Implementation of Behavioral Medicine in Primary Care: The Kaiser Permanente experience.

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Overview of presentation.

- Reasons for Kaiser Northern California's redesign of Primary Care Services
- What was implemented
- Description of the program components
- Measurement/ program monitoring issues
- Obstacles to implementation
- What have we learned over the past nine years

Why a Primary Care Redesign?

- Adult Primary Care initiative was part of a larger effort to redesign how primary care services were delivered to Kaiser Health plan members

Specific Reasons for a Primary Care Redesign

- Effort to develop a truly integrated primary care system
- Unsustainable medical practices
- Patient health concerns in general were not being met
- A understanding that mental health needs of patients were not being met

Integrated Primary Care Redesign Included

- In 1998, adult primary care services were divided into several roles
  - Physician
  - Nurse Practitioner
  - Behavioral Medicine Specialist
  - Pharmacist
  - Clinical Health Educator
  - Extended RN role

Integrated Primary Care Redesign, continued

- Eight years after the redesign the Behavioral Medicine Specialist is the only role which still exists as originally implemented across the Northern California Kaiser service area.

Integrated Primary Care Redesign, Some reasons for current status

- Interdepartmental budgetary conflicts
- Practice was a poor fit with the primary care culture
- Lack of program development efforts

The Behavioral Medicine Specialist Role

- Overview
- BMS Key Functions
  - BMS role is different from traditional mental health provider in Mental Health Outpatient settings
  - Detection, treatment and triage
  - Education role
  - Collaboration with patients, physicians and other services

The Behavioral Medicine Specialist Role; Program Goals

- Behavioral Medicine vs. Traditional Mental Health focus
  - Promote physician efficacy
  - Support small client change efforts
  - Prevent morbidity in high risk clients
  - Achieve medical cost offset or value added
  - Alleviate symptom distress, increase functioning
  - Physician in collaboration with BMS are in charge of the patient care
  - Brief behavioral medicine consultation model is the treatment model

Behavioral Medicine Specialist Program Goals, continued

- The BMS role is designed to identify, treat , triage and manage primary care patients with medical and/or behavioral health problems..
- The BMS role is designed to promote a smooth interface between medicine, psychiatry, Chemical Dependency Services, specialty behavioral medicine and other behavioral services such as Chronic Pain and “Early Start” Programs in ObGyn.
- Adult Primary Care Team Members and Patients Are Primary Customers
- The BMS program is grounded in a population based care philosophy that is consistent with the mission and goals of the Adult Primary Care model of care

Behavioral Medicine Specialist Role, Population Based Service

Population care strategies includes stratification of patient care into three levels.

- Level one- usual primary care services needing minimal support – e.g.; Health education class
- Level two- patients – e.g.; chronic conditions and the need for more hands on strategies, such as that provided by a Behavioral medicine specialist.
- Level three- Special severe chronic condition patients mandating a need for specialized chronic conditions manager focus, BMS case care or referral to Psychiatry service.

Behavioral Medicine Specialist Services, Team Integration

- Co-located on module
- Integrated into module team - regular team meetings
- Schedule and progress notes are open to Primary Care provider - Electronic charting
- Constant communication between providers on patient

Benefits of co-location include

- Patients See BMS as part of primary care service thus erasing the stigma of referrals to mental health services
- Providers have easy access to BMS providers and see BMS as a member of their team, builds cohesive working teams
- BMS receive positive feedback and are usually a valued member of the primary care team

Mentoring Program

- All Behavioral Medicine Specialists are trained in the role by a BMS mentor
- Use the “See one, do one and teach one” model.
- This process includes shadowing a mentor and then having the mentor shadow the new BMS

Mentoring Program, continued

- Mentor model provides an induction to the role and its differences between traditional care
- Also provides for a non defensive learning and sharing enviroment
- There is no assumption that all clinicians can work effectively in this model

Measurement and monitoring of the BMS role

- What is measured?
  - Net loss/productivity
    - Monthly appointment supply and what percent which goes unused
  - Patient satisfaction
    - Satisfaction with BMS services
    - 5 item scale / percent very good to excellent

Measurement and monitoring, continued

- Physician Satisfaction
  - Satisfaction with ease of referral and with timely communication from BMS
- Access
  - Percentage of 2 week access to service/ booked to seen
  - Percent new appointments to returns

Typical BMS Daily schedule template

- **Standardized BMS Schedule Profile**

Time	Code	Booked By	Release Time	Convert to BNS (2 AM Same Day)
8:30	PCT[*a]	----------	----------	----------
9:00	1Z	call center	7 days	yes
9:30	BNS[1]	BMS/module	----------	----------
10:00	BN[2]	module	21 days	yes
10:30	CPM[*b]	----------	----------	----------
11:00	BNS	BMS/module	----------	----------
11:30	BR[3]	module	60 days	yes
12:00	BNS	BMS/module	----------	----------
12:30	Lunch			
1:30	BR	module	60 days	yes
2:00	BN	module	21 days	yes
2:30	BNS	BMS/module	----------	----------
3:00	CPM	----------	----------	----------
3:30	TAV[4]	module	7 days	no
3:45	TAV	module	7 days	no
4:00	BR	module	60 days	yes
4:30	CPM	----------	----------	----------
5:00	off			

BMS Appointment Types

•The **BMS new visit**: this visit type is for members who have not been seen by the BMS in the past year.

•The **BMS urgent visit**: This visit type is for same day or next day visits for members whose condition requires immediate attention.

•The **BMS return visit**: This visit type is for return appointments.

•The **BMS telephone visit:** This is a pre-appointed telephone visit that may take the place of a face to face visit.

Obstacles to implementation

- Relevant training for BMS and new BMS staff on the interface between psychological and health topics.
- Turf issues with other specialties and request for services. Collaboration , continuity and coordination of care.
- Boundaries with MD's Psych, Patients and Staff.

Obstacles to implementation

- Financial considerations for training
- Staying connected with other BMS leadership - managers supporting each other
- Need for research - support

Learning's

- Remembering physicians are a quick study, don’t work out of a job
- Need to stay relevant and visible to medical providers, consultation and feedback. Old (Mental Health) work habits are hard to break
- BMS with closed doors are often not a good sign

Learning's

- Keeping up with change with the organization priorities
- Patient care model has evolved to include an emphasis on motivational interviewing , solution focused intervention strategies
- New interest in exploring the common factors model and practice based evidence (Duncan & Miller)