.

Recent Innovation: In 2014, HFP initiated a pilot project, with funding from the Scattergood Foundation and in partnership with the Philadelphia College of Osteopathic Medicine (PCOM). In brief, the HFP team—Suzanne Daub, LCSW, clinical director of the HFP Primary Care Behavioral Health Network (and senior consultant at The National Council for Behavioral Health); Neftali Serrano, PsyD, consultant to HFP and chief behavioral health officer at Access Community Health in Madison, WI; and Natalie Levkovich, CEO of the Health Federation—with input from the team at PCOM, developed a novel concept to assess BHC practice. The team created a typical primary care behavioral health case to be used to simulate BHC intervention using trained standardized patients. HFP also developed or adapted assessment tools that were used to observe the simulated encounters and rate BHC competencies. BHCs received feedback from standardized patients as well as raters, and also

recommendations for ongoing professional development. BHCs were also asked to complete a survey regarding their satisfaction with the experience and feedback regarding process improvement. HFP is in the process of summarizing and disseminating the findings from this pilot, which will serve to inform ongoing plans for training priorities as well as a preliminary evaluation of the efficacy of the learning community structure.

Advocacy and collaboration with CBH have been effective in establishing an approach to payment and credentialing that reflects the unique and essential definition of primary care behavioral health. It has also been effective in supporting the spread of integrated practice in Philadelphia and in supporting advocacy with other payers in neighboring counties. However, to truly bring to scale the integration of behavioral health in primary care, and to realize the full potential of the patient-centered medical home—a recognized priority in health care reform efforts—further regulatory reform is needed to enable the spread of primary care behavioral health beyond the network of FQHCs to include all primary care settings. Bundled payment models, further research, interprofessional education, practice-based learning communities, technology-supported tracking, practice innovations and public and private investments are gaining momentum to encourage the delivery of integrated care to populations across the country. The same strategies are being explored and exploited locally, placing Philadelphia among

the leaders in this national movement.

Throughout this process, core lessons have been learned. What distinguishes this model, and has sustained it, is a commitment to working from the bottom up. It is critical to elicit and honor the wisdom of practitioners who lead and sustain the culture of collaboration. The workforce must be nurtured. Front and center, always, is the knowledge that practice transformation is an evolutionary process, and simultaneous attention to clinical practice, policy and payment reform and workforce development is essential. This would not be possible without the key ingredients of partnership and advocacy. It would also not be possible without a good deal of stamina. Strategically, it is critical to take the long view. Finally, it must be recognized that implementing innovation requires concrete resources; it takes more than good will. Taken together, these are the lessons and tactics that have underpinned the Philadelphia primary care behavioral health network.

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