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# Integrated Behavioral Care Training in Family Practice Residency: Opportunities and Challenges

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**Abstract** The value of integrated behavioral care has been noted for many years, but there are few descriptions of integrated training of primary care physicians, prescribing psychologists, and psychological/behavioral specialists. The authors describe a family practice residency program that trains family medicine physicians, prescribing psychology practicum students, and pre-doctoral and post-doctoral behavioral health consultants. Barriers to training in integrated care are described and solutions offered. The unique clinical and teaching roles of licensed prescribing psychologists in primary care are described.

**Keywords** Integrated behavioral care · Behavioral health consultants · Family medicine residents · Prescribing psychologists · Training in integrated care

The value of integrated behavioral care (IBC) has been noted for many years, yet there are relatively few reports in the literature of co-training of physicians and behavioral health care professionals in an integrated primary care setting. There are no reports in the literature of training sites for prescribing psychology practicum students (RxPs) in integrated care settings.[1]

The challenges faced in implementing IBC services are numerous (see Hunter, Goodie, Oordt, & Dobmeyer, 2009; Vogel, Kirkpatrick, Collins, Cederna-Meko, & Grey, 2012), and those challenges would also be expected in a training program that includes physicians, psychologists, and other primary care professionals. The additional component of training RxPs presents unique challenges. A non-exhaustive list of challenges includes: contrasts between the culture of primary care medicine and psychology; communication difficulties among providers with separate routes of training; unfamiliarity with the expertise of, and potential contributions of, the contributing professions; insufficient experience in collaborative and integrated treatment; and difficulties obtaining adequate payment for behavioral services in a medical setting.

This paper presents the model of an IBC service and training site at the Family Medicine Center (FMC) of Memorial Medical Center in Las Cruces, New Mexico. Our experiences provide provisional responses to many of the above challenges, as family medicine residents, counseling psychology doctoral students and RxPs are being trained together in the same setting, with an emphasis on collaborative practice. This model is made possible by the inclusion of practicum students from the Department of Counseling Psychology of New Mexico State University, as well as RxPs from the Southwestern Institute for the Advancement of Psychotherapy/New Mexico State University Collaborative. Finally, the Southern New Mexico Family Medicine Residency Program at Memorial Medical Center is unique in that the faculty includes two licensed prescribing psychologists, whose role includes the

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[1] As used in this article, RxPs refers to prescribing psychology practicum students, who are all licensed doctoral level psychologists who have graduated from, or are currently enrolled in, a Postdoctoral Master of Science Program in Clinical Psychopharmacology. Legislation and policy in various jurisdictions require specific amounts and types of supervised practicum experiences. The term prescribing psychologists refers to psychologists who have completed all training and supervision requirements, and are licensed to prescribe independently.

behavioral training of the family medicine residents as well as the supervision and training of behavioral care providers (BCPs) and RxPs.

In this model, IBC means more than simply providing psychotherapeutic and pharmacological/medical services to patients with psychiatric disorders in a primary care setting. The BCPs at the Family Medicine Center of Memorial Medical Center do the following: (1) assist in the modification of health related behaviors; (2) assist the primary care providers (PCPs) in enhancing the therapeutic alliance between providers and patients; (3) provide the PCPs with intervention tools of stepped intensity for the PCPs to use in providing behavioral care to patients; (4) provide counseling sessions of varying length and number to patients with psychological/psychiatric disorders; (5) develop psycho-educational resources for the patient population; and (6) co-lead group medical visits with PCPs. The additional unique feature is that the prescribing psychologists and RxPs collaborate with PCPs in the provision of psychotropic medications.

This comprehensive array of integrated services sometimes includes BCPs and PCPs meeting with the patient (and their families at times) together in examining rooms. At other times the PCP will bring in a BCP for a "warm referral handoff" or, in like manner, a BCP will arrange a PCP visit at the end of a behavioral encounter for a patient whose presentation suggests the need for an immediate physician visit. Because the physical and behavioral care are provided, often simultaneously, in the same clinic setting there are ample opportunities for hallway consultations. The immediate availability of physician and behavioral faculty enables both BCPs and PCPs to obtain consultations and expert second opinions regarding a patient's current needs.

Communication among providers is solidified by the use of a single electronic medical record (EMR) in which all visits are recorded in sequence, with PCPs and BCPs able to review each other's notes and all lab and other evaluative reports as well as external provider documents which are scanned into the EMR when they are received. The EMR provides for a "problem list" that includes both medical and behavioral problems which are formulated and addressed by the healthcare team including the PCPs, BCPs and RxPs. This joint record is an effective tool for communication, as recent encounters can be forwarded to faculty and providers with issues of concern attached in the "routing" explanation. This will "flag" issues for other providers. Additionally many encounter notes generated by PCPs and BCPs are immediately reviewed by faculty as part of the normal educational and documentation process.

## Training Model

We believe that integrated training is essential for integrated practice. When learners learn together they have a fundamental understanding of how to work together in future practice. In the Family Practice Residency Program at Memorial Medical Center, the education of RxPs and family practice residents is truly integrated. The RxPs, predoctoral psychology students, medical students, residents, MD faculty, prescribing psychologist faculty, and Pharm. D. faculty work together in the clinic and the hospital, and attend the same didactics within the residency. The integration of teaching, using MDs, prescribing psychologists, and PharmDs presenting together, increases the depth of knowledge available to each learner. The "official" supervisor of the learner is based on regulatory requirements.

The medical training for RxPs in the residency program includes doing a Physical Assessment Practicum consisting of following the residents and medical faculty as they practice. The RxPs first participate in primarily an observer capacity, and, after one week, begin to take a complete history and to do a review of systems. They present their conclusions to a senior resident who will then interview and examine the patient with the RxP participating. Findings from the physical examination and any subsequent lab, imaging, and other physical results will be examined by the RxP with the senior resident and physician faculty to develop a treatment plan. This models what the RxP will do in practice: to be alert to the possibility of and treatment of medical illnesses as they may exacerbate, or simply coexist with, psychological and behavioral illnesses. The Prescribing Practicum is longer, and involves the RxP managing the psychotropic medications of patients under the supervision of a faculty physician.

The two prescribing psychologists are the primary teachers/supervisors of psychopharmacology for the Family Practice residents. The residents have some exposure to psychotropics in an inpatient setting through a one-month intensive experience in the psychiatry unit, followed by three years in the outpatient clinic. Both the physician faculty and the residents consult with the prescribing psychologists regarding psychotropic medications and other behavioral treatments in the outpatient clinic and the hospital (with the exception of the psychiatry unit, where a psychiatrist is in charge). There have been instances when a faculty physician must obtain the authorization of a prescribing psychologist in order to prescribe a psychotropic medication because an insurance company may limit the formularies of licensed physicians (except psychiatrists) to non-psychotropics. The residents relate to the prescribing psychologists as faculty and accept that these faculty members are responsible for teaching them to prescribe psychotropics. A similar observation was reported in the evaluation of the Department of Defense Psychopharmacology Demonstration Project: The prescribing psychologists were accepted by physicians, including

psychiatrists, and "were active in teaching clinical psychopharmacology to residents and other physicians" (American College of Neuropsychopharmacology, 1998).

In summary, there is "crossover" with the physician faculty supervising physical medicine and pharmacotherapy of behavioral specialists, and with the prescribing psychologists teaching and supervising psychotropic medication use by medical residents and teaching/supervising behavioral treatment.

## Culture Differences

A great deal has been written about the "culture of medicine" and how different it is from the culture of mental/behavioral health providers (see Hunter et al., 2009; Vogel et al., 2012). As a thought exercise the co-authors prepared a list contrasting the "cultures" of psychological versus medical intervention. The list appears in Table 1. This list is discussed early in training sessions with family practice residents, counseling psychology doctoral students, and RxPs. Vogel et al. (2012) mentioned a number of activities through which psychologists can become familiar with medical culture, including shadowing with a physician, developing mentorships with seasoned health psychologists, conducting brief interviews with physicians to identify behavioral health needs and the barriers that the physicians face in addressing them, and reading books about medical culture (e.g., "How Doctors Think" by Jerome Groopman). Tulkin and Guzman (1999) mentioned that focus groups of physicians and psychologists met prior to implementing an integrated care model, and Bray (1996) wrote that in his setting, "psychologists and physicians met in small groups to discuss training and cultural differences,…(including) stereotypes of each profession and factors that might obstruct collaborative practice" (p 94).

These stereotypes need to be addressed. Too often the view from the psychology silo reinforces prejudices about physician training that diminish and demean the training they have received in psychology, including the provision of behavioral care. This is especially true for family practice. The residency training of family physicians is governed by the Accreditation Council for Graduate Medical Education (ACGME) which mandates the components of training. For more details about what psychologists need to know about the ACGME competencies for physicians please refer to Cubic and Gatewood (2008). Training for family medicine is mandated to include:

- Human Behavior and Mental Health
  - Should acquire knowledge and skills in this area through a program in which behavioral science and psychiatry are integrated with all disciplines throughout the residents' total educational experience.
  - Training should be accomplished primarily in an outpatient setting through a combination of longitudinal experiences and didactic sessions.
  - Intensive short-term experiences in facilities devoted to the care of chronically ill patients should be limited.
  - There must be faculty who are specifically designated for this curricular component who have the training and experience necessary to apply modern behavioral and psychiatric principles to the care of the undifferentiated patient. Family physicians, psychiatrists, and behavioral scientists should be involved in teaching this curricular component.
  - There must be instruction and development of skills in the diagnosis and management of psychiatric disorders in children and adults, emotional aspects of non-psychiatric disorders, psychopharmacology, alcoholism and other substance abuse, the physician/patient relationship, patient interviewing skills, and counseling skills. This should include videotaping of resident/patient encounters or direct faculty observation for assessment of each resident's competency in interpersonal skills. This will require sufficient faculty who participate on an on-going basis in the program, and in the FMC, in particular.
  
  (ACGME, 2007) FM-RRC Program Requirement IV.A.5.b.8.

**Table 1** A Comparison of Psychological and Medical Cultures

| Seperate professional cultures | |
|---|---|
| Psychologists | Family Physicians |
| Thorough | To the point |
| Covers all bases | Covers essential topics |
| No diagnosis until data are definitive | Makes definitive decisions on ambiguous data |
| Education based more on reading than apprenticeship | Education based more on apprenticeship than reading |
| Responsible to NOT DO something for the patient unless sure ($p < .05$) | Responsible to TO DO something for the patient even when not sure |
| Expected to study what they are being shown many times before acting | Expected to have to do what is demonstrated to them immediately |

## Our Experience with Cultural Differences

One of the first issues we faced with psychologists was the need to modify the format and length of behavioral notes in order to make them useful as part of the record. It became clear quickly that providers with psychological training were accustomed to writing notes of much greater length and detail than was the norm for PCPs, and that psychologists needed training in brevity and clarity in note writing. For this purpose, outlines were developed for initial assessments, notes documenting the treatment of the psychological aspects of medical disorders, and notes documenting ongoing behavioral interventions which are usually no more than one half page in length and which generally follow the Assessment, Plan, Subjective and Objective (APSO) format. Of course, initial assessments require a slightly longer note but, even in this case, the general pattern of reduced utility of the note with the greater length is acknowledged. Hunter et al. (2009) were specific in their recommendation:

> "Verbal feedback should typically be delivered in 60 seconds or less; if more detail is needed, PCPs will ask for clarification. …Make recommendations that are brief, specific, and action-oriented. Remember that PCPs may be spending as little as 5 to 7 minutes with the patient"(p. 19).

In a similar manner, PCPs need to become more familiar with the skills and potential contributions of BCPs. The PCPs must expand their view of the long-standing role for the traditionally trained "medical psychologist" as focused primarily on treating the behavioral aspects of medical disorders. Although BCPs in our setting are trained to provide those services, they are also trained to provide psychotherapeutic services for psychological disorders collaboratively with PCPs and to assist in enabling patients to change health related behaviors. The BCPs also assist the PCPs in learning motivational interviewing and brief counseling methods so that the PCPs can provide behavioral treatment themselves. Finally, in the case of RxPs, the training includes experience in the management of psychotropic medications in collaboration with the PCPs. This co-training of the BCPs and RxPs with the PCPs has enabled the following advances in the integration of behavioral care in primary care:

1. A new "normal" is established in that both PCPs and BCPs assume it is normal to collaborate in a primary care setting.
2. BCPs and RxPs speak the medical language and can communicate effectively with PCPs.
3. PCPs are better able to understand and utilize the skills of BCPs in providing behavioral care in the primary care setting.
4. Patients are more likely to accept referrals in the same setting where warm handoffs are made.
5. Patient progress and adherence is more easily monitored if services are provided by a "team" using the same EMR and working in the same setting.

## The Reimbursement Issue

A final challenge is the problem related to reimbursement for integrated behavioral services. There are some mechanisms for the reimbursement for these services. For example, although PCPs are generally barred from being reimbursed for counseling services there are exceptions: brief counseling (5 min) addressing the needs for smoking cessation or for substance abuse treatment have their own CPT codes (CPT 99406, 99407, 99408, 99409) and can be billed by the physician during a physician visit. BCPs that are licensed may provide billable services which are reimbursed by many insurance panels. Many readers may be aware of the problems that remain with psychologists using the Health and Behavior codes which would seem ideal in this setting for many of the services provided. There remains, however, a substantial gap in the reimbursement net for brief treatment interventions lasting less than 20 min and for consultative services and psychoeducation, with few exceptions. In our clinic, the BCPs are funded through a HRSA grant obtained by New Mexico State University for practicum training, and training grants for the co-training of PCPs and BCPs in the same setting provide the most immediate mechanism for reimbursement. It is our hope that, as the as the co-training of PCPs and BCPs continues to expand, the pressure to adapt health care funding to integrated care provision will also expand.

## Clinical Role for the Prescribing Psychologist

In addition to teaching and supervising, the prescribing psychologist faculty members (including the first author) have clinical responsibilities. Medications most often prescribed are (in descending order of frequency) antidepressants, anxiolytics, attention enhancers, hypnotics, mood stabilizers, and antipsychotics, with occasional use of ACH esterase inhibitors and medications for sexual dysfunction. It has been surprising to find that, because of cost, some patients continue to use first generation antipsychotics and lithium. Drugs most frequently discontinued or titrated down are (in descending order) anxiolytics, hypnotics, sedating antidepressants, and medications with high anticholinergic indices. Quite often the number of medications is reduced by providing one medication as a substitute for

two or more. The biggest surprise has been the complexity of the cases referred to the prescribing psychologists. Straightforward cases that involve a single antidepressant and cognitive-behavioral therapy are handled by family medicine residents in collaboration with BHCs. The caseload of the first author consists of more difficult to treat, complex, and challenging patients—often people with chronic medical illnesses. There are more patients with bipolar I and psychotic disorders than was expected in an outpatient primary care population. The prevalence in primary care of people with severe mental health problems underscores the need for someone on the primary care team to have specialized expertise in psychopharmacology. The prescribing psychologist is the ideal choice for this role.

In summary, co-training PCPs, BCPs, and RxPs provides a crucible in which the difficulties in the provision of IBC can be identified and addressed. Collaboration with family physicians in primary care clinics and offices has been identified as the forefront of health care in the future – both medical and behavioral. A health care team comprised of providers working together offers the most efficient model for the care of the whole person. Psychologists will find rewarding training and service opportunities in primary care residencies including pediatrics, obstetrics and gynecology, and emergency medicine. This is especially true for psychologists with advanced training in psychopharmacology, as this training further enhances the collaborative professional relationships in these departments. The most rewarding aspect of the work is the opportunity to provide both psychological and pharmacological services in an integrated primary care setting where psychologists and physicians work collaboratively, and train the next generation of professionals—for whom the concepts of integrated care are familiar, and the cultures of medicine and mental health are no longer in silos.

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