What Does a Behavioral Health Clinician Add In a Good Primary Care Practice?

A Set of Stories

Alexander Blount, EdD
Department of Family Medicine and Community Health
University of Massachusetts Medical School

Primary care is filled with the medically commonplace, but because something is common does not mean it is not complex. Consider the top ten presenting complaints in adult primary care: chest pain, fatigue, dizziness, headache, swelling, back pain, shortness of breath, insomnia, abdominal pain, numbness. (Kroenke & Mangelsdorf, 1989). Kroenke and Mangelsdorf followed the people in the study who presented these complaints for one year. In that year, about 15% of them were found to have a biological pathology of some type underlying the complaint. The most of these complaints were followed and many were resolved without an abnormal finding on exam or on a lab test. To be a medical provider in this environment requires a substantial tolerance for uncertainty. For those living in the dichotomized world of physical versus psychological explanation of phenomena, this picture can lead to a mis-statement that is common in the literature that 70% of visits to primary care are for problems that are psychosocial in nature. This does not adequately represent the experience of either the physician or the patient.

While there is a substantial literature on the behavioral health needs in primary care and on the types of services that can be offered, it is very hard for someone who has not been in an integrated practice to imagine how the actual clinical routines might play out. Presented below is one set of examples. They are by no means descriptive of the way all good practice is carried out. The number of behavioral health needs is generally supported by the literature, though they seem excessive because they are presented in every case. Usually a number of these situations would not be addressed and most of these stories of patients’ lives would go undiscovered. The interventions are generally based on evidence, though at the level of detail we are observing, much is based on experience where there is no evidence.

Let me give you an example of a representative morning schedule in primary care. This example was first created by Thomas Campbell, MD. I have modified and extended it a good bit.

- 56 yo diabetic with poor control
- 19 yo smoker for P.E.
- 33 yo with multiple somatic complaints
Now here is the same list with representative mental health, psychosocial and behavioral health needs highlighted.

**Mental Health Needs**

- 56 yo diabetic with poor control
- 19 yo smoker for P.E.
- 33 yo with multiple somatic complaints
- 7 yo for earache
- 67 yo w/insomnia
- 70 yo w/sinusitis
- 52 yo hypertensive patient
- 45 yo w/tinnitus
- 38 yo w/acute asthma
- 29 yo w/acute asthma
- 29 yo w/acute asthma & SOB

Then there are psychosocial problems that people bring that may not meet criteria for a mental health diagnosis, or may not be identified because there is a physical problem that takes up the available time and attention.

**Psychosocial Distress**

- 56 yo diabetic with poor control
- 19 yo smoker for P.E.
- 33 yo with multiple somatic complaints
- 7 yo for earache
- 67 yo w/insomnia
- 70 yo w/sinusitis
- 52 yo hypertensive patient
- 45 yo w/tinnitus
- 38 yo w/acute asthma
- 29 yo w/acute asthma & SOB

Finally, there are behavioral health needs, in the form of changes of health behavior that can be extremely important for the health and happiness of patients.
Behavioral Health Needs

- 56 yo diabetic with poor control  smoking/weight loss
- 19 yo smoker for P.E.  smoking cessation
- 33 yo with multiple somatic complaints
- 7 yo for earache
- 67 yo w/insomnia
- 70 yo w/sinusitis
- 52 yo hypertensive patient  cardiac risk factors
- 45 yo w/tinnitus
- 38 yo w/acute asthma  medication compliance
- 29 yo w/ chest pain & SOB

For every need listed, there is a reasonable behavioral health intervention available. It would seem that a health psychology practice near this primary care site would get a number of referrals out of this morning’s work. However the average number of referrals out of an array like this would be 0 to 1.

Let’s look at the list a little more closely.

**The first patient is a 56 year old smoker** with diabetes who is anxious about the course of her disease. She also has congestive heart failure and she got a diagnosis of bi-polar disorder some years ago. She comes in a wheelchair pushed by her husband, a retired steel worker. She has heard about people going blind and losing limbs. She knows that her obesity is a contributory factor, yet she has had a hard time losing weight. Her nerve pain in her legs makes walking and other exercise painful. She is worried about her weight and about what she eats most of the time. When anxious she can have shortness of breath or chest pains. These and various other symptoms have lead to ED visits averaging about one per week. She sees her worry as a natural response to her medical situation and would never accept a referral for help to be less anxious.

**Usual Care:** Usual care is to prescribe a complex list of medications for her chronic illness and respond to each of her symptoms as they come up, making her a very high utilizing patient. If she is identified as an outlier by her insurance company, she may be given a case manager on the phone who offers to help and who wants to encourage her to eat right. It is possible that she will also get another caller who will offer to help her quit smoking.

**Integrated Care:** Since she is one of the top ten percent of patients in utilizing services, she would be given an assessment by the team that includes a physician, a behavioral health clinician and a care manager, if the BHC was not performing that function. The assessment would involve the patient and her husband. It would be framed as a period of mutual education. The assessment period would lead to an education program for her and her husband, as much as he would/could be included, that made sure that they both understood the complex dynamics of her illnesses and why small changes in diet an behavior can be both helpful or harmful. She would be offered a weight loss and smoking cessation program over time, though we would want to refrain from barraging
her with messages about change. There would be one person who was most regularly in touch with her and her husband. That person, the care manager, would be the source of information for the team on what she was learning, how she was responding to the information she was getting, and what sort of change she seemed most ready to pursue. The care manager would meet with her when she came to the practice, no matter who else she was seeing.

For a person with so many trips to the ED, there would be an investigation of the particular sequence of interactions that typically lead to that outcome. The team would learn that there is a characteristic struggle between herself and her husband that precedes the trip. She often wakes up in the middle of the night with a symptom or worry of some sort and calls for him. When he feels relaxed, in charge and comfortable, he comes and lays hands on her and prays. That calms them both, makes them feel that things are in order, and they both go back to sleep. When he feels stressed or alienated, he shouts at her for ruining his sleep. At that point, she becomes more insistent and miserable, leading them to make a trip to the ER, to have her symptom assessed and to defuse the growing tension between them. Looking at symptoms in context will be a central feature of Integrated care. In this situation, regular check-ins with them as a couple will be used to encourage their bond, to assess his level of stress. There will be an ER plan developed that is satisfactory to the couple to find a way of having contact when things are difficult so that an unnecessary trip can be avoided and a way of enhancing their own problem solving routines can be in place. Because they will be regularly engaged with one person in the practice, the reactivity of their connection with each other can be soothed as the acuity of her symptoms are reduced.

As part of their regular care today, the couple would meet with the care manager before seeing the physician. The CM would run through the breathing exercises with her that she had taught the patient previously. She would check on how she had managed her stress in relation to her diet. She would make a brief assessment of the husband’s stress level and possible congratulate the patient for bringing both of them today so they can find a way to calm down and be reassured. She would highlight the process that they used to keep from going to the ER during the previous night. After a 15 minute meeting, the physician would arrive. The CM would tell the doctor, in front of the patient and her husband, how they had avoided going to the ER, how she had successfully used her breathing techniques for calming herself and how she had kept to her diet, even though she was tempted to eat to calm herself. The physician would do an exam and look at recent labs. She would congratulate the patient and her husband for any improvements or stability observed and make a suggestion to both the patient and care manager about emphases in their work together based on her findings. The CM would spend some time planning with the patient and her husband after the physician left the room. Total time today: CM 40 min, MD 15 min.

The 19 year old is coming for a physical to get a license to drive a truck. He is not concerned about his smoking and would not accept a referral to smoking cessation. If anything, the challenge for his doctor is to try to make some connection with him so he
will come back to the doctor more often. This might make a conversation about his smoking possible at some future date. From an epidemiological perspective, his greatest risk is from accidents. It would make more useful to lower the chance that he will drive to exhaustion in his truck or take substances while driving.

**Usual Care:** The physician would assess the patient’s readiness to change. He would discover that he was in pre-contemplation on the “stages of change” and would offer to be available if and when he is ready to talk more about smoking cessation.

**Integrated Care:** The physician would ask the patient if he was willing to talk briefly to her colleague in the practice who is learning about what makes people decide to talk about stopping smoking and what is involved when they decide not to have that conversation. She will say to the patient that talking to someone who is not considering quitting can be extremely useful in helping the smoking cessation program in the practice be better targeted and more understanding of people who don’t want to be in the program. The physician promises that it won’t take more than 15 minutes. If the patient consents to the conversation, and most will, she pages the BHC. She introduces the patient to the BHC in front of the patient, saying that he is a person who smokes about a pack a day and who is not considering quitting. She offers the same rationale to the BHC for the contact that she offered to the patient. The BHC agrees that this could be very helpful. This presents an opening for 15 minutes of motivational interviewing, a very neutral and respectful interviewing process that investigates the thought processes and logic behind the decisions that the patient makes. The patient is never advised to change, but the process of discussing his decision-making history creates an unspoken attribution that he is the sort of person who thinks things through, makes decisions and acts on them. It is very likely that he will leave the visit able to be reasonably described as in the “contemplation” stage in relation to his smoking: Time: MD ½ hour for a physical, BHC 15 min.

**The next patient is a 33 year old woman who is an immigrant** from South America. While a screening test would identify her as meeting criteria for a diagnosis of major depression, the concept of an emotional disorder would make no sense to her. She complains of fatigue, generalized body aches and headaches. She has heard of depression but doesn’t really know what it is. In her culture, people are either considered sick or crazy. She is not crazy, like some of the homeless people she has seen talking to themselves, so to her, she is sick. It would make more sense to her for someone to tell her that a former girlfriend of her husband had put a curse on her than to tell her that she has an emotional disorder related to chemical processes in her brain. She is not going to follow through on a referral or treatment, though out of respect for the doctor, she will certainly agree to go for counseling or to take medication when she is in the consulting room.

**Usual Care:** She would be given some tests (eg. TSH and hematocrit). When all was normal, over time the physician might broaden the assessment, asking about stressors, substance use, and domestic violence. She might be given a PHQ-9. The physician might prescribe an anti-depressant, possibly trying to teach the patient about what depression is
and possibly by describing the medication just as aimed at folks with symptoms like hers. She would have her somatic complaints addressed as they presented and her physician would continue to check on her compliance with her SSRI. She continues to report being willing to take the medicine and taking it some of the time, but her record of filling prescriptions does not fit with her story. She could be sent for other tests related to her somatic complaints from time to time, and may develop a record of non-compliance with appointments. A trip across town to a specialist’s office is very hard for a person with no car, and her depression makes her give up easily since relief is very hard for her to visualize.

**Integrated Care:** The team will address her depression in a manner that conforms with her understanding of her illness. Because she experiences herself as having a physical illness, she will be aware of the physician at the head of her care all the time. Once the initial tests were negative, the introduction of a behavioral health clinician would occur in a meeting lead by the physician. The conversation would go something like this, “Ms. Ruiz, I believe that stress may be harming your health, making it harder for you to keep yourself healthy and harder to keep your spirits up. I would like to bring in my colleague, Mr. Blount, who is an expert on stress. Would that be alright?” When she agrees, Mr. Blount is paged to the room. Without conversation in the hall, the physician says to Mr. Blount in the room, “This is Ms. Ruiz. She has been coping with a lot of health problems lately. I think that stress may be hurting her health and making it harder for her to keep her spirits up. I would like you to meet with her and look into the sources of stress in her life and report back to me.” And Mr. Blount would say “Yes, Doctor.” The physician might also say something complimentary about Ms. Ruiz from her experience of working with her. In passing a relationship, it is important to pass a clear reason for mutual good feeling.

At this point, unless Ms Ruiz has to leave, the meeting to assess the stresses in her life would begin. It would last about ½ hour, while the physician goes on to see one or two more patients. When the physician returns, Mr. Blount will be able to very briefly summarize some of the stresses they have identified so far and to offer additional compliments about Ms. Ruiz as a person who cares about her health, copes with stress well in some ways and is ready to make progress. The physician will ask them to continue meeting and a separate meeting between Mr. Blount and Ms. Ruiz would be scheduled. This is a meeting she is far more likely to keep and one that will take the place of numerous tests and specialty visits. Time: MD meetings of 10 min and 5 min. BHC 30 min.

**The 7 year old has an ear ache.** At the end of the visit, his mother says that she is concerned that he has started wetting the bed. She does not offer the information that she and the child’s father have recently separated after nine years of marriage. She feels bad enough about it without entertaining the idea that their stress is contributing to the child’s problems. She expects a medical definition of the problem and sees the physician as the person who should address it. A behavioral health referral would not be acceptable.
Usual Care: In all likelihood this would need an additional visit. There would need to be an exam after which a plan could be formulated. There would be questions about family history of enuresis and an assessment of the stresses the child faced. A bed alarm has been shown to be effective and safe, though it is less commonly used than the evidence would support. The physician would also speak to the child about any worries he was having. This might elicit an account of some nightmares he has had. Further questioning with the mother about any changes in the child’s or the family’s life may get the story of the separation. This could lead to the advice that the enuresis is likely to be self-limiting and that the bed alarm is a way that parents can help the child get over it. Its use will depend on the mother’s ability to get up at night. The alarm may not be covered by insurance. There could also be star charts kept by the mom to reward dry days, restricted fluids in the evening, and wake-ups to go to the bathroom in the night.

Integrated Care: In a Integrated practice, any of the interventions such as advising about the alarm, star charts, and assessing family stress could be done by physician or BHC. If in an assessment of family stress, the rift between the parents seems fresh and perhaps possible to impact, it might be possible to use the symptom of the child that seems to follow from the split to be an entry to healing the split. If both parents are willing to do what they can to help the child’s problem, it often indicates a possibility for greater resolution. It might be possible for the father’s temporary return to the house to be part of his helping with the bed alarm so that the whole load doesn’t fall on the mother. These meetings would be very supportive and complimentary to the parents, increasing the likelihood of a successful resolution of their marital difficulties or of a successful referral for couples counseling.

The 67 year old who can’t sleep tells the doctor he drinks five or six beers a night when he is asked about alcohol use. The doctor has to ask because he was going to prescribe a sleeping medication. The patient has been a little worried that his alcohol use might hurt his health, so he is willing to tell about it to see what the doctor says. He is thinking he might cut back at some point. He mistakes the physician’s non-judgmental response as meaning there is little to worry about. He is relieved and is not interested in any behavioral health referral to reduce drinking.

Usual Care: The physician administered the CAGE questions in conversation with the patient. There was one positive response. The patient admits that he sometimes gets angry at his wife for telling him he should cut back. The Physician discusses the impact of alcohol on a person’s sleep quality and says that he is reticent to prescribe sleep medicine for someone who is drinking as much as the patient. He says that he would be glad to talk to the patient about his drinking in the future so that if he can cut back, it would be safe to prescribe some medication.

Integrated Care: The interaction happens as described in Usual Care. After this interaction, the physician asks the patient if he would like to meet with his colleague who is expert at teaching people ways of getting to sleep using non-pharmacological approaches so that he will have some help in the short run. (We will always be trying to keep our eye on the patient’s goals and use those goals as the beginning point for other
If the patient accepts the meeting, the BHC is paged. In the room or in the hall, the physician outlines the patient’s goal of sleeping better and reports his concern that alcohol use is part of what is keeping the patient from reaching that goal. The BHC makes a connection with the patient and teaches him a relaxation exercise for sleep. He asks if the patient would like to see a measure of how much his drinking might be impacting his sleep. The patient is interested, so the BHC gives him the AUDIT screening tool which is more sensitive in identifying alcohol use disorder than the CAGE. The AUDIT questions allow for more detailed discussion of his drinking patterns. The BHC also examines role that drinking plays in the relationship of the patient and his wife. The BHC has time to focus on when things have gone better, times when he drank less, times when he got along better with his wife and times when he handles stress particularly well. He arranges to meet separately with the patient to follow up on his sleep. He sends him home with a tracking form that monitors sleep, drinking, times he enjoys his wife’s company, and a couple of general scales on depression and anxiety. When the patient returns, they can have a solution focused biopsychosocial discussion based on the tracking form that will be comfortable and logical for the patient.

The 70 year old with a sinus infection has been shoved around by her 16 year old grandson when she told him he couldn’t have any more money. The doctor asked her about the bruises on her shoulder, but she says she fell. She may tell the physician a minimized version of what happened, but would never accept a referral for behavioral health help. She is worried that social workers will come and take him away from her.

**Usual Care:** In this situation, the usual care depends on the physician’s relationship with the patient. Without a longitudinal, trusting relationship, usual care could be treating the sinus infection, assessing the possibility of further falls, examining the injury to be sure that other care is not needed and nothing more. If the physician has an excellent relationship with the patient and has a sense when something more is wrong than is being presented, he or she may ask if there is anything else going on. In the presence of such a relationship, the patient would feel an urge to tell. At that point, the physician will be a mandated reporter of elder abuse in many states, and will be required to initiate some sort of social service intervention. This is exactly the step that the patient doesn’t want, which the physician will defend as necessary to protect the patient.

**Integrated Care:** The physician finds this a very challenging situation and pages the BHC to join the process. He explains the situation to the BHC in front of the patient. The BHC knows that people will often accept help for a loved one, even if they won’t accept it for themselves. She also knows that just because a loved one is treating the person badly does not necessarily mean that she feels the loved one should leave, suffer consequences or not be helped. The BHC asks the patient more about her grandson. The patient’s story about her grandson’s struggles would yield a picture of an unsuccessful teenager who is likely supporting a drug habit. When she asks the patient if she were ever concerned that her grandson was using drugs, the picture gets even clearer. Because the BHC is aware that the welfare of the grandson is the patient’s primary concern, the next steps, prescribed by law, are cast in the light of getting treatment for the grandson while protecting the grandmother.
The BHC, with the physician and patient listening explains the social service choices, including the “child in need of services” law, if one exists and articulates the rules in relation to reporting elder abuse. After the explanation, the grandmother and the physician see the call to the Elder Services authority as initiating a process to help her grandson, and are likely to be able to steer things in that direction. The worker assigned to the case will find a physician and behavioral health clinician able to articulate a plan for the son and to support the grandmother’s sense of being more in control and less likely to be a victim in the future.

The 52 year old has hypertension and high cholesterol. He is a type A personality who is driven in his work and stressed a lot of the time. He could benefit from stress management and relaxation work in addition to help with motivational interviewing about his diet. Because his insurance company does not pay the Health and Behavior codes for behavioral health care where there is not psychiatric diagnosis, he is not covered. He will not accept a referral.

**Usual Care:** His physician talks to him about the long term risks of hypertension and hyperlipidemia. She helps him think about the degree of change in diet and exercise that might be likely to reduce his risks to an acceptable level. They go over the possibility of managing both risks with medication and the likely side effects and risks of the meds. He decides that medication is a preferable option, given how busy he is and how unlikely he thinks it is that he can keep up with his responsibilities and still make meaningful lifestyle change.

**Integrated Care:** In addition to the usual care, the physician would offer a meeting with a BHC so that the patient could make a personal assessment of the possibility of a gradual withdrawal from medication if a behavioral regimen can be identified that the patient found possible. If the patient decided to make such a meeting, the BHC would get to know his medical and family situation, assess sources of stress in his life, do a bit of values clarification using motivational interviewing and offer both individual and group approaches to lifestyle change. These could be carried out at the practice or at some other facility in the area. There may come a time in the future when integrated practices funded on a per member per month basis can offer the facilities for making the health behavior changes patients need such as an exercise facility, classes in stress management and diet as part of the services of the practice. This would allow the practice to perform functions that now are offered in cardiac rehabilitation to patients before they had a heart attack as well as after.

The 45 year old with ringing in her ears has come back often for symptoms that the physician sees as minor. She sees each symptom as the figurative tip of iceberg of a deadly, if undiagnosed, disease. She would not accept a referral for help with this worrying because she would feel blamed and discounted by the doctor.

**Usual Care:** Her physician would try to reassure the patient about her physical condition. He might well invite the patient to come for regular visits without regard to
her having symptoms. In this way the patient would not need a complaint to be able to ask questions.

**Integrated Care:** In addition to usual care, the physician might consult the BHC to ask if there was something in addition that she could do to be helpful to this patient who was so worried about her health. The BHC might suggest that the physician talk in more depth about other worries that the patient might have. The hope would be that addressing other worries successfully might lower her worry about her health. Together they might consider medication options and how they could be framed to the patient. He might suggest a dual meeting with patient in which the physician could discuss the difficulties she has had in finding a way to reassure the patient and the patient could be encouraged to talk about her expectations and hopes from care in addition to the contexts in her life that could lead to hyper vigilance about health. The BHC could offer to meet with her to teach her some techniques for reducing this hypervigilance.

**The 38 year old with frequent asthma exacerbations** is struggling with family issues. Her physician has told her she must be in a smoke-free environment. Her husband thinks she uses her asthma as a weapon to try to make him quit smoking. He is not about to go for counseling about their relationship or about his smoking. She will not take a referral.

**Usual Care:** the physician would try to educate the patient as much as possible about her asthma and her sensitivity to smoke. There would be medication adjustments and an emphasis on maintaining airway health to reduce the necessity for rescue medication. The physician might offer to meet with the husband to explain the urgency of the regimen for the patient.

**Integrated Care** might not be different. The physician would be able to access the BHC’s expertise in one of several areas: how to involve the husband, how to draw out the ways that the wife has been effective in influencing her husband in the past, how to broaden the conversation to other struggles and issues in their marriage where there might be more flexibility for resolution of the impasse. The physician would be able to make clear that brief couples approaches to resolution was available in the practice.

**The 29 year old with chest pain** has panic disorder. His physician was suspicious after his first trip to the ER with chest pain and shortness of breath. A person his age is at very low risk for heart disease. After doing some tests, the doctor is now confident that he has panic attacks. He comes today with a mild one, but he still wants more tests. When he is told the diagnosis of panic, he is torn about whether to take the medication his physician prescribed and go for behavioral health treatment she suggests, or to find another doctor who will do more tests.

**Usual Care:** The diagnosis of panic disorder is made by excluding cardiac causes and by examining the symptoms in detail. An explanation of what panic disorder is and of the usefulness of medication in treating it is made. A follow up appointment at about a month is offered with the invitation to call the practice if any further attacks make the patient feel he has to go to the ER.
**Integrated Care:** In addition to usual care, the physician says that he insists that the patient be given every tool available for managing his overly reactive body to maximize the likelihood that the medication will be effective. He introduces the BHC to the patient and charges him (the BHC) to teach diaphragmatic breathing to the patient before he goes home. The charge is delivered in front of the patient. The BHC agrees to teach breathing today and to have the patient return in the future for guided relaxation and imagery. The physician approves the plan and leaves for the next patient. The BHC asks what the patient understood from the physician about panic disorder. He endeavors to clarify, deepen and better target the explanation to the understanding of the patient. A second explanation almost always adds value, no matter how good the first one was, because it can include a better assessment of the understanding of the learner. The BHC also teaches diaphragmatic breathing, makes another appointment and sends the patient home to track his panic/anxiety, his taking of medication, the level of external stressors, his use of diaphragmatic breathing and perhaps other life events that seem in the interview to be possibly contributory.

I hope these stories have been helpful in elucidating the possibilities for increased service that can be added by a behavioral health clinician who is part of a primary care practice. I would be very interested in examples from other clinicians and programs if they would like to share them with me. I can be contacted at blounta@ummhc.org.