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The primary care behavioral health model (PCBH) and medication for opioid use disorder (MOUD): Integrated models for primary care

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ABSTRACT

Recent decades have witnessed increases in (a) integrated physical and behavioral health services and (b) the treatment of opioid use disorders (OUD) in primary care settings – also known as office-based opioid treatments (OBOT) – using a combination of medication and psychosocial support. Providing these services requires a workforce trained to address addiction's psychosocial components and interventions addressing addiction's biological and neurological mechanisms. This paper examines the implementation factors, clinic workflow and roles, and administrative considerations of two models of integrated care in order to identify ways of increasing treatment capacity and expanding OUD treatment uptake in integrated primary care settings.

KEYWORDS

Integrated behavioral health; integrated care; medication for opioid use disorder (MOUD); opioid use disorder (OUD); primary care behavioral health (PCBH); medication assisted treatment (MAT); behavioral health providers; social work; integrated models of care; office based opioid treatment (OBOT)

Integrated care

Integrated health care research (i.e., a patient-centered approach delivering whole-person care for physical and behavioral health needs) has increased in recent decades (Miller et al., 2017). Integrated care exists on a continuum that at minimum includes (a) care coordination, (b) co-located behavioral and physical health services in shared workspaces but separate workflows, and (c) fully integrated and coordinated treatment plans via shared administrative systems (Heath, Romero, & Reynolds, 2013). Establishing clear workflows and reaching shared understandings of treatment models are essential for expanding integrated care within primary care.

Treating OUD in primary care

Persons with substance use disorders – especially opioid use disorder (OUD) – are in particular need of integrated care. In the current opioid epidemic, overdose deaths have quadrupled since 1999 (Centers for Disease Control

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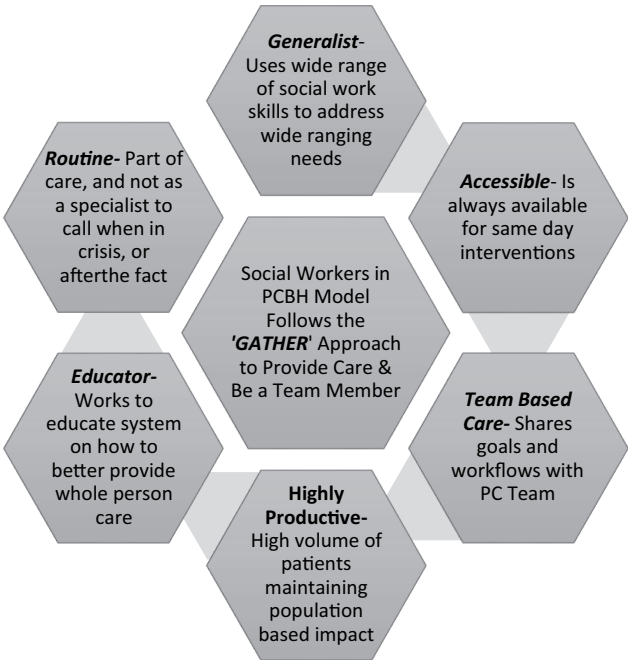

Figure 1. Social work role in a primary care behavioral health context. Note: The GATHER acronym is based on earlier work by Robinson and Reiter (2007) and Reiter et al. (2018).

and Prevention, 2020). OUD treatment requires interventions addressing biological and neurological mechanisms of addiction as well as biopsychosocial determinants (North Carolina Department of Health and Human Services [NCDHHS], 2017). The expansion of treatment for OUDs within primary care settings, also known as office-based opioid treatment (OBOT), has paralleled efforts to expand integrated care (Korthuis et al., 2017). Since 2000, the growing availability of medication for opioid use disorder (MOUD) within primary care has increased the accessibility of OUD treatment (Fiellin et al., 2008). Fortunately, though OBOT requires a specialized workforce, intentional workflows, and policies designed to meet complex physical and behavioral health needs, the behavioral health and recovery support services critical to MOUD draw on social workers' field-specific skills and knowledge (Lombardi, Zerden, Guan, & Prentice, 2019).

Although MOUD is an evidence-based approach to treat OUD (Fiellin et al., 2008) several barriers to its implementation remain: the number and location of Drug Enforcement Administration (DEA)-waivered prescribers (Andrilla, Coulthard, & Larson, 2017); stigma experienced by individuals with OUD (Yang, Wong, Grivel, & Hasin, 2017); financial and regulatory barriers (Netherland et al., 2009); a lack of consistent, evidenced-based psychosocial supports (Zerden, Guan, Lombardi, Sharma, & Garcia-Rico, 2020); and competing clinical demands (Jones, 2018). As OBOT continues, best practices for

implementation within integrated models of care remain underexplored. One widely operationalized and implemented integrated model is the Primary Care Behavioral Health (PCBH) model (Reiter, Dobmeyer, & Hunter, 2018). Given the evidentiary support for the PCBH model and the role of social workers as the behavioral health consultants (BHC) within this model (Mann et al., 2016), this paper compares OBOT and PCBH models to further explore methods and venues for integrated care delivery for individuals with OUD. Among other things, we argue that social workers' expertise as behavioral health providers in medical settings is conducive to the aims of PCBH and OBOT (Table 1).

Ample research supports the PCBH model and MOUD's implementation in primary care settings, but few studies have compared them. Moreover, no standard delivery protocols exist for behavioral health and psychosocial interventions in OBOT settings (Zerden et al., 2020). Therefore, this paper compares PCBH's and OBOT's philosophies of care, team-based approaches, and workflow and reimbursement mechanisms in order to make practice, administrative, and workforce recommendations that may increase OUD treatment capacity and expand uptake of OBOT to match the wide usage of PCBH.

Overview of the PCBH model

The PCBH model was designed to meet the behavioral health needs of numerous individuals who either did not receive treatment or received it in primary care (Robinson & Reiter, 2007). Multiple barriers prevent individuals from seeking behavioral health treatment, including access, proximity to providers, stigma against mental illness (Holder, Peterson, Stephens, & Crandall, 2019; Yang et al., 2017), high costs and/or insufficient insurance coverage (Hunter et al., 2018), and long wait times (Reiter et al., 2018).

PCBH has been implemented across large settings such as the Veterans Administration (Kim et al., 2018), community health systems (Miller et al., 2017), and academic hospitals (Reiter et al., 2018). PCBH typically provides same-day, same-location primary care and behavioral health services utilizing a shared medical record and workflow. Across these different settings, PCBH has proven effective for behavioral health conditions that commonly present in primary care such as anxiety and depression (Katon et al., 1996), PTSD (Cigrang et al., 2015), sleep disorders (Goodie, Isler, Hunter, & Peterson, 2009), obesity (Sadock, Auerbach, Rybarczyk, & Aggarwal, 2014), and tobacco use (Sadock et al., 2014). Figure 1 depicts how social work can be specifically utilized within the PCBH model and further advance this type of integrated behavioral health care delivery.

Table 1. Shared roles for social workers as behavioral health clinicians in primary care and office-based opioid treatment models.

Social Work Attribute	Sharing of Roles
Educating Others	Given the field's longstanding emphasis on social justice initiatives, social workers are well positioned to lead efforts to reduce stigma, model appropriate language, and advocate for patients in ways that foster learning and patient-first mind-sets.
Effective Team Based Care	Social workers in PCBH and OBOT settings must communicate with primary care providers, nurses, medical assistants, and other staff. Supporting patients and their care teams requires effective workflows that are clearly understood by all team members. Having experts in different domains adheres to Quadruple Aim of healthcare, which includes improved patient care, reduced costs, increased population health, and support of providers to prevent burnout (Bodenheimer & Sinsky, 2014).
Efficient Service Delivery	With skills in case management, interprofessional collaboration, rapport building, and a host of evidence-based therapeutic interventions, social workers are well equipped to help patients acquire the motivation, behavioral changes, and change maintenance needed to support their physical health and substance use recovery.
Family Support	In PCBH and OBOT settings, social workers can support families of patients by sharing resources about behavioral health and conditions specific to SUD, providing family support, or involving the family in care provision. The PCBH model frames the family as key individuals involved in promoting a client's successful treatment via increased support.
Person-in-Environment Perspective	Beyond providing interventions in the clinic, social workers in PCBH and OBOT settings must also determine how to perform interventions at mezzo and macro levels. Identifying interventions and supportive services at the community level will require knowledge of and familiarity with community resources, recovery community organizations, faith-based agencies, schools, housing supports, and others. Advocacy efforts with professional organizations are necessary to ensure policies that support patients' recovery are in place.
Population Health Perspective	By providing services that support the collective health of a whole patient population rather than just individual patients, PCBH focuses on disease prevention and routine care needed to improve rates of diagnoses. Social workers in OBOT can capitalize on insights from a population health perspective through the early identification of substance use and targeting known, at-risk populations such as patients diagnosed with Hep-C and HIV.
Psychoeducation re: SUDs, Medication, and More	Behavioral health providers on the PCBH and MOUD team must have knowledge of medications (e.g., buprenorphine, naloxone, acamprosate, naltrexone). Social workers must be able to evaluate clients for symptoms of SUDs and determine whether a medication is working in order to address SUD-related symptoms (e.g., craving, control, functionality) and establish reasonable treatment goals. Social workers can also help clarify important treatment information to the patient that is not covered during the visit with their PCP.
Treating the Whole Person	Patients presenting in primary care often have co-occurring medical and psychiatric diagnoses. To assist the patient and their care team, social workers must function as generalists and in OBOT settings, serve as addiction and OUD specialists. These two types of treatment can be offered in the same clinic.
Use of Evidence-Based Treatments (CBT, ACT, MI)	Primary care providers in PCBH and OBOT settings utilize evidenced based practices to address psychiatric, health behavior, and substance use concerns. These interventions are adapted to fit within the primary care workflow and therefore require unique skills to be provided efficiently and effectively.

Comparison of the PCBH model and OBOT

PCBH differs from the specialty care provided in OBOT settings and receiving MOUD. Additionally, the skillsets practitioners need to treat severe substance use disorders may differ from those required to perform PCBH's generalist

interventions. To further articulate the differences between PCBH and OBOT, the following compares each model's core functions, team-based approach to care, interventions, and workflow.

Core functions

PCBH and OBOT share overlapping core functions. Both operate within primary care systems treating physical and behavioral health needs. Typically, PCBH provides care across the life span and offers a generalist approach to primary care treatment. By contrast, OBOT requires a specific diagnosis (OUD) and related medication prescription(s). Patients receive services in clearly delineated cycles that coincide with medication management and prescription refills requiring patients to engage in treatment in order to meet requirements of OBOT care (e.g., attendance, proper medication use). MOUD patients typically transition to a lower level of care once they complete their medication's dose reduction process.

Behavioral health interventions and workflow

PCBH and OBOT utilize similar treatment interventions such as cognitive behavioral therapy, motivational interviewing, and general supportive counseling (Dugosh et al., 2016). Behavioral health interventions in OBOT include individual and group counseling, case management, mutual help groups, and referral to specialized outpatient treatment (Zerden et al., 2020). PCBH shares some of these interventions but operationalizes them differently, utilizing BHCs as generalists often requiring the person-in-environment perspective and skillset of social workers (Mann et al., 2016) (see Table 1). BHCs are accessible, engage in team-based care, educate their fellow providers, and offer consultations during primary care visits.

Unlike traditional mental health services or outpatient Opioid Treatment Programs (OTPs), PCBH adheres to primary care workflows and uses "warm hand-offs" for same-day behavioral health care (Serrano, Cordes, Cubic, & Daub, 2018; Vogel, Kanzler, Aikens, & Goodie, 2017). By contrast, a systemic review of psychosocial supports in OBOT found they lacked detailed workflows and consistent intervention programming (Zerden et al., 2020).

Team-based care and patient panels

Research has shown that when providers have support from their team, it can decrease burnout (Kim et al., 2018) and improve patient satisfaction (Hunter et al., 2018). PCBH and OBOT approaches both require care coordination among a diverse treatment team. For PCBH, the primary care provider works with the BHC and coordinates care as a team. OBOT requires a DEA-waivered prescriber (Korthuis et al., 2017) and relies on a multidisciplinary team whose composition can vary (Zerden, Lombardi, Richman, & Sharma, 2020). Whereas estimates suggest that BHCs see more than 1,000 patients per

each year and do not have finite patient limits (Advancing Integrated Mental Health Solutions [AIMS] Center, 2020), OBOT is limited on the number of patients who can be served based on DEA-waivered regulations of a maximum of 75 patients annually – a number that is also lower for non-physician mid-level DEA-waivered providers (e.g., 30 patients in year 1) (Andrilla, Moore, Patterson, & Larson, 2019).

Electronic medical record and communication

In the PCBH workflow, the BHC considers the patient's and the primary care provider's treatment goals in performing the intervention and provides updates to relevant team members (Serrano et al., 2018). BHCs also conduct risk assessments to monitor unique patient populations via more frequent follow-ups. Given their various team compositions, there is no MOUD standard protocol for managing patient registries (Zerden et al., 2020), record sharing, or collaborative decision-making. Operationalizing these components of OBOT would improve the assessment of outcomes based on the team-based components of care.

Emphasis on prevention

Behavioral healthcare is a core component of PCBH (Holder et al., 2019), which emphasizes prevention and early intervention across the care continuum. Providers can add a BHC to a care team addressing prevention, early intervention, chronic illness, or crisis situations. Because of their routine availability, PCBH increases patients' likelihood of receiving and benefitting from behavioral health treatment. This in turn may mitigate the impact of opioid and other substance use disorders, chronic health issues, and psychiatric illness (Reiter et al., 2018).

Because OBOT requires an OUD diagnosis prior to treatment, it is not preventative treatment. However, it may serve as an early intervention if this diagnosis occurs in OUD's early stages. MOUD can serve as relapse prevention and a means of addressing cravings.

Payment, insurance, and administration

As PCBH expanded, so has the complexity around reimbursement for integrated models (Freeman, Hudgins, & Hornberger, 2018).The administrative bureaucracies around billing continues to be impeded by procedures that require reimbursement mechanisms, codes, and providers' permission to bill. PCBH services are primarily supported with grants, Medicare/Medicaid payments, value-based contracts with insurance agencies, and costs saved due to reduced resource use and increased productivity (Miller et al., 2017). As insurers increasingly recognize the importance of behavioral health care, finding sustainable ways to bill and be reimbursed for these critical services is vital.

In OBOT, urinalysis labs may present additional costs, though many labs are willing to adjust contracts and forego reimbursement for those who are uninsured. Medications for OUDs present another added cost. With insurance, some formularies require prior authorization, often requiring the patient to pay for expenses out-of-pocket while paperwork is processed. Further, the self-pay costs of medication vary widely across drug companies and pharmacies, meaning that OBOT providers need to explore patients' best options in partnership with local pharmacies.

Discussion

As behavioral health services continue to integrate into primary care settings, providers should replicate best practices to optimize patient outcomes. OBOT should establish operational specificity given the robust evidence of streamlined implementation in successful PCBH models. Because OUD frequently represents a more severe type of behavioral health condition, PCBH providers should treat behavioral health as a continuum of conditions that may include common diagnoses (e.g., depression, anxiety) and substance use disorders like OUD. By approaching OUD care as an extension of their services, practitioners in PCHB models can expand patients' access to treatment and comprehensive services. At the same time, because OUD treatment requires a DEA-waivered provider, policymakers and administrators must create systemic resources that connect these providers with behavioral health providers. They should also regulate the number of clients that an integrated behavioral health team can serve (similar to the limits on the number of patients per MOUD registry) in order to ensure a standard of care with strong treatment outcomes. As health systems continue to shift toward value-based care models, providers must be able to address the whole patient and the full spectrum of behavioral health and psychosocial needs.

A well-trained behavioral health workforce is necessary to improve OUD care. The social work profession is well equipped to provide the behavioral health support required by PCBH and OBOT models (Lombardi et al., 2019; Mann et al., 2016). Social work foregrounds the importance of individual interventions informed by a macro perspective of environmental factors and population health outcomes. From this unique vantage, social workers can lead behavioral health efforts within PCBH and OBOT settings. Training social workers to deliver these services will increase the field's professional opportunities and the availability of comprehensive whole-person care services.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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