"Did you read my note?" Opportunities for Collaboration Between Primary Care and Behavioral Health

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Oregon Health & Science University

Primary Care Review

February 11, 2026

Disclosures

- Drs. Byerly and Nagarkatti-Gude have no financial disclosures related to the content of this talk.
- Dr. Byerly serves as the Project Director of a HRSA-funded Geriatrics Workforce Enhancement Program; her views and presentation do not represent those of the US Government.
- AI use: image generation (OpenAI)

Objectives

By the end of this session, attendees will be able to:

Describe	Describe the reasons for medical multimorbidity in adults with serious mental illness.
Describe	Describe care plan related communication challenges for adults with behavioral health diagnoses.
Identify	Identify 3 opportunities for improving collaboration and communication between primary care and behavioral health.

Meet David! aka “the Psychiatrist”

OHSU Department of Psychiatry

- Associate Professor
- Provider Informaticist (aka nerd about Epic)
- Practice focused in integrated care (Collaborative Care Model, embedded consultation, e-consult, OPAL)

Meet Laura!
(aka "the PCP")

School of Medicine
General Internal Medicine

School of Medicine
MD Program

“Lizzie” (because always a case…)

- 71yo cisgender woman in residential care
- BPAD diagnosed in late-20s, MVA related TBI, mild dementia
- PMHx: Elevated BMI (33), GERD, Heart failure, HTN, HLD, OSA
- Community psychiatrist (EClinicalWorks), new PCP in different system (Epic)
- Seen in ER for confusion → BP 198/102, persistent through stay
- Saw PCP for follow up → BP remains elevated (declines medication though difficulty expressing reasons)
- Chart flags overdue for mammogram, lipid panel, and colonoscopy → out of time to discuss
- PCP notes Lithium at discharge was different than prior (?error vs intentional) → faxes note to psychiatrist
- Patient readmitted the following week for stroke and incidentally noted supratherapeutic lithium levels
- Transitions to long-term care, psychiatrist brings up comfort care, enrolls in hospice

Multimorbidity & its origins in SMI

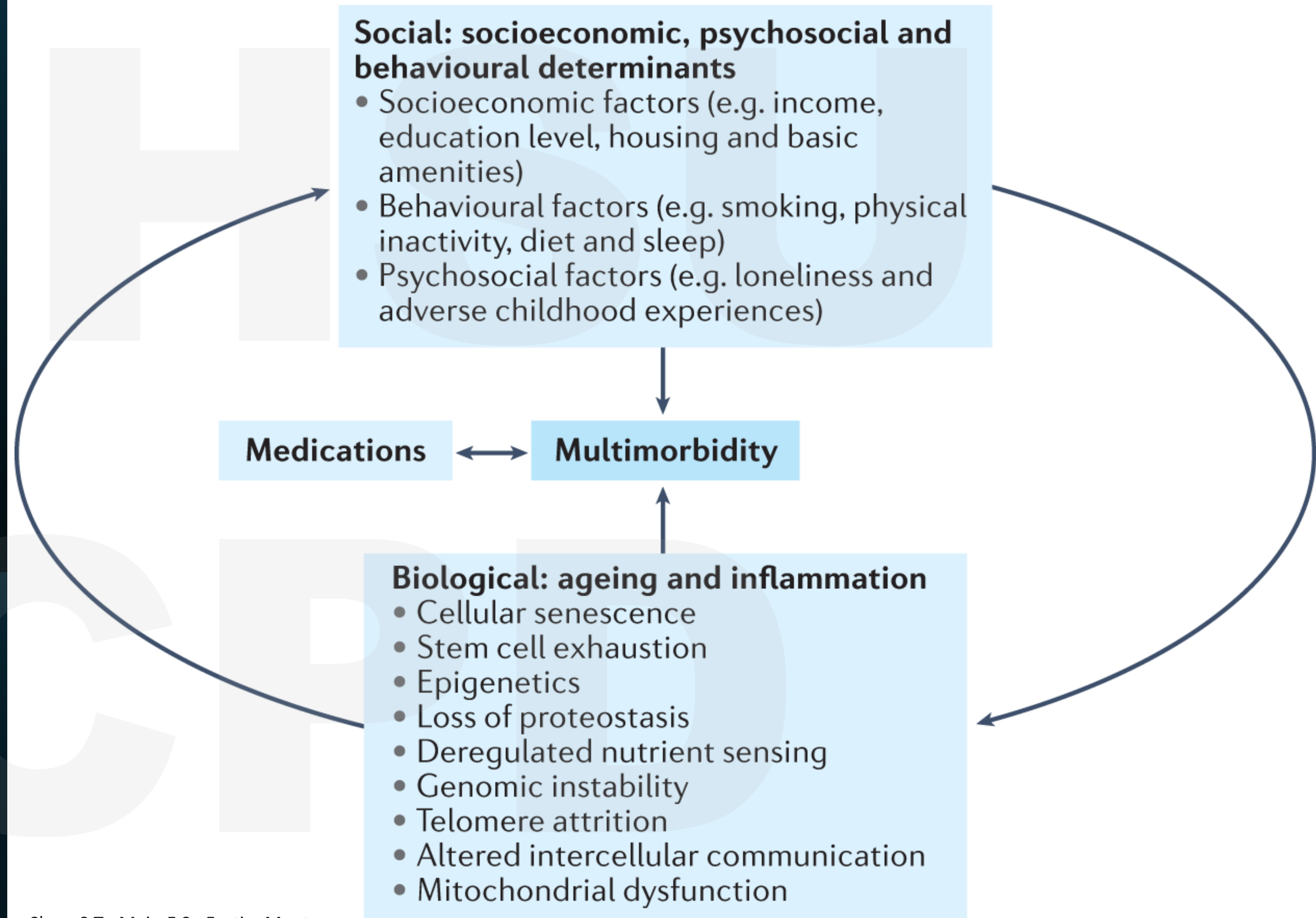
Lasting impacts of trauma

Multimorbidity definitions

- **3* or more** chronic medical conditions that collectively have adverse effects on health, function, and quality of life.
- Requires **complex healthcare management, decision making, and coordination**.
- *"...having more than one condition, including a mental health disorder, translates into a higher health-care load and treatment burden, which is equally important to or more important than the precision in the 'technical' definition of multimorbidity"*

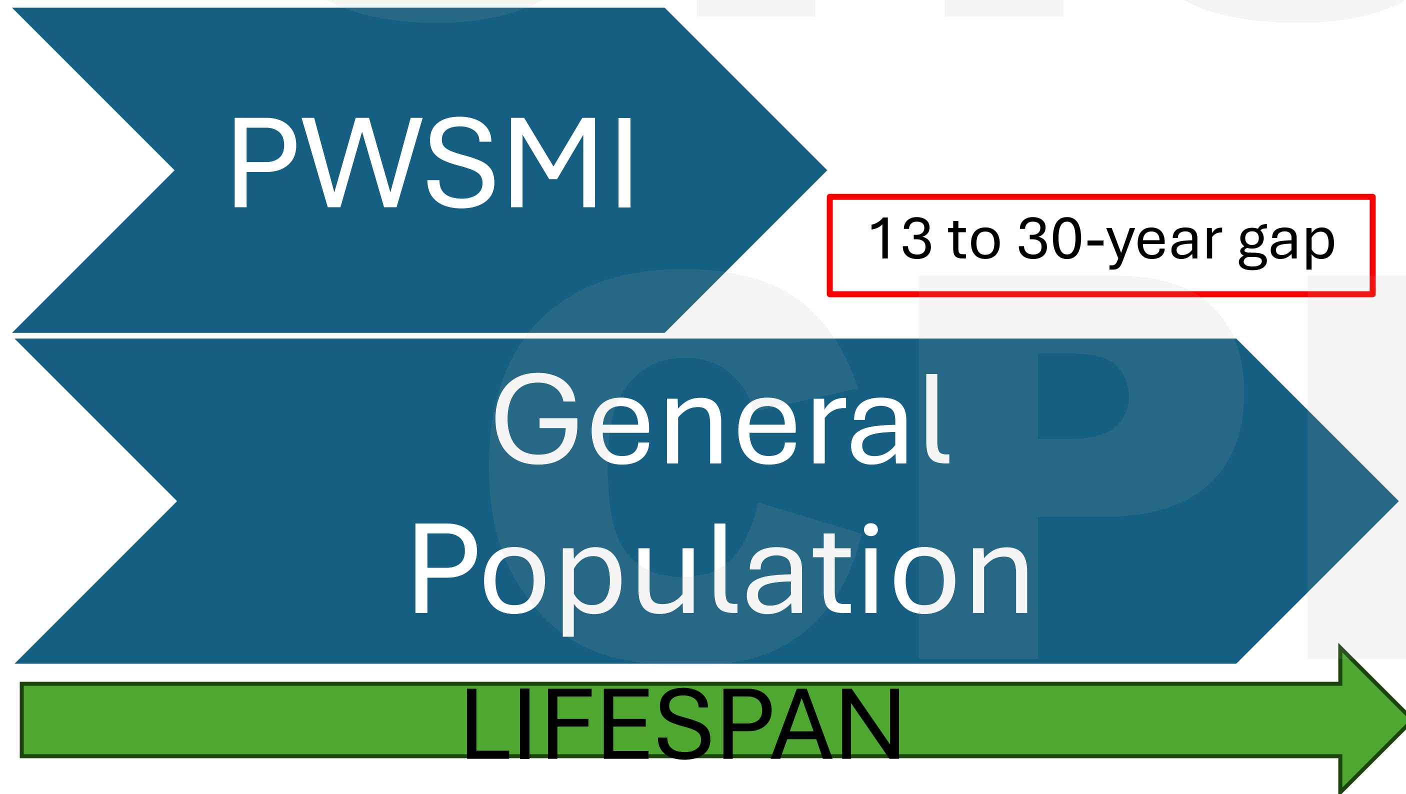
Yancik et al. J Gerontol 2007;. Akner G. VDM Verlag Dr. Muller GmbH & Co. KG; 2011; Boyd Aging clin exper research 2008, Skou et al, Nature Reviews 2022.

Mechanisms of Multimorbidity



Skou, S.T., Mair, F.S., Fortin, M. *et al.* Multimorbidity. *Nat Rev Dis Primers* 8, 48 (2022).

SMI and Multimorbidity: Lifespan Challenges

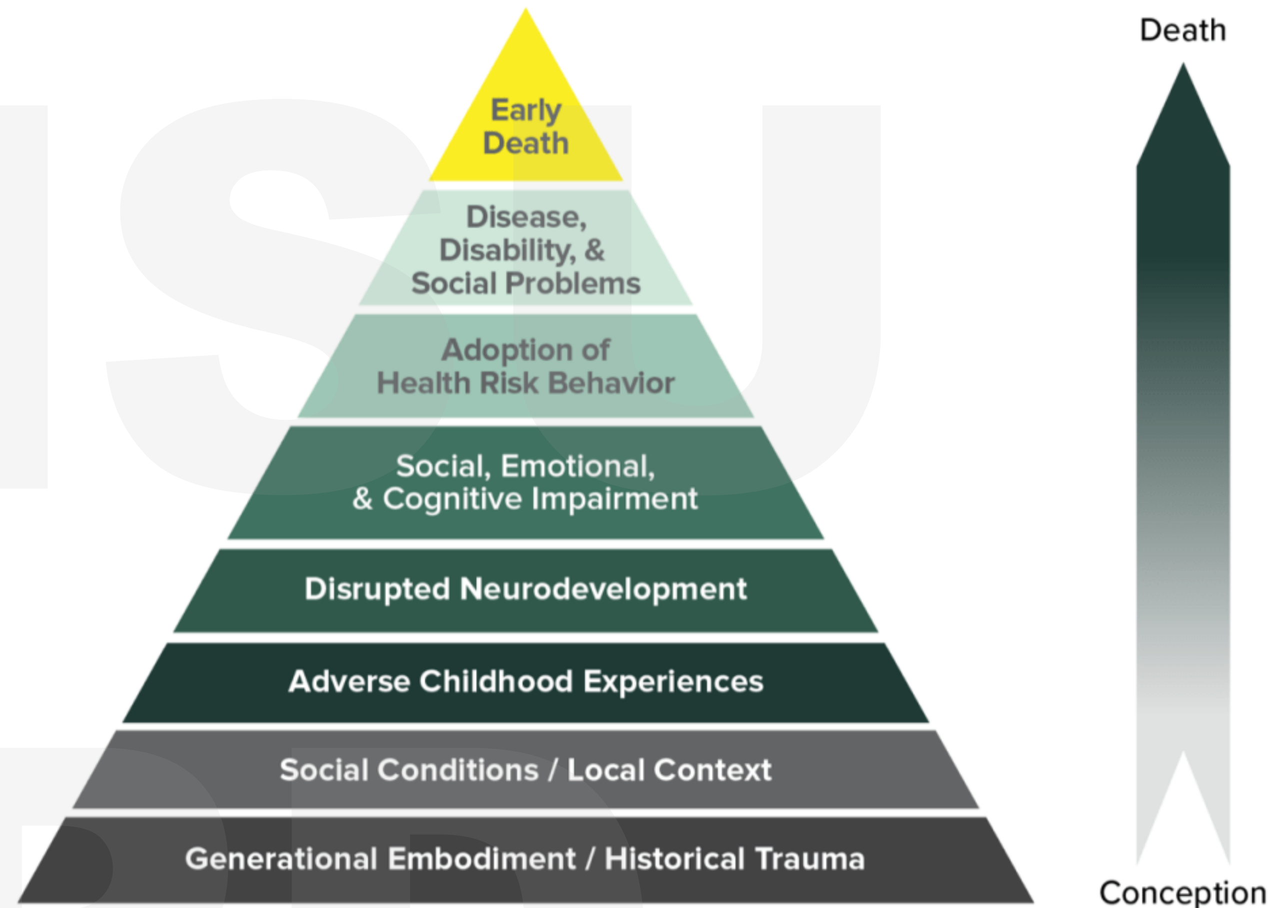


How many of you have seen this in practice?

What factors lead to this lifespan gap?

The ACE Effect

“One doesn’t ‘just get over’ some things” – Vincent Felitti, MD



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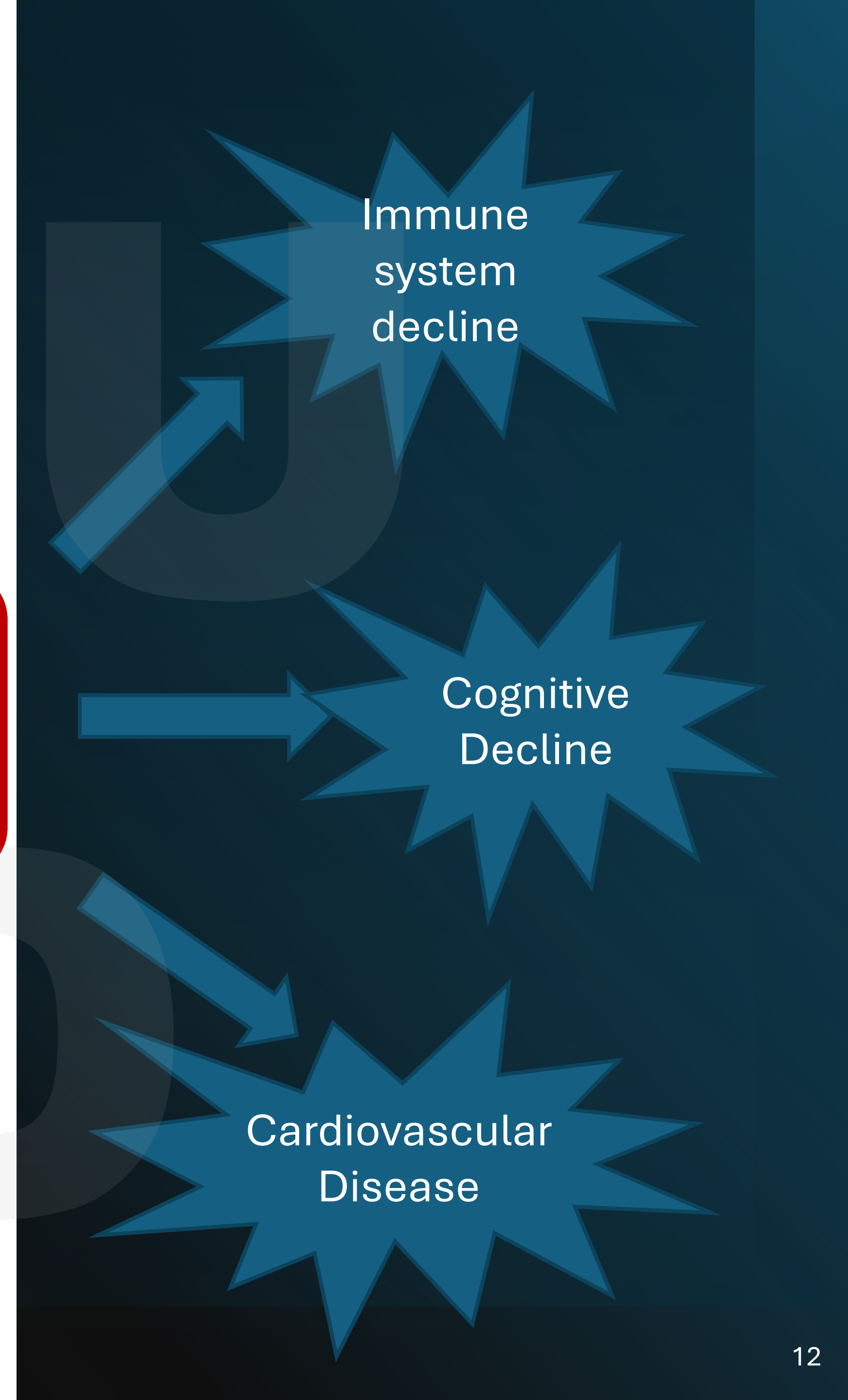
How our brains develop affects the choices we make—and the likelihood of multimorbidity

Accelerated Aging: **Wear, Tear, and Inflammaging**

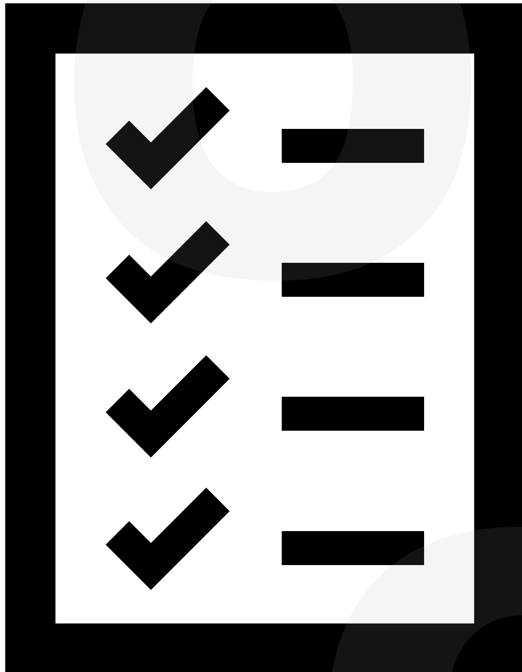


- "Allostatic Load"
- Increased **chronic illness & functional decline** at a younger age

Chronic disease and SMI

- Diabetes
- Cardiovascular disease
- Hyperlipidemia
- Elevated BMI
- Tobacco use
- Dementia

80% with SMI have 1+ chronic conditions



Summarizing Multimorbidity and SMI

- Multimorbidity can be associated with trauma; PWSMI have experienced trauma
- The cells of people who have experienced trauma/stress age faster than their peers
- Aging cells lead to disease
- For all these reasons, adults with SMI have a higher risk of multimorbidity
- ***For all these reasons, adults with SMI have more behavioral health and healthcare coordination needs***

OHSU CPD

Behavioral Health in Primary Care

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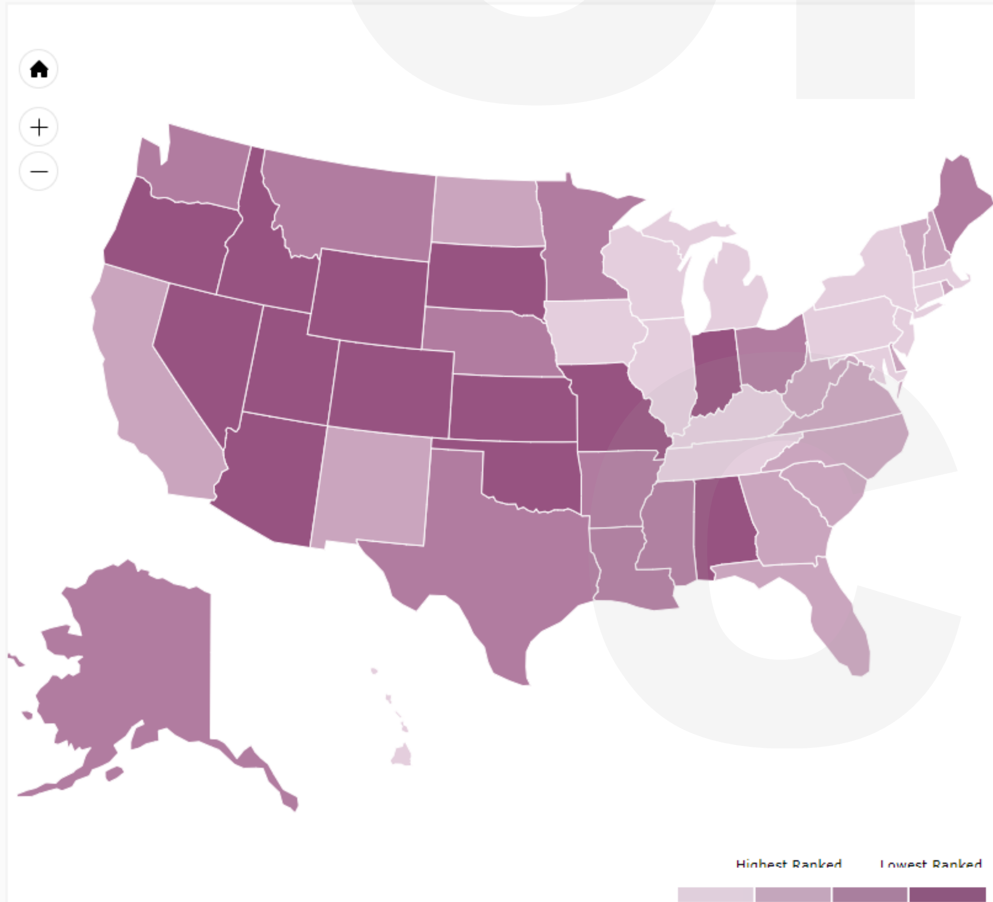
CPD

Oregon is particularly challenging



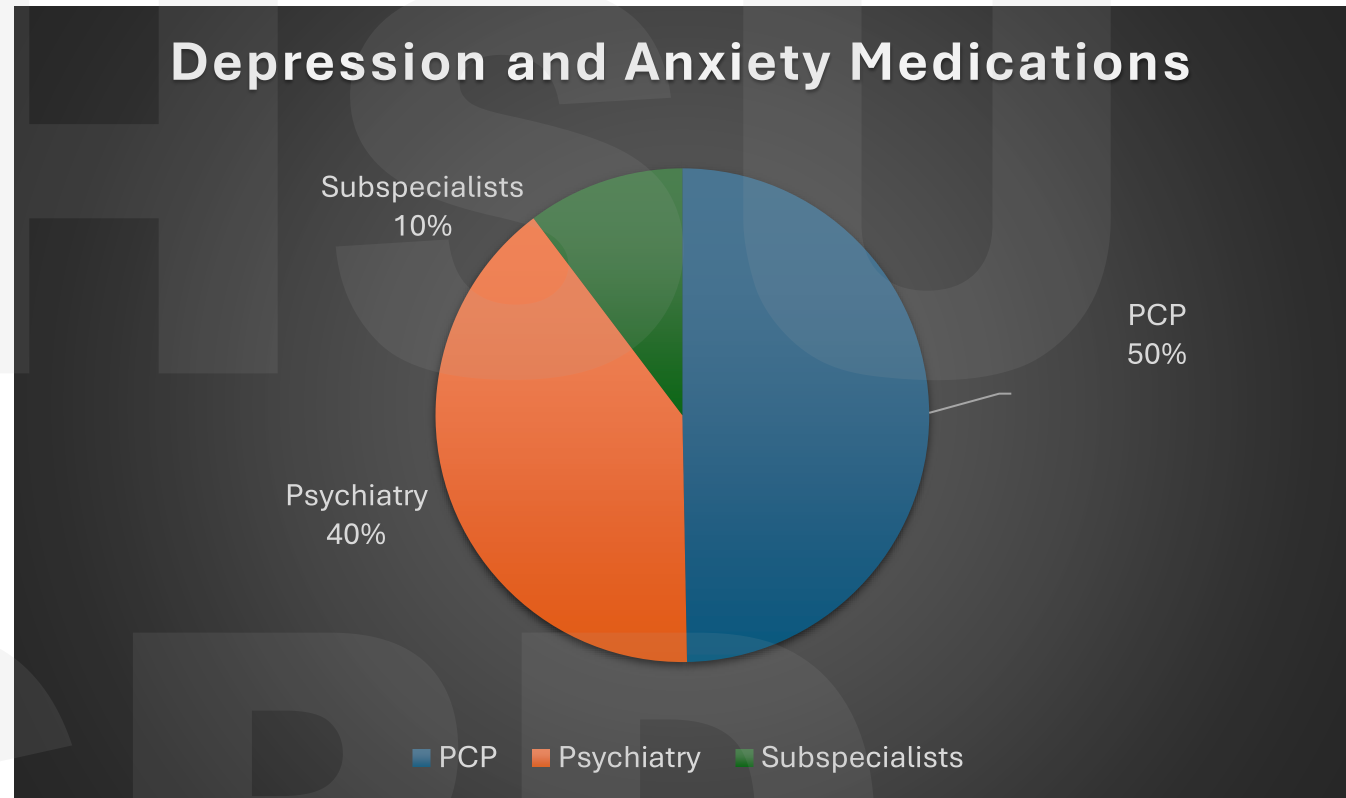
Rank	State
01	Kentucky
02	Hawaii
03	New York
04	Pennsylvania
05	Wisconsin
06	Connecticut
07	Tennessee
08	New Jersey
09	Illinois
10	Maryland

Rank	State
40	South Dakota
41	Indiana
42	Nevada
43	Oklahoma
44	Idaho
45	Colorado
46	Utah
47	Alabama
48	Oregon
49	Arizona
50	Wyoming
51	Kansas

Mental Health American “Ranking the States” 2023

mhanational.org/issues/2023/ranking-states

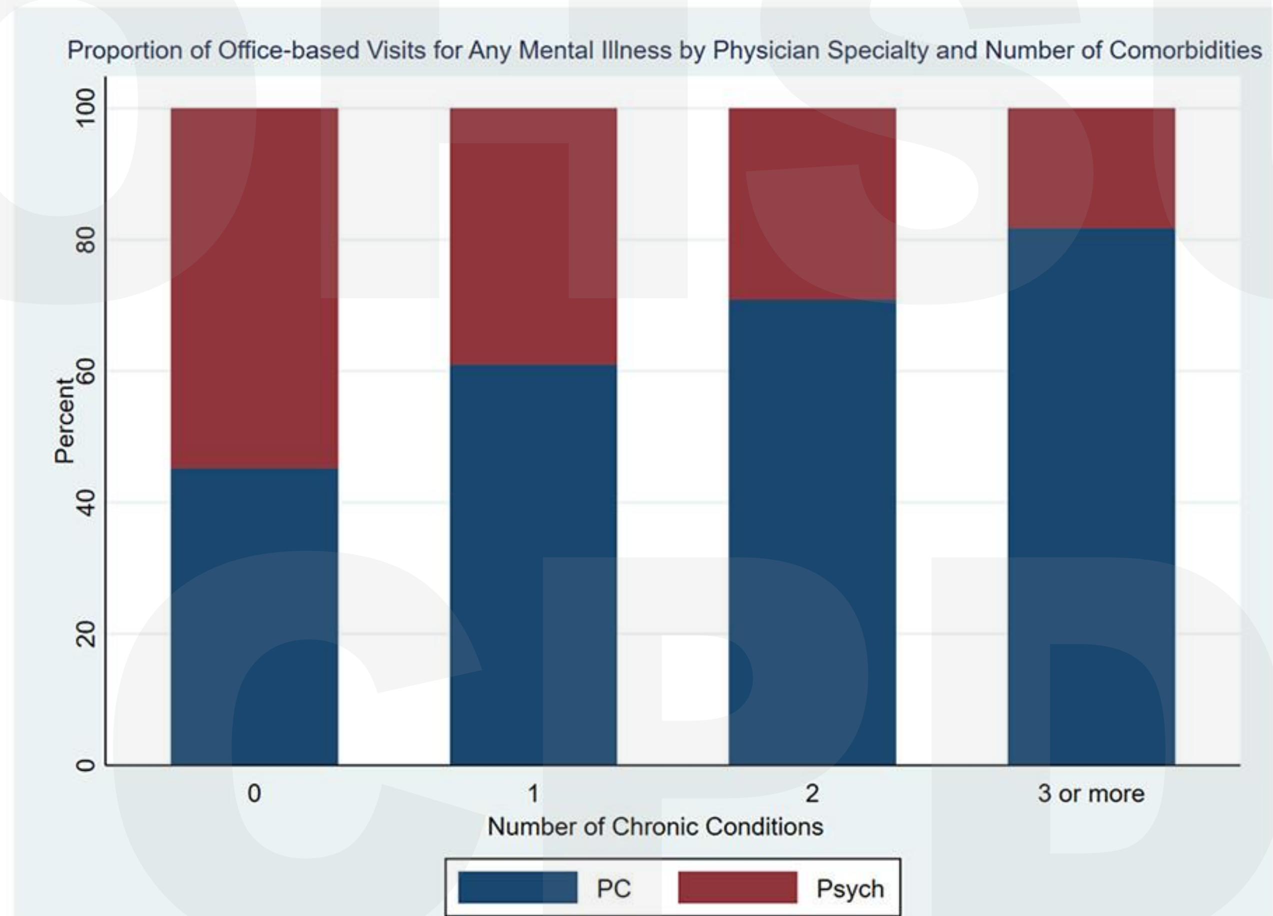
Primary care delivers *most* mental health care



Source: Jetty A et al 2021 J Primary Care & Community Health “Assessing Primary care Contributions to Behavioral Health: A Cross-sectional Study Using Medical Expenditure Panel Survey”

- N=394,023 office visits 2016-2018, Medical Expenditure Panel Survey data, 5 interviews over 2-year period

Primary care delivers *most* mental health care



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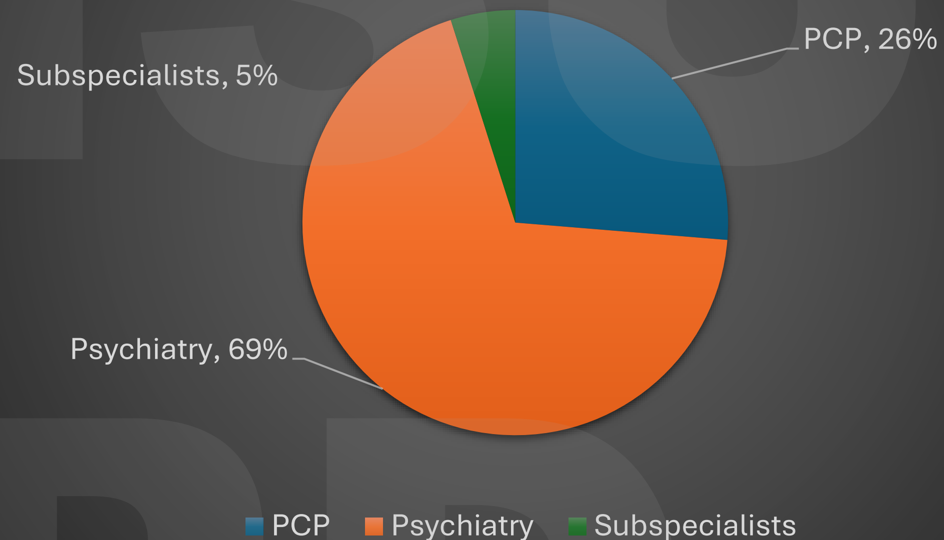

Source: Jetty A et al 2021 J Primary Care & Community Health "Assessing Primary care Contributions to Behavioral Health: A Cross-sectional Study Using Medical Expenditure Panel Survey"

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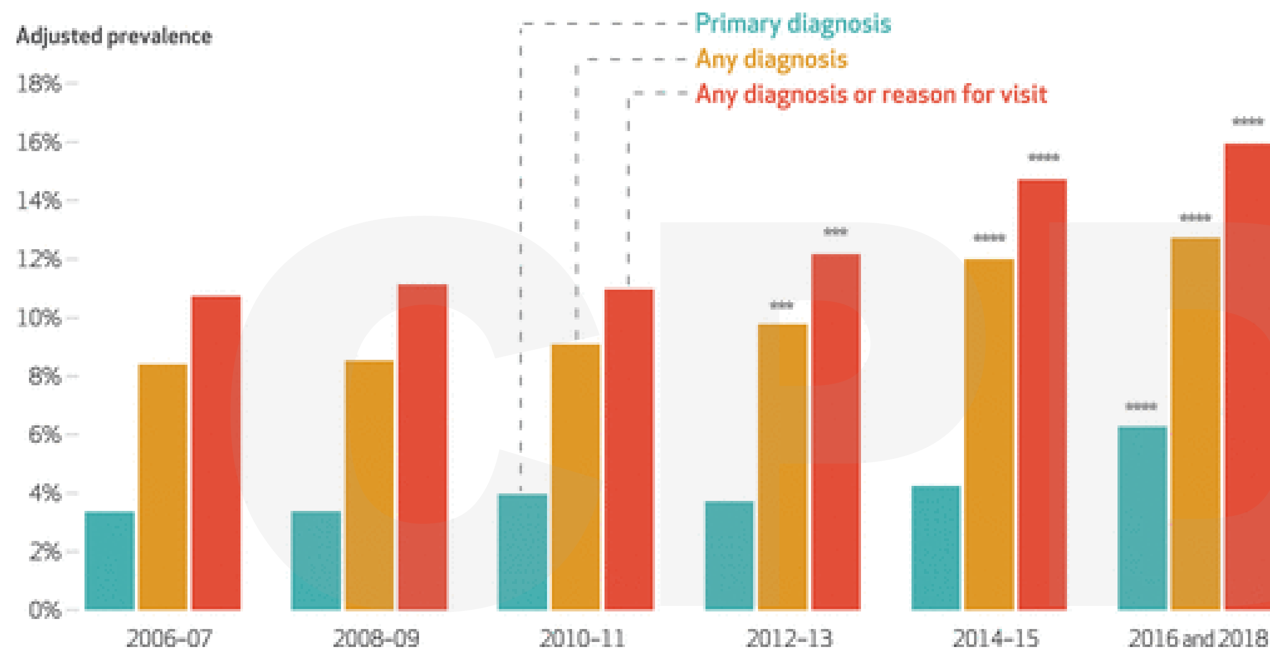
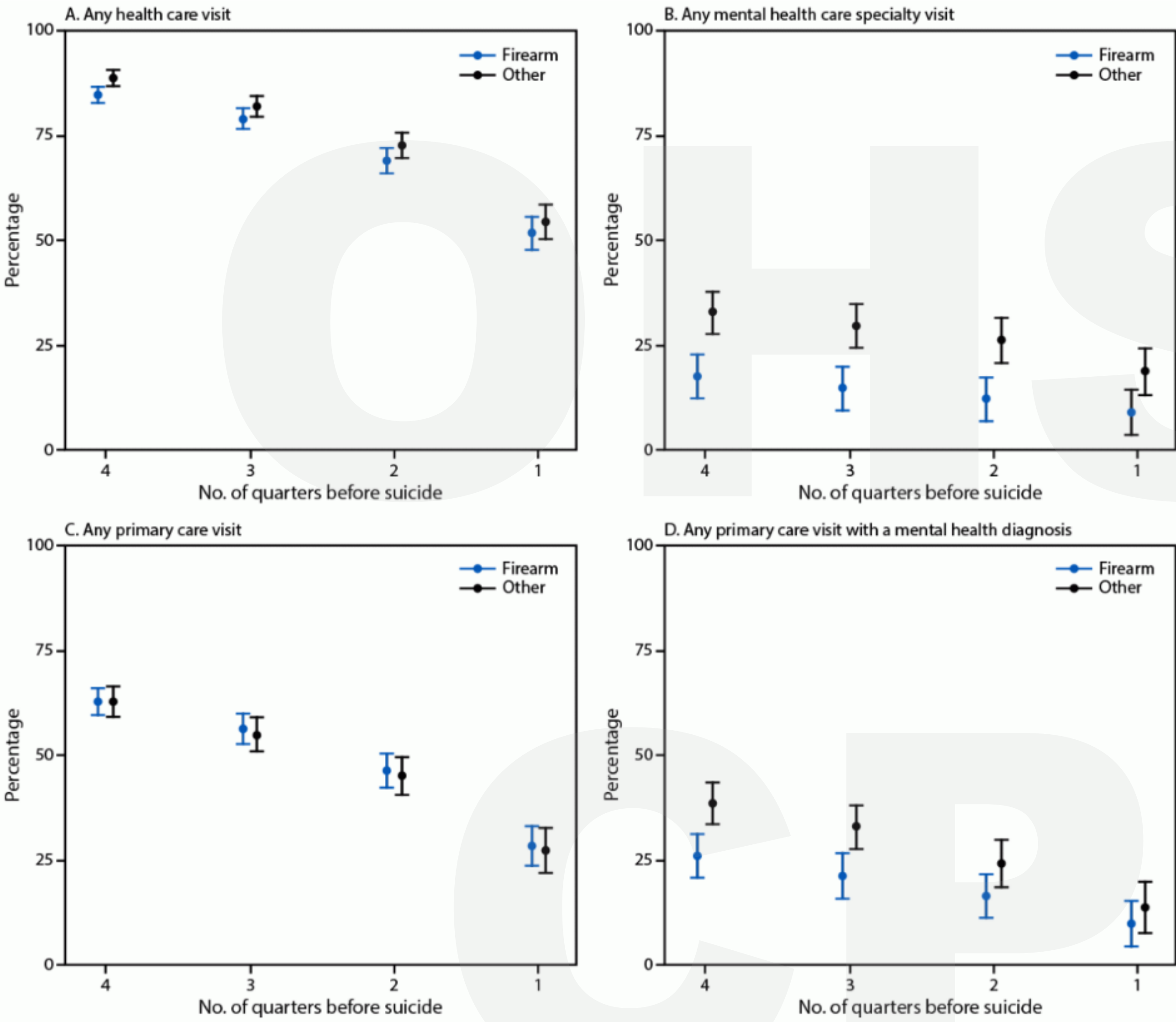
Much of primary care is mental health care



Source: Rotenstein S et al 2023 Health Affairs "Adult Primary Care Physician Visits Increasingly Address Mental Health Concerns"
N=108,898 visits, weighted sample representing 3.89 BILLION visits, National Ambulatory Medical Care Surveys 2006-2018



- Source: CDC.gov
- Angerhofer JE et al. Health Care Use Preceding Suicide by Firearm Compared with Suicide by Other Means — Alaska, Colorado, and Washington, 2020–2022. MMWR Morb Mortal Wkly Rep 2025;74:365–371.
  DOI: http://dx.doi.org/10.15585/mmwr.mm7421a2

Primary Care is front line in behavioral health care

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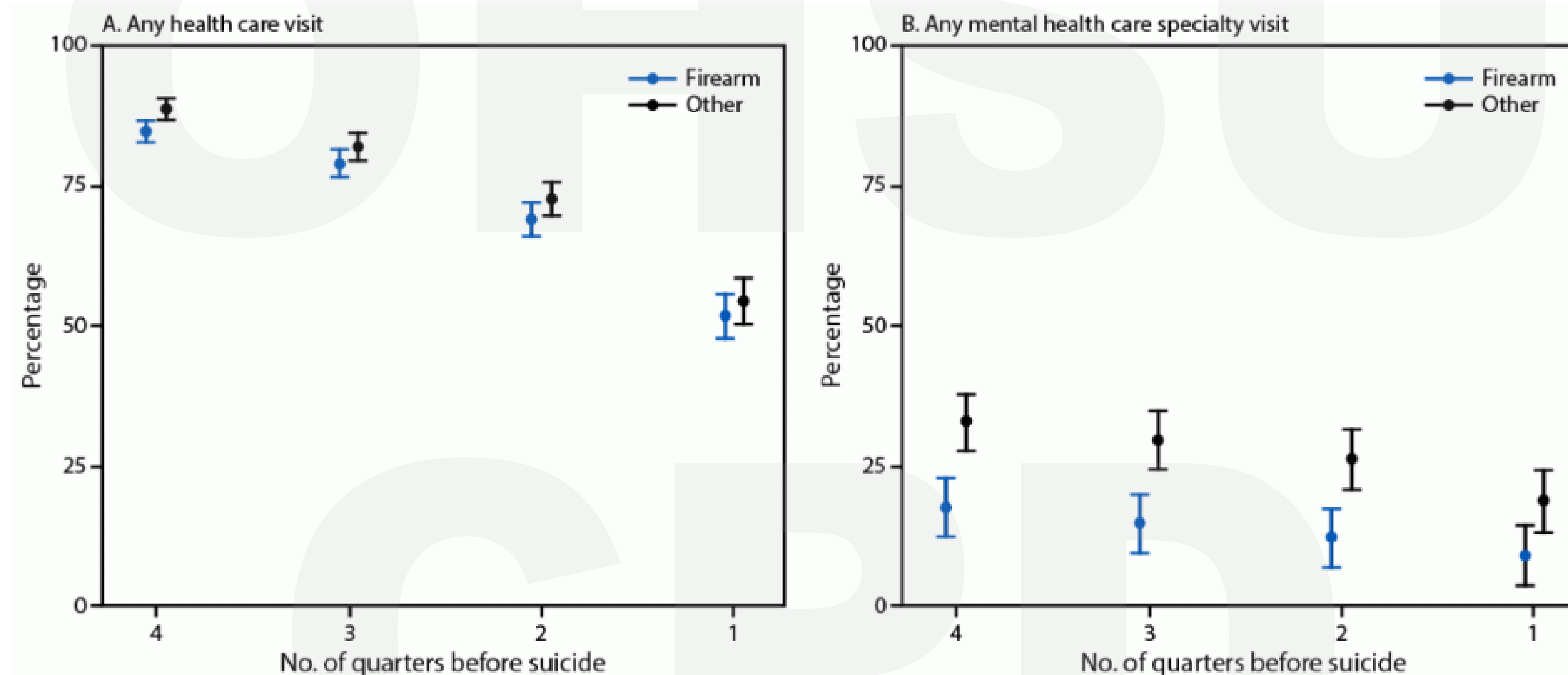

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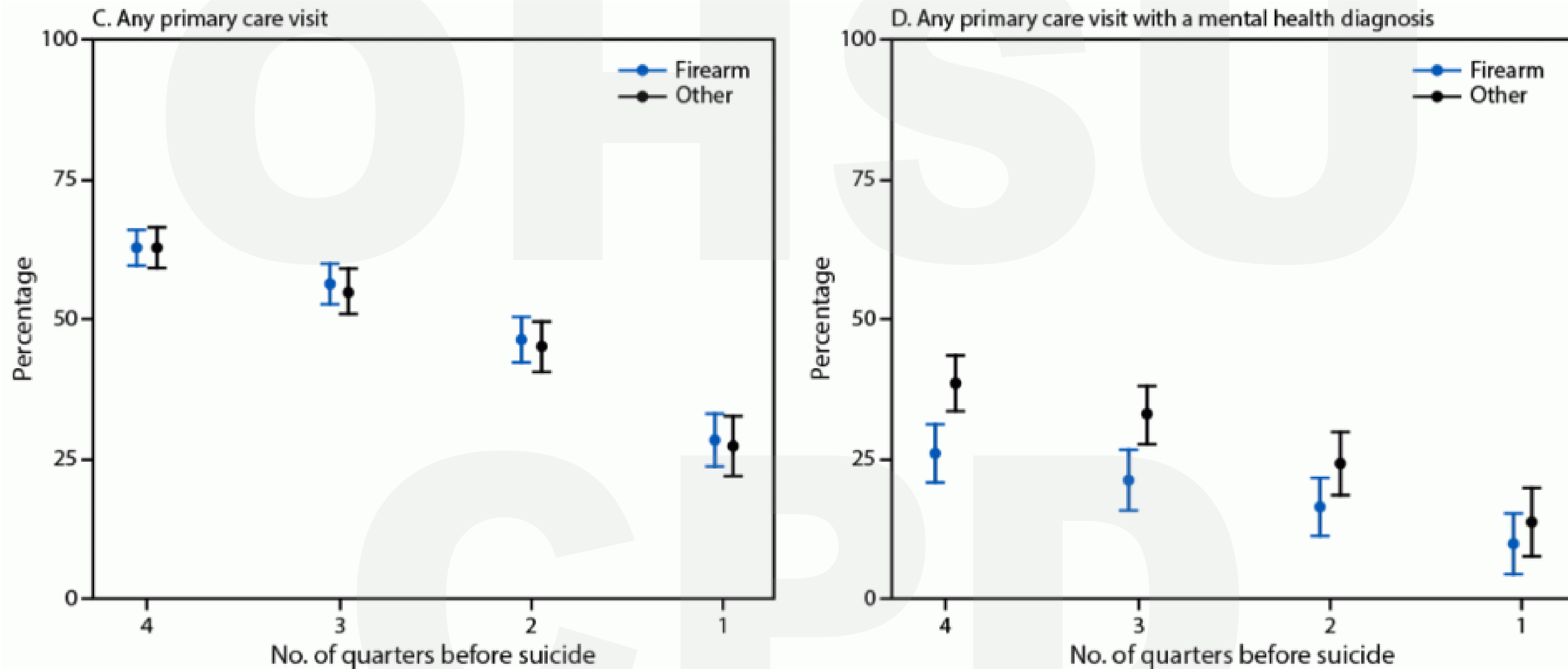

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Primary Care & Behavioral Health

A need for team coordination

OHSU CPD

Primary Care Skills in PWSMI

SCREENING & PREVENTATIVE CARE

CHRONIC DISEASE MANAGEMENT

POLYPHARMACY REVIEW

LIFESTYLE COUNSELING

OHSU CPD

Behavioral Health Skills in PWSMI

OHSU CPD

DIAGNOSIS OF SMI

PHARMACOLOGICAL MANAGEMENT

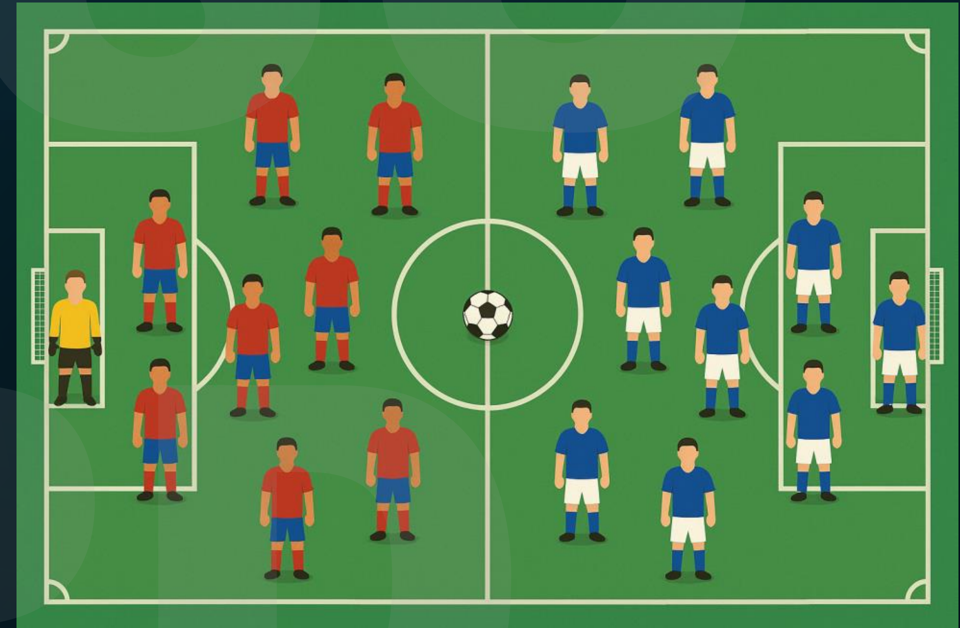
PSYCHOTHERAPY

POLYPHARMACY REVIEW

Care coordination for ALL…but it’s not that simple

Ever feel like you’re the only one on the team?

Team Effort or Team *Efforts*?



Why is coordination hard?

Multifactorial challenges

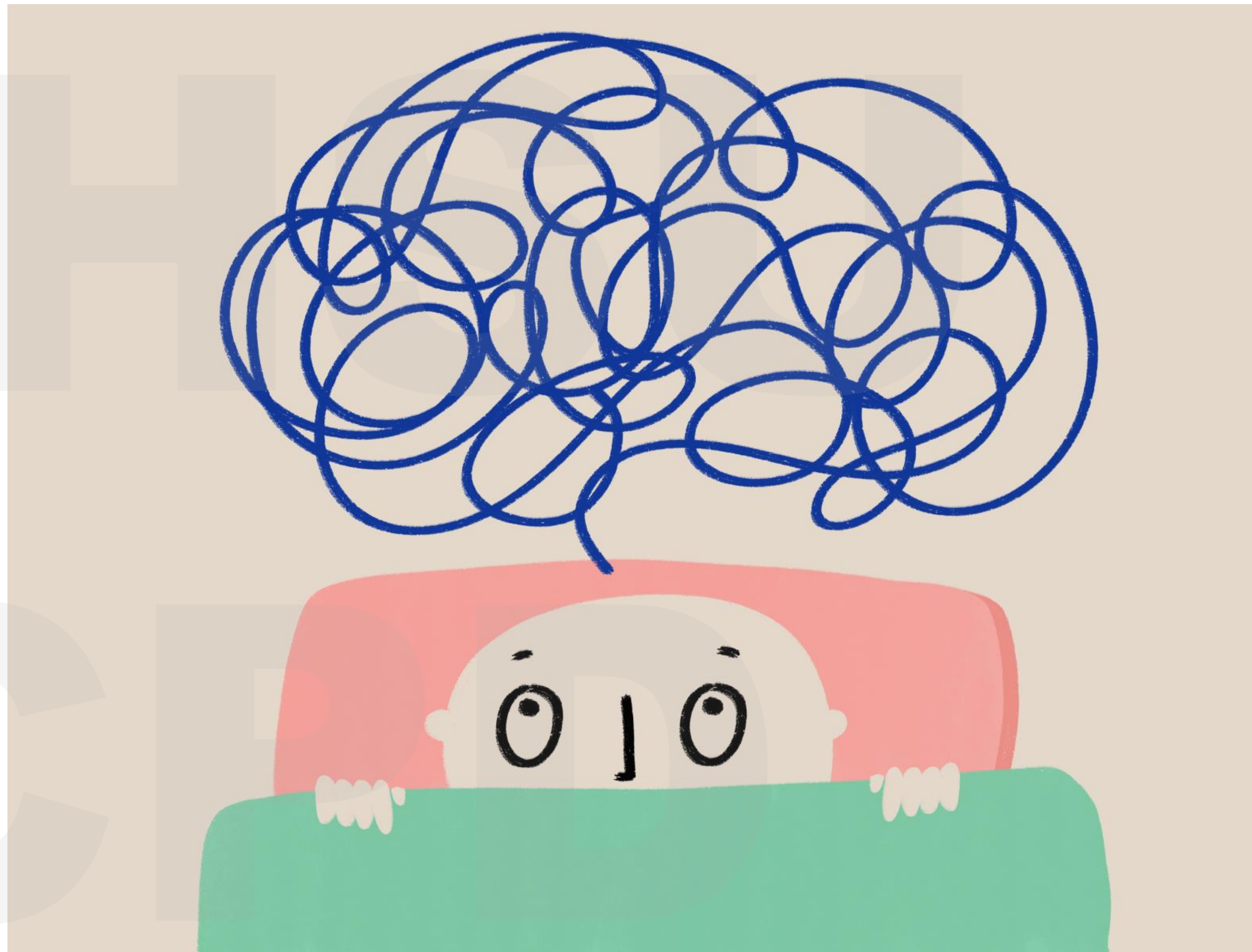
Think of a time when coordinating care was challenging…

Brain Challenges

Executive Function is Impaired!

Problem solving, planning, follow through....

Executive Function Challenges + Complex Care...



Insufficient Support and Patient “Blame”

Did you tell your PCP about the medication we changed last month?

Can you tell your psychiatrist that I’m worried about your memory on these benzos?

Why haven’t you scheduled your mammogram, DEXA scan, colonoscopy, and physical therapy appointments yet?

Can you ask your PCP if they have any concerns about starting this antidepressant?

Health System Challenges

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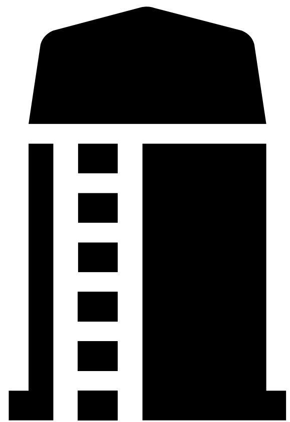
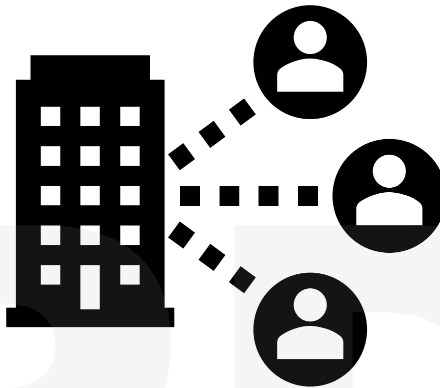
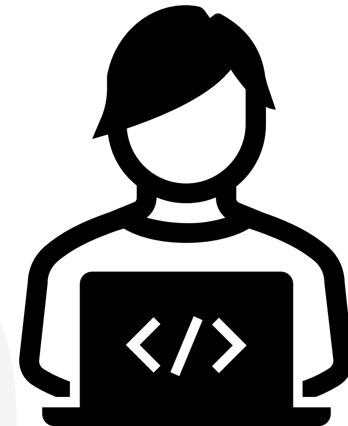
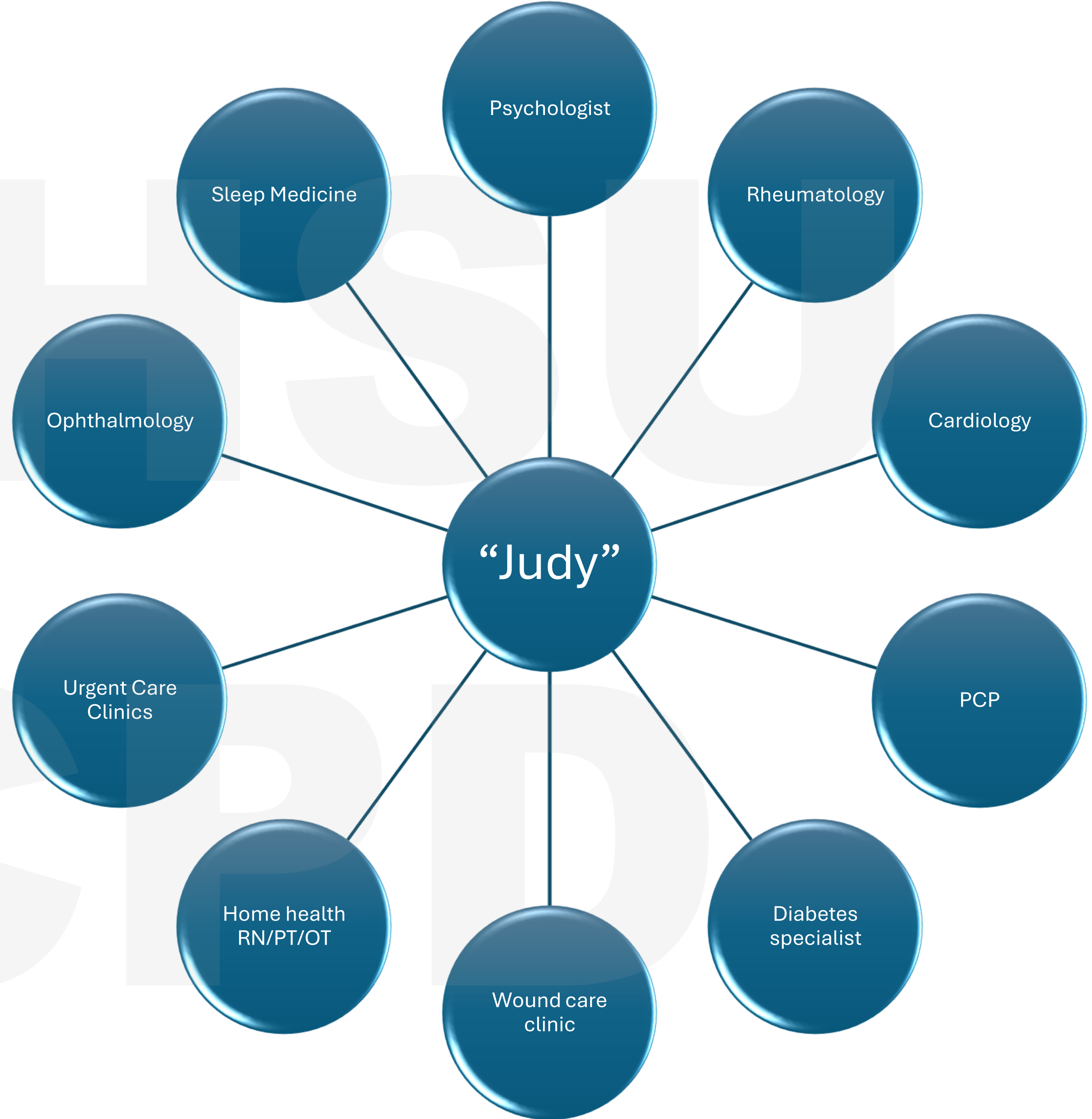


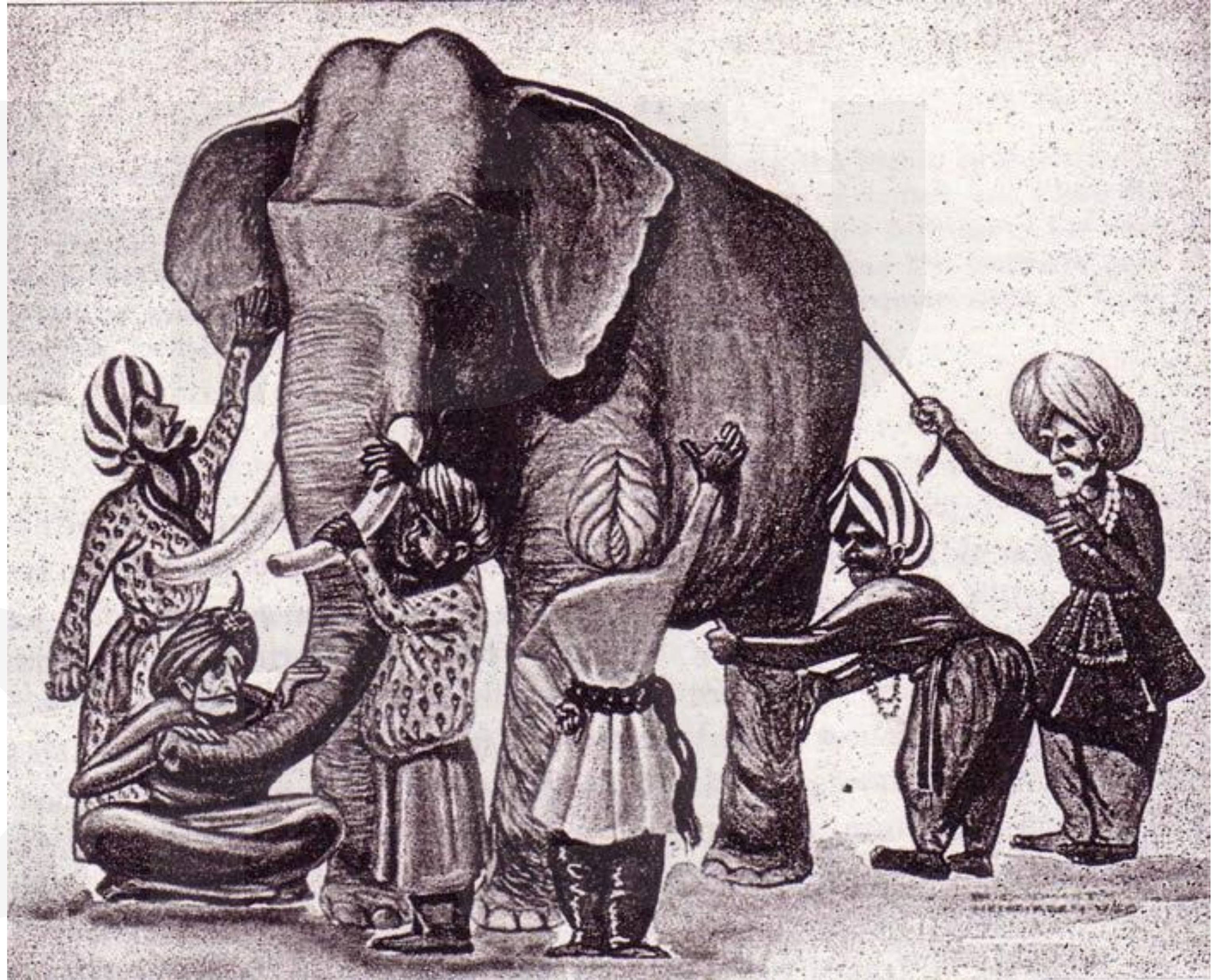




Health System Fragmentation



Team Member Perspective Challenges



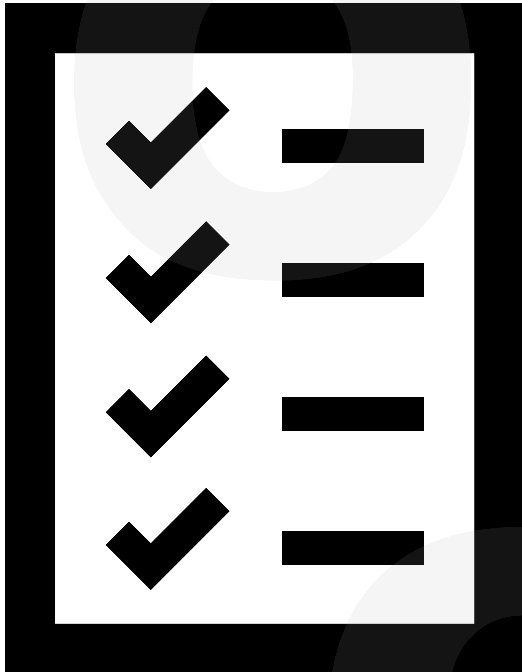
https://www.cltruth.com/2015/the-blind-men-and-an-elephant/

Provider Discomfort Challenges

We are really comfortable with the things we're really comfortable with

When we are not comfortable, we punt to someone else

Provider discomfort with "What am I allowed to know? What am I allowed to read?"



Summarizing Coordination Challenges

- Consider how well patients care coordinate on their own
- Our system isn't idealized for communication
- We see the same patient but not the same conditions/concerns
- ***For all these reasons, older adults with SMI need active care coordination between each other***

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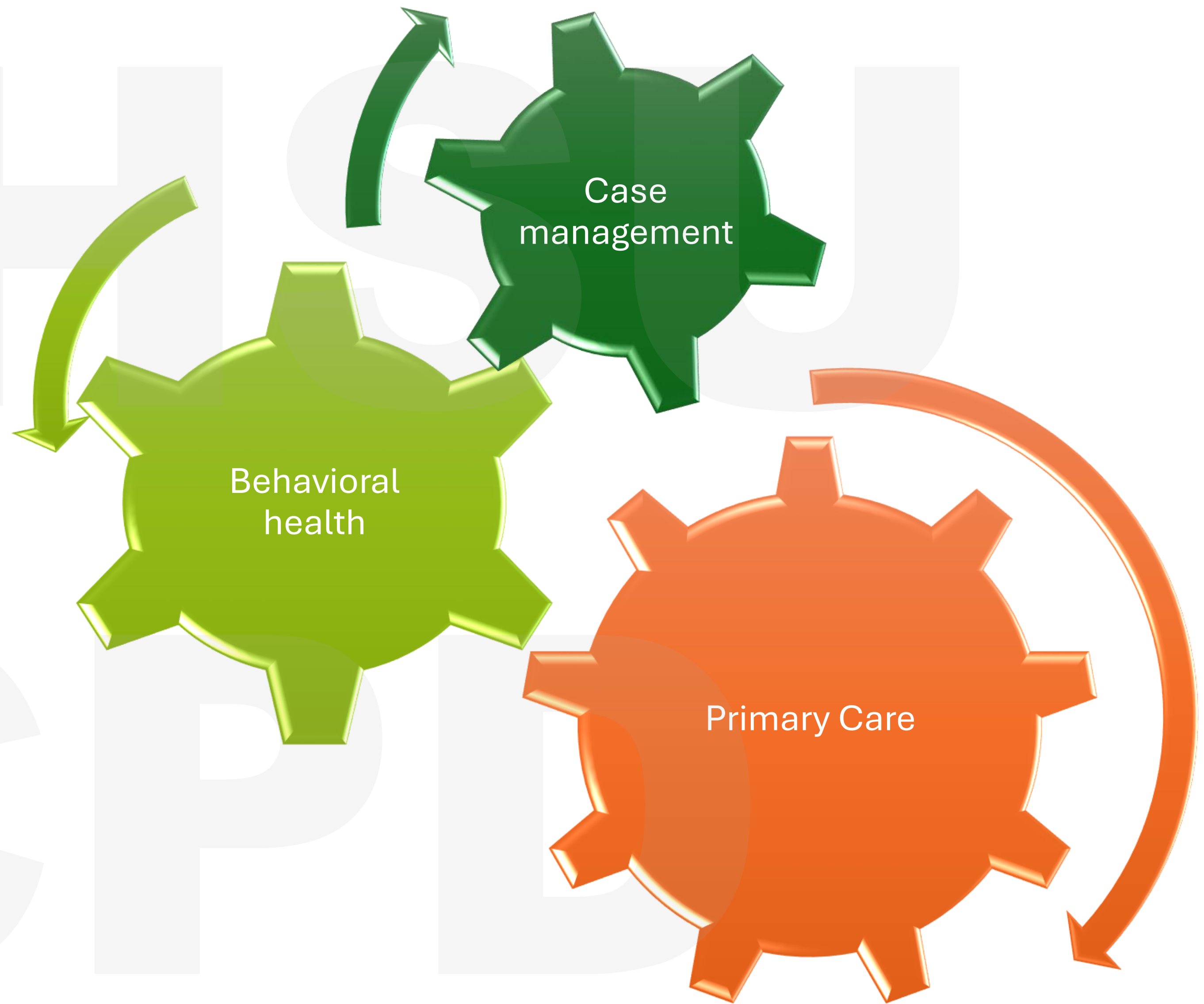
How do we make this better?

Steps to improve coordinating care

The Idealized Solution: Integrated Care



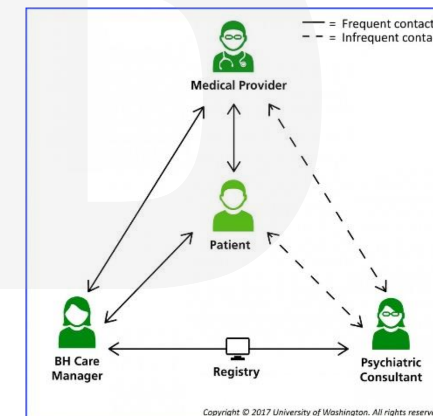
Integrated Care

Co-location

Primary Care Behavioral Health (PCBH)

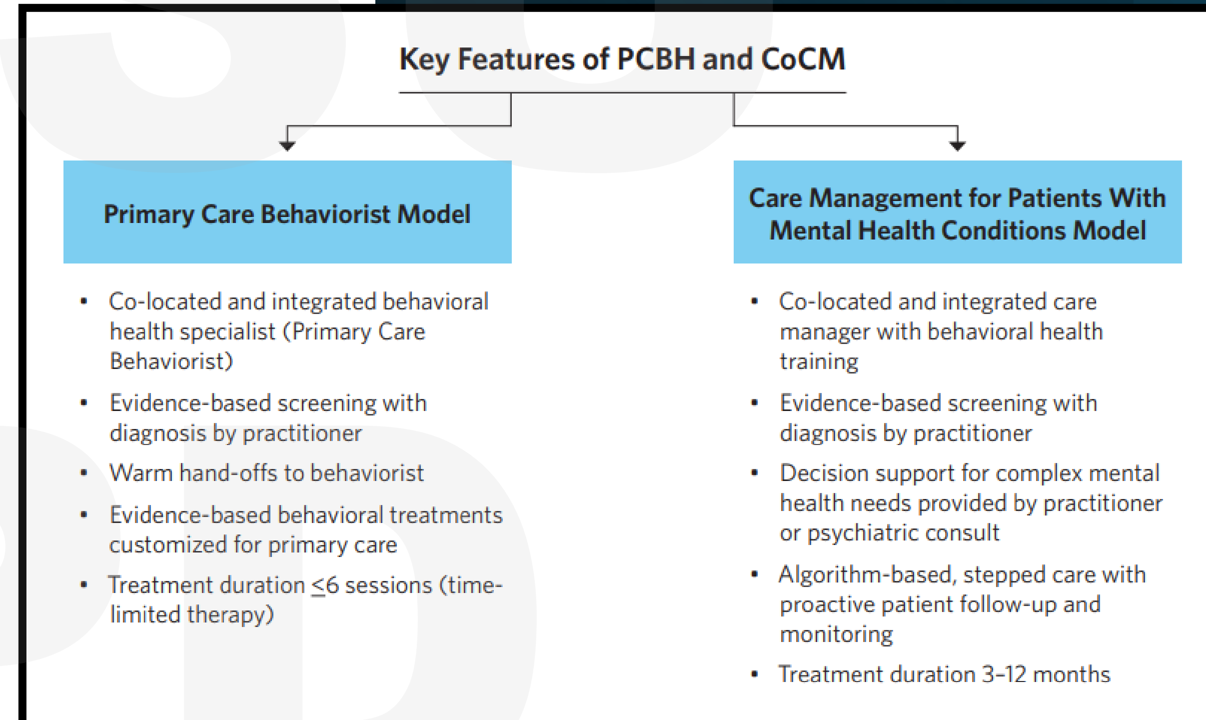
Consultation

Collaborative Care Model



APA: Behavioral Health + Primary Care Integration

- Two primary models through APA:
  - Primary Care Behavioral Health Model (PCBH)**
  - Collaborative Care Model (CoCM)
- Integration of BH with PCP
  - Improved patient/family experience
  - Better guideline-derived outcomes
  - More cost-effective
  - Improved provider experience
  - More supportive team environment



American Psychological Association (APA), *Factsheet: Behavioral Health Integration*, 2022.

BH and PCP Integration: Cost Savings

BH specialists embedded to treat a wide range of BH conditions at 6 PCP sites in Western NY found that PCBH integration model is associated with:

14.5% reduction of ED visits.
12% reduction in PC provider visits.
7.5% increase in BH specialist visits.

Maeng et al., 2022

Slide courtesy of Dr. Walt Dawson

AMA: Behavioral Health Integration

BHI Workflow Example:

Care Team On-site Initial Visit (Co-Location or Integrated Care Model)

Screening for BH may take place at home prior to scheduled appointment

Admin — **Patient Arrives for Scheduled Appointment**
- Patient checks in for appointment
- Patient signs BH treatment consent form

MA — **Screening for BH (In-Office)**
- Patient completes PHQ-2 and, if indicated, a PHQ-9
- New patients complete PRIME-MD
  - *May administer PHQ-9 (not the PHQ-2), GAD-7, YBOCS, AUDIT-C, or battery of questions to assess BH at yearly physical*

MA — **BH Positive Indication**
- Screener(s) reviewed
- PCP is informed of problematic symptoms
  - *Communicated in-person or via EMR, depending on practice preference*

PCP — **BH Negative Indication**
- Proceed with appointment
- Re-screen with PHQ-2 every visit and, if indicated, a PHQ-9

PCP — **Discussion with Patient**
- Discuss patient behaviors, symptoms, functional impairments, past medical history (PMH), drug history (DH), family history (FH) and social history (SH)
- Review status/diagnosis with patient and/or caregiver, and recommend BHI services and treatment

PCP — **Proceed with BHI Handoff**
- Patient signs BH treatment consent form, if not signed earlier
- Warm handoff to BH specialist, if available

PCP / BHS/CC — **Seek Higher-Level Care for Patients in Immediate Risk or with Complex/Severe Cases**
- BH specialist and PCP develop a treatment plan with patient while higher-level care is sought
- Use referral list to contact appropriate level of care
- Patient signs "Release of Information" form
  - *Interventions may include an IOP (Intensive Output Program), PHP (Partial Hospital Program), Input psych unit or withdrawal management*

BHS/CC — **BH Coordination and Collaboration of Care**

LEADER OF ACTION STEP
- Primary Care Admin
- MA
- Patient
- PCP
- BH specialist/care coordinator
- BH billing/coding specialist

CRUCIAL ACTIVITY STEPS
- Billing/Coding Action Required
- Documentation in EHR/ Registry Required

Level 1: **Minimal Collaboration**	Level 2: **Basic Collaboration at a Distance**	Level 3: **Basic Collaboration On-site**	Level 4: **Close Collaboration On-site**	Level 5: **Close Collaboration**	Level 6: **Full Collaboration**
Care is delivered in separate facilities with separate systems; communication is infrequent and typically initiated only under compelling circumstances driven by physician and other clinician needs; understanding of the others' roles is limited.	Behavioral and non-behavioral health clinicians practice in separate facilities with separate systems; periodic communication about shared patients is driven by patient issues; there is appreciation of other physicians' and other clinicians' roles as resources.	Physicians and other clinicians practice in the same facility but not necessarily in the same offices. Although they have separate systems, they communicate regularly about shared patients due to the need for each other's services and referrals.	Physicians and other clinicians practice in the same facility with some shared systems, such as scheduling and medical records. They collaborate through consultation, co-create coordinated care plans for patients, and interact face-to-face about shared patients on a regular basis.	Physicians and other clinicians are in the same facility with some shared space and identify delivery system challenges and implement system solutions together. They collaborate via frequent in-person team meetings to discuss patient care and specific patient issues and have an in-depth understanding of others' roles and culture.	Physicians and other clinicians are in the same facility and share all practice space, functioning as one integrated team. There is consistent communication at the team and individual levels, and collaboration is due to a shared concept of optimal health care. The roles and cultures of care team members blur or blend together.

AMA, Integrated Care Spectrum, Behavioral Health Integration Compendium, 2024

Varied degrees of collaboration

But....these require a huge lift

Table 3. Advantages and Weaknesses at Each Level of Collaboration/Integration

COORDINATED		CO LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Weaknesses					
Services may overlap, be duplicated or even work against each other; Important aspects of care may not be addressed or take a long time to be diagnosed	Sharing of information may not be systematic enough to effect overall patient care; No guarantee that information will change plan or strategy of each provider; Referrals may fail due to barriers, leading to patient and provider frustration	Proximity may not lead to greater collaboration, limiting value; Effort is required to develop relationships; Limited flexibility, if traditional roles are maintained	System issues may limit collaboration; Potential for tension and conflicting agendas among providers as practice boundaries loosen	Practice changes may create lack of fit for some established providers; Time is needed to collaborate at this high level and may affect practice productivity or cadence of care	Sustainability issues may stress the practice; Few models at this level with enough experience to support value; Outcome expectations not yet established

SAMHSA-HRSA Center for Integrated Health Solutions

Time, space, commitment, and enough primary care and BH providers

OPCA Resources for Integrated Care

Oregon Behavioral Health Integration Toolkit

A resource for Oregon's Community Health Centers.

Selecting a Delivery Model to Implement

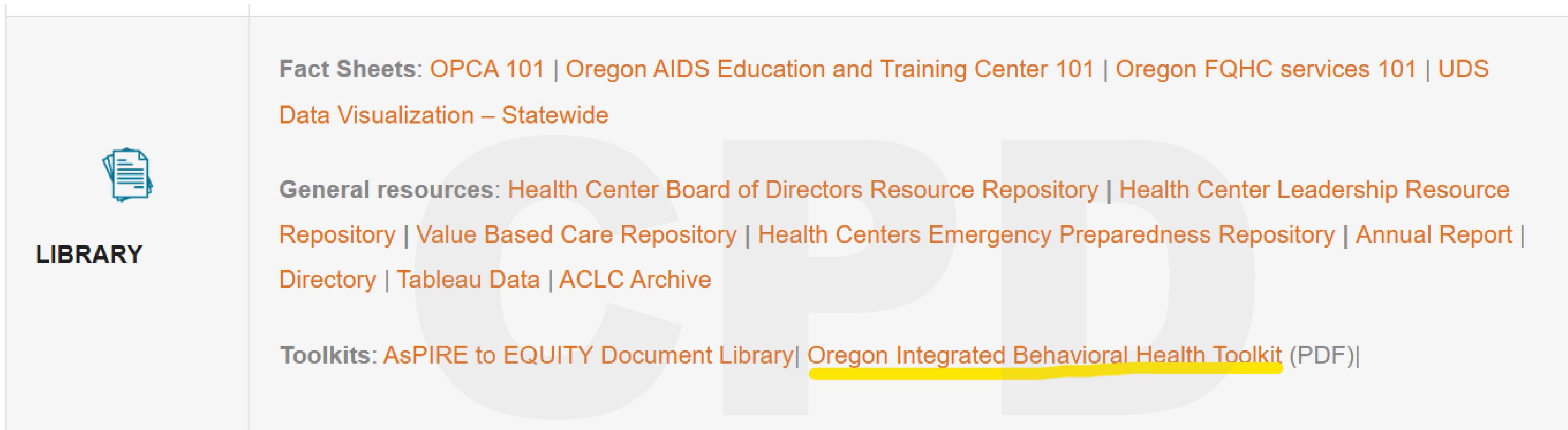
Co-located specialty Behavioral Health	Collaborative Care Management (CoCM)	Primary Care Behavioral Health/ Integrated Behaviora Health Alliance- Patient Centered Primary Care Home Standards
•On-site referral from Primary Care Physicians for ongoing therapy for patients w/ diagnosed mental health and substance use disorder conditions	•Intensive care management for patients with specific behavioral health conditions •Primary Care Physican support from a consulting psychiatrist/ Psychiatric Mental Health Nurse Practitioner •Registry management and treat-to-target approach	•Integrated team-based care for a broad range of patient concerns, including prevention and early intervention and behavioral medicine •Focus on same day warm hand-offs and other high-value services

Staffing Ratios

Patient Centered Behavioral Health/ Integrated Behavioral Health Alliance	Collaborative Care Management	Co-located specialty Mental Health/ Substance Use Disorder
Recommend minimum 1:6 Full-Time Equivalent Behavioral Health Clinician per Primary Care Physician	60-100 patients per 1.0 Full-Time Equivalent Behavioral Health Care Manager (but depends on patient complexity)	30-100 patients per 1.0 Behavioral Health Clinician Full-Time Equivalent

https://orpca.org/wp-content/uploads/2026/01/Oregon-IBH-Toolkit.Final_-1.pdf

Accessing the IBH Toolkit



https://orpca.org/opca-member-portal/

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So, let's talk about some practical strategies for the real-world

What would you do?

82-year-old woman w/ anxiety and osteoporosis, living in independent living

- Increasing cognitive decline, falling, vague sensory distortion symptoms
- Prescriptions for clonazepam and alprazolam from Psychiatrist out of state
- PCP call to Psychiatrist
    - "She's been on this for years she sounds fine on the phone"

-->How would you proceed?

-->How can we help this patient?

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Oregon's Coordination Resources

Care Coordination Services Team

YOU

Your Care Coordinators

Primary Care Providers

Mental Health Providers

Specialists

Pharmacies

Social Services

- Coordinates outpatient mental health and SUD w/ physical health care services
- Coordination with primary care and transitions to integrated care settings

Regional Care Teams (Tri-County Region)

Find a Provider Your Benefits

Coordinated care

Cascade Health Alliance

Home \ For Members \ Member Benefits \ Care Coordination Services

Care Coordination Services

MEMBERS PROVIDERS ABOUT

UMPQUA HEALTH MEMBERS

Care Coordination Services

Amazing care managers!

How have your care managers helped coordinate care plans for your patients/clients?

Do your patients have one for primary care and behavioral health?

David's Coordination & Communication Pearls

- Patients do better when we treat them as whole people
- Face to face conversation works best
- Real time is better than communication that lags
- Be OK with interrupting busy days
- Be persistent!
- Creativity counts
- Instructions no more complicated than 6th grade reading level
- Consider regularly scheduled coordination conversations

Avoid relying on patients to communicate with other providers

Laura's Coordination & Communication Pearls

No one reads the notes

Seriously, no one reads them

If someone reads the note, they likely will still miss the nuances

Rely on active communication when it matters

Straight from the provider's mouth

"Don't assume the chart is being read..."

"I've learned I need to write nuanced questions if I want a nuanced answer"

"Some form of exchange of information is critical for good care"

"I relentlessly give out my cell phone number"

"Don't 'assume' that we're managing something"

"I love engaging with PCPs. But it's hard if I reach out to a PCP and then get crickets—I wouldn't call if I didn't want to talk with them"

Laura’s personal hierarchy of communication

Phone call w/ cell number (“I need to talk with you, this is complex, worrisome, or unsafe”)

Epic message/Teams message (“I need an answer to this question or advice on this situation in the next 24 hours”)

Routed Epic encounter w/ specific question (“There’s just this one thing I want you to consider…”)

Note in chart (“Nothing changed, nothing to report, you can basically disregard because I would have messaged you if important”)

Communication “Buckets”

CONSULTING
ADVICE SEEKING/GIVING

COORDINATING
SEPARATE, BUT ALIGNED CARE DELIVERY

COLLABORATING
SHARED SENSE MAKING, DECISION MAKING

Cohen DJ et al, Integrating BH and PC: Consulting, Coordinating, and Collaborating among professionals, J Am Board Fam Med, 2015

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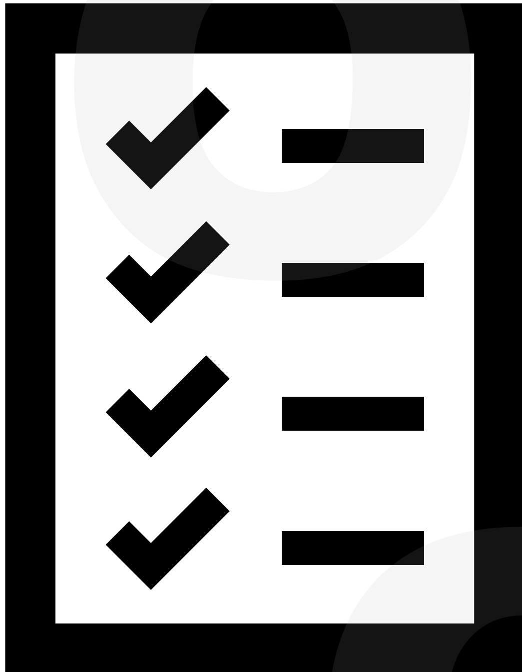

Summarizing Coordination Opportunities

- Integrated care is amazing
- In the meantime, **pick up the phone,** or some other formed of closed loop communication
- We should not rely on patients to communicate for us– we can do this!
- ***We can do better for our patients and each other!***

OHSU CPD

Be the neck!

OHS CPD

Thank you!

David Nagarkatti-Gude: nagarkad@ohsu.edu
Laura Byerly: byerlyl@ohsu.edu