# Behavioral Health Acculturation in Primary Care:
## Removing barriers to integration through multi-disciplinary teams

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## Problem Statement

Unacknowledged interdisciplinary differences between medical and behavioral health providers in primary care lead to failed integration. These blind-spots impair team functioning and decrease productivity.

## Initial Discovery

### Medicine and Behavioral Health are Different Cultures.

1. I began my CHIP by developing a behavioral health triage quality improvement strategy
2. Interviewed primary care providers, behavioral health providers, chief medical officers and CEOs

The message I heard:

**"Behavioral health and primary care 'Are very different!'"**

Medical and Behavioral Health providers are taught differently, think differently and use different methods; *albeit towards the same goal of health and well being*

3. My insight**:** Seeing medicine and behavioral health as different cultures.

**Acculturation:** "The process of change when different groups converge."

4. Pivoted to address acculturation of mental health in primary care.

## Mission Model Canvas

| Key Partners | Key Activities | Value Propositions | Buy-in & Support | Beneficiaries |
|---|---|---|---|---|
| Provider and primary care organizations<br><br>Provider Organizations<br>Grant Funding<br>APA<br>CPCA<br>CHCF | • Create training protocol<br>• Write grant proposal<br>• Publish<br>• Pilot training | Improved interdisciplinary teams improves quality, productivity and provider satisfaction<br><br>PCP productivity up 4-8%<br>Number of visits up 1 per day up per provider<br><br>Provider satisfaction = Reduced burnout<br>PCP Retention up 10% | Interviews with Senior leadership<br>Published results<br><br>Physician champions<br><br>Publishing on Acculturation model | • CMOs<br>• Primary Providers<br>• Behavioral Health Providers |
| | **Key Resources**<br>Grant funding | | **Deployment**<br>Present to Provider and Management Organizations (CPCA, CHCF)<br><br>Contact with senior leadership in Community Clinics | |

**Mission Budget/Cost**

- Minimal cost to create and disseminate protocol
- 12 months for one (0.5 FTE) psychologist = $75K grant funded
- Weekly MDT meetings for 10 primary and 5 BH providers = $72,000 per year

**Mission Achievement/Impact Factors**

- Better Integrated Behavioral Health leads to 8-10% greater productivity and PCP retention
- With an annual savings of onboarding 1 provider = $150,000 per year
- Productivity increase of 4% = $36,000/year/provider increased revenue
- FQHC with 10 providers saves $36,000 x 10 + $150,000 = $510,000
- ROI = 700%

## Discovery

### Behavioral Health Acculturation Strategy Affects:

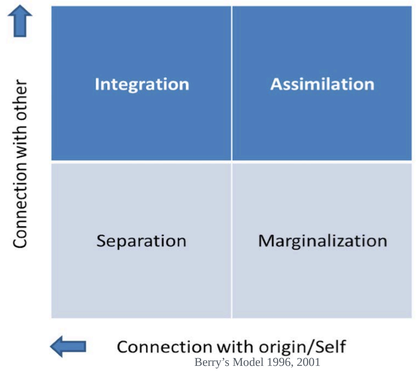
- **Team Functioning**
- **Quadruple Aim**

**"*Integration*" is one of many acculturation strategies used when different groups converge**

**"*Integration*" = high level, shared understanding, mutuality and change that does not exist at many FQHCs**

**Successful Interdisciplinary Acculturation Leads to Increased:**

- **Provider trust**
- **Productivity**




Examples:

- **Assimilation** requires behavioral health providers to become like primary care providers, giving up strengths specific to their training and practice: (e.g. relying on uncertainty, centrality of relationship building, & consultation as treatment)
- **Integration** happens when behavioral health adapts to the language, practices & clinical goals of primary care and primary providers understand the strengths of mental health practices (e.g. how do psychotherapy, motivational interviewing etc. work), & learn behavioral health techniques (e.g. active listening, containing countertransference anxieties)

## Lessons Learned

### Successful Behavioral Health Integration Must Include Mutual Interdisciplinary Understanding

- Medicine and behavioral health = separate but converging lineages
- Behavioral health and primary care are based on relationships

**Relationships = "Mutual change through shared experience"**

- Interdisciplinary differences impact communication, collaboration and team functioning, and are likely affecting productivity and quadruple aim.

**Behavioral Health and Primary Care Providers**
**Must Build Long Term Relationships with Each Other**
**in parallel to relationships with patients**

### Interdisciplinary Differences are Bridged Through Multidisciplinary Teams

- Weekly facilitated **Multi-Disciplinary Team Meetings:**
  - Build team relationships
  - Successfully piloted this with an Archstone Foundation Grant for Elder Depression
- ALERT! - CMS requires Behavioral Health Parity/Integration
  - Integration Quality Improvement is accelerated through multi-disciplinary teams

## Next Steps

### Quality Improvement Through Education, Training and Team Building:

### Weekly Multi-Disciplinary Teams

1. Develop facilitated multidisciplinary team guidelines
2. Primary Care and Behavioral Health Provider training & education on behavioral health acculturation-integration
3. Explore multidisciplinary vs transdisciplinary team models
4. Obtain grant funding for education and pilot program