

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



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Oregon Health & Science University

Adult Mental Health Update

March 6, 2026

Disclosures

- Drs. Betlinski and Byerly 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
- Dr. Betlinski serves as Principal Investigator for a project funded through HRSA's Telehealth Technology-Enabled Learning Program; his 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 Jon! (aka “the Psychiatrist”)

OHSU Department of Psychiatry

George Saslow Professor

Medical Director, OPAL-A

Clinical Advisor, Oregon ECHO Network

Principle Investigator, Heal Oregon

(HRSA TTELP grant)

Boards: Big Lake Youth Camp, CareOregon
Inc., Columbia Pacific CCO, NAMI Oregon



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

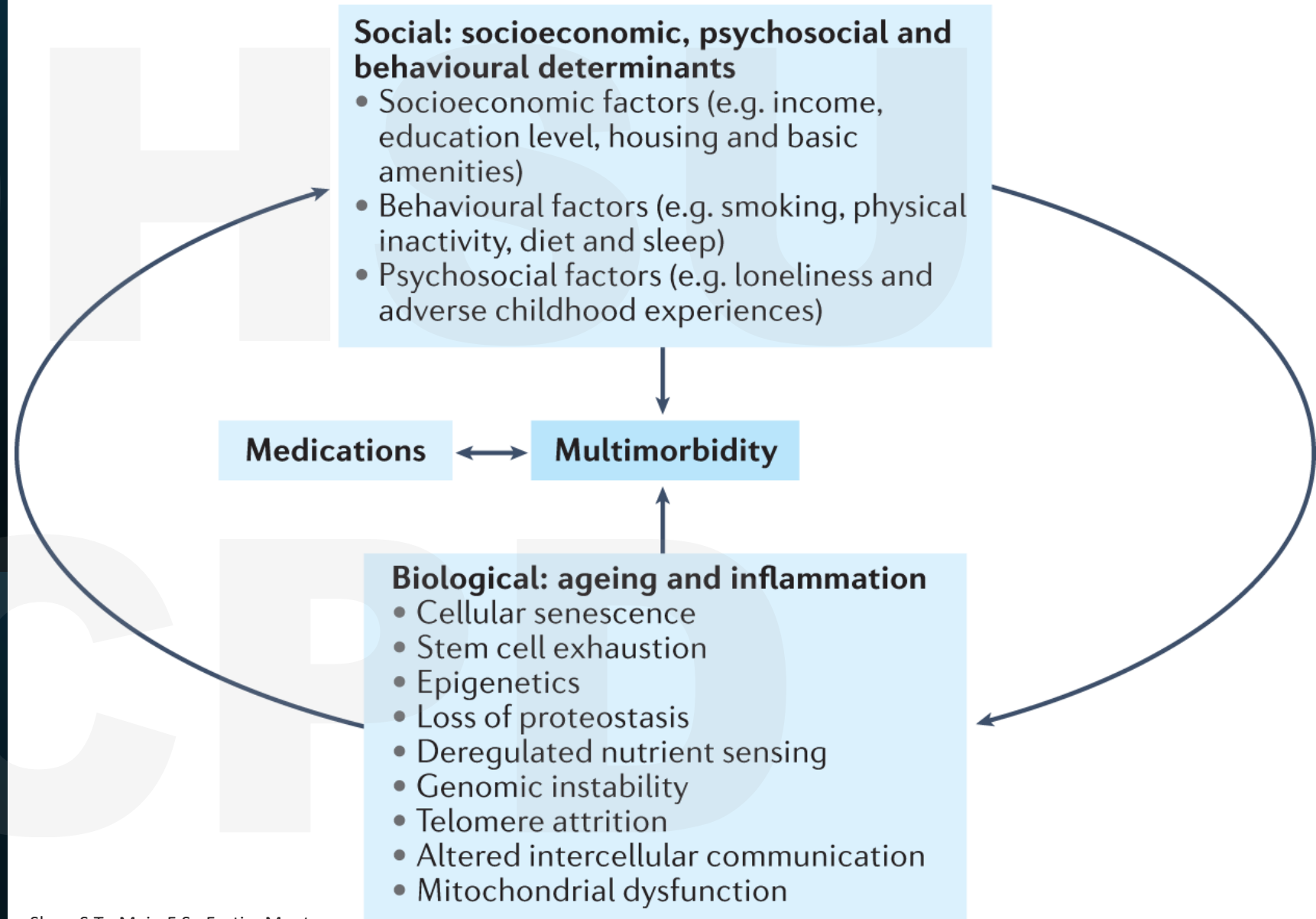
Lasting impacts of trauma

Multimorbidity definitions

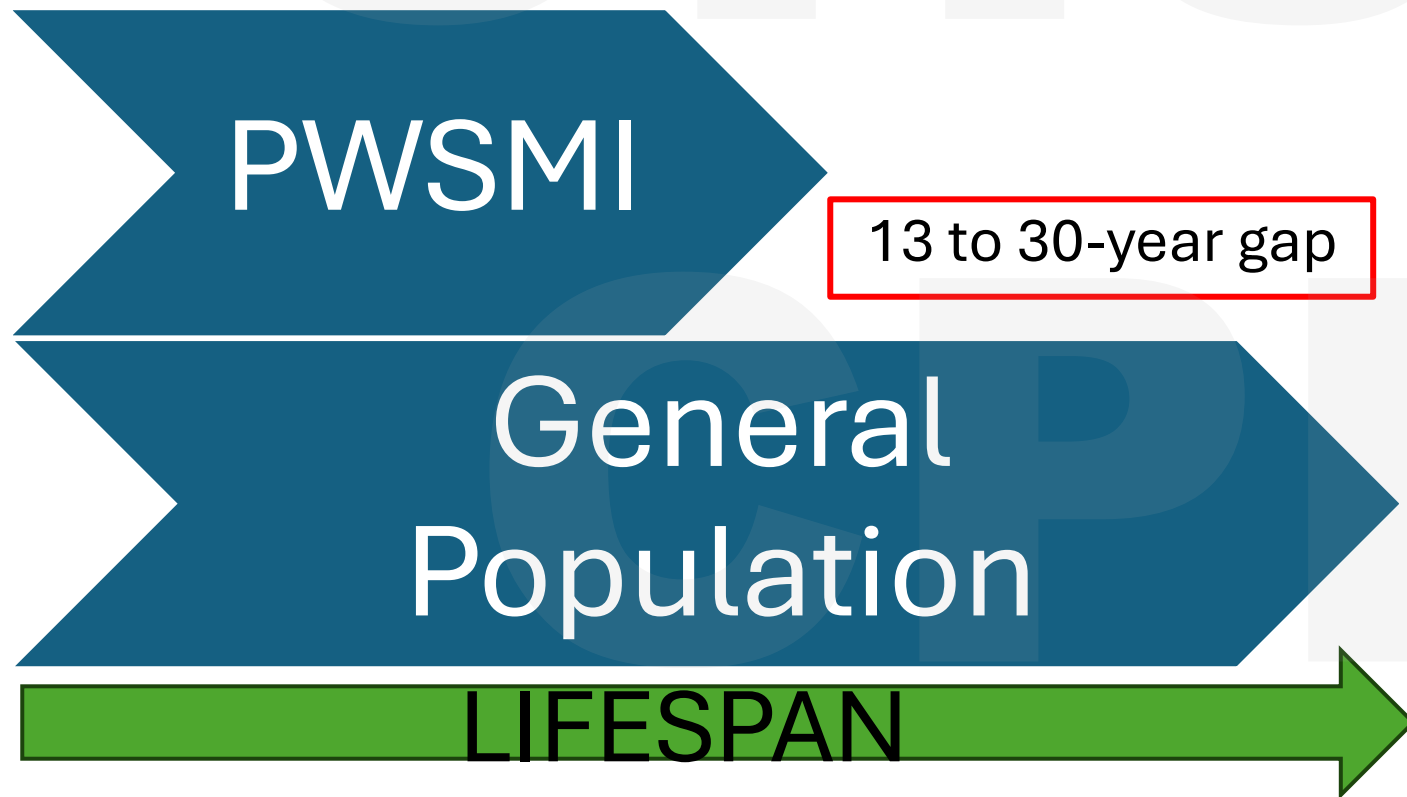
- **3* or more** chronic medical conditions that collectively have adverse effects on health, function, and quality of life.
- Requires **complex healthcare management, decision making, and coordination.**
- *“...having more than one condition, including a mental health disorder, translates into a higher 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



SMI and Multimorbidity: Lifespan Challenges



13 to 30-year gap

How many of you have seen this in practice?

What factors lead to this lifespan gap?

Chronic disease and SMI

Diabetes

Cardiovascular
disease

Hyperlipidemia

Elevated BMI

Tobacco use

Dementia

*80% with SMI have 1+
chronic conditions*

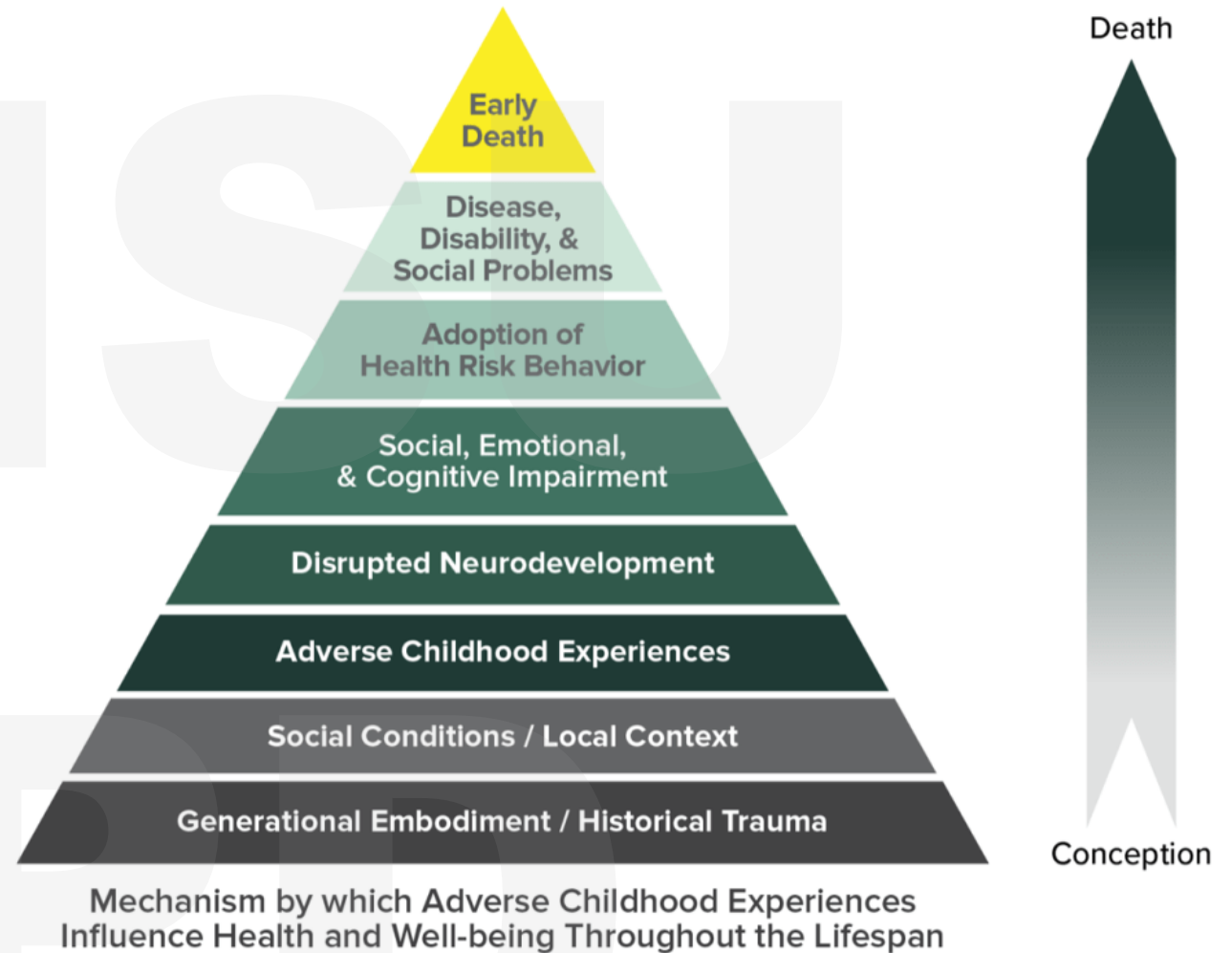
Dementia and Serious Mental Illness (SMI)

- **Higher prevalence (2x)** of dementia diagnosis in persons with SMI
 - People with Bipolar Disorder and Schizophrenia studied
 - More difficulties with **executive function**



The ACE Effect

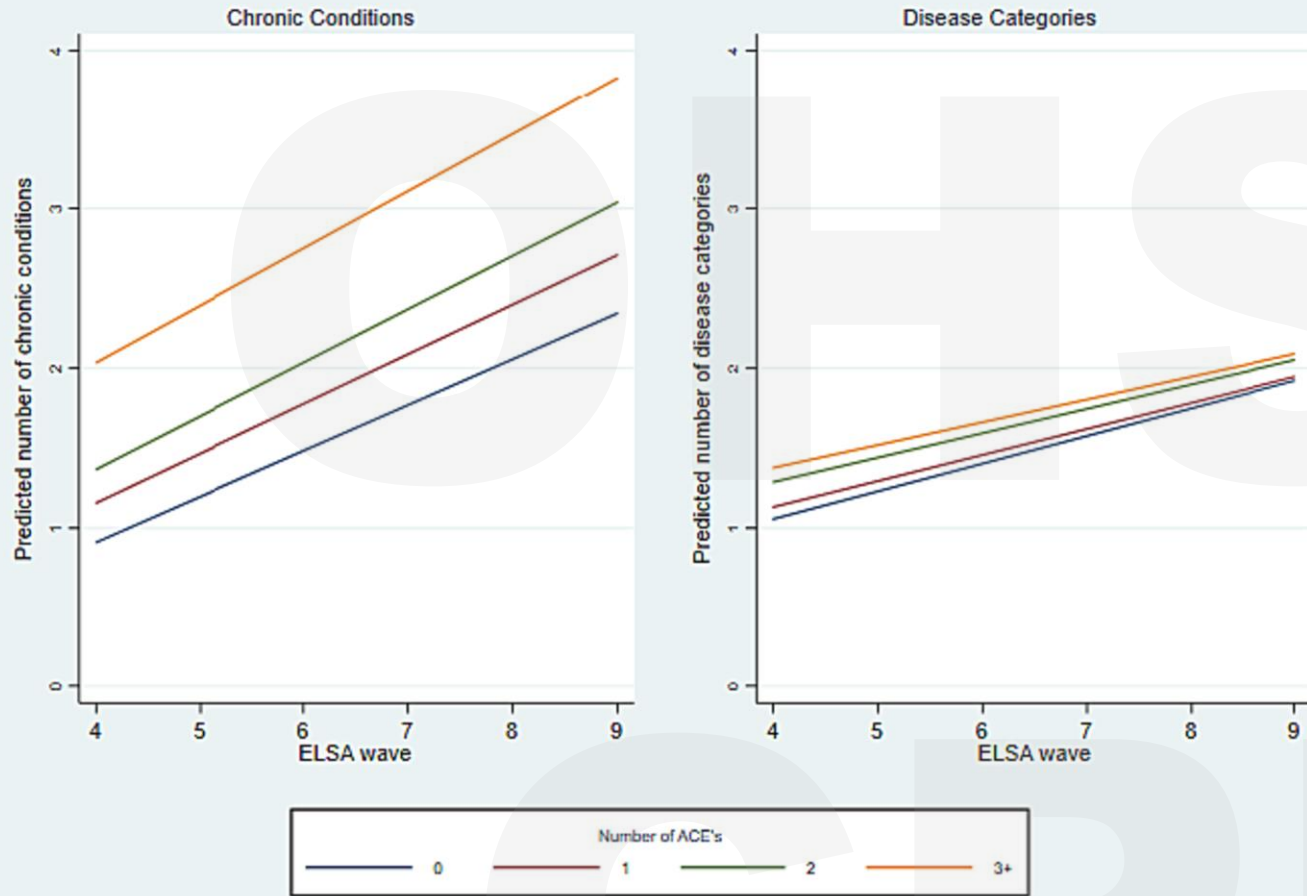
“One doesn’t ‘just get over’ some things” – Vincent Felitti, MD



This Photo by Unknown Author is licensed under [CC BY-ND](#)

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

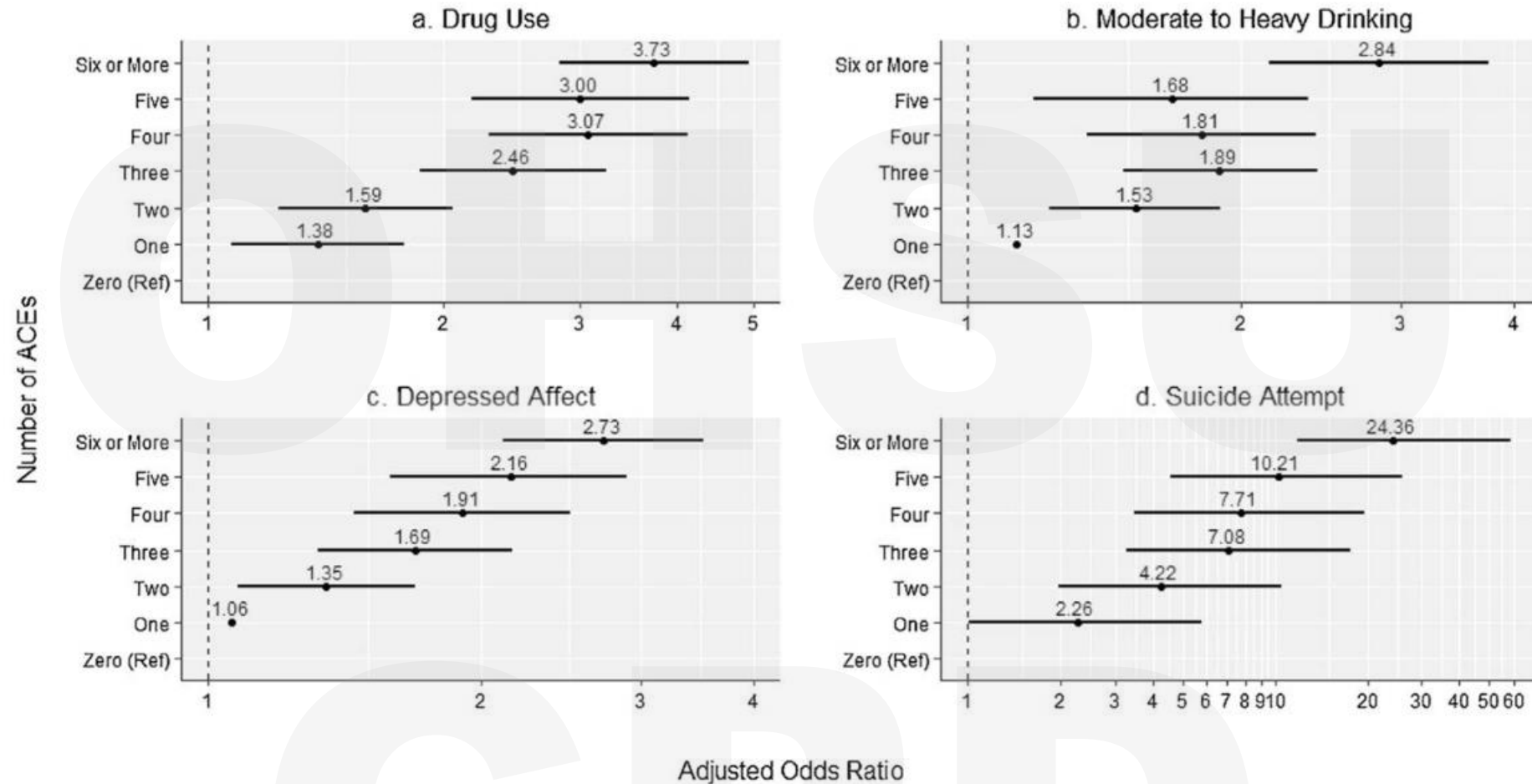
Trajectory of multimorbidity by ACE category



- 3+ ACEs triples the risk of 3+ chronic conditions
- Diseases had formed *prior* to age 50

Taylor and Demakakos, Child Abuse Negl, 2024

The ACE Effect on Multimorbidity in Adults



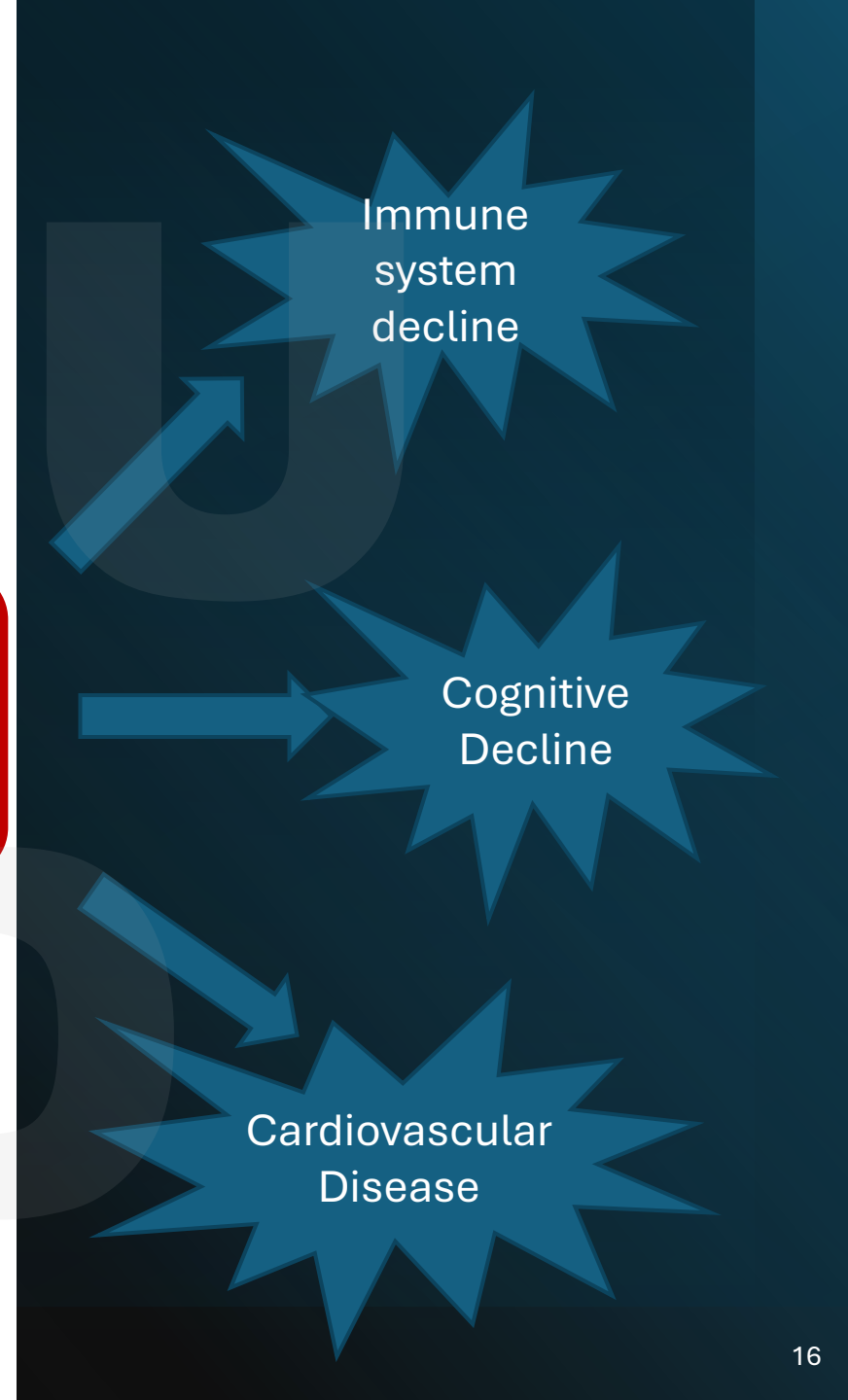
Merrick et al, Child Abuse Negl, 2017.

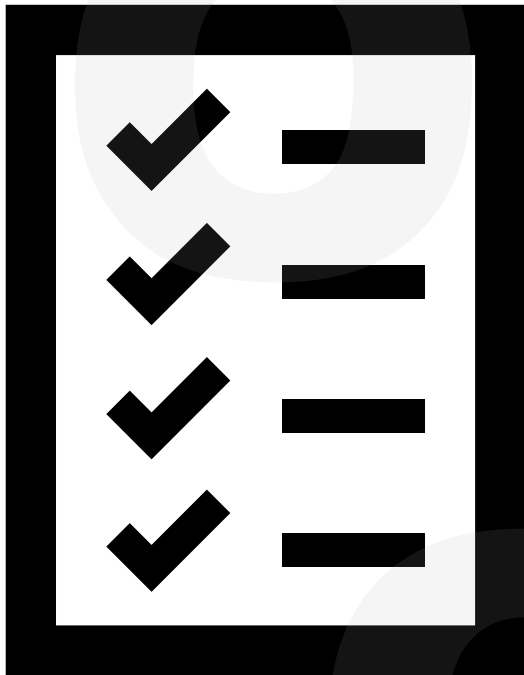
The ACE Effect on SMI in Adults

Accelerated Aging: Wear, Tear, and Inflammaging



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





Summarizing Multimorbidity and SMI

- Adults with SMI have likely experienced trauma
- Trauma along the lifespan changes how your brain develops
- The cells of people who have experienced trauma/stress age faster than their peers
- Aging cells lead to disease
- For all these reasons, older adults with SMI have a higher risk of multimorbidity
- ***For all these reasons, older adults with SMI have more healthcare coordination needs***

Primary Care & Behavioral Health



A need for team coordination

Primary Care Skills in PWSMI



SCREENING &
PREVENTATIVE CARE



CHRONIC DISEASE
MANAGEMENT



POLYPHARMACY
REVIEW



LIFESTYLE
COUNSELING

Behavioral Health Skills in PWSMI



DIAGNOSIS OF SMI



PHARMACOLOGICAL
MANAGEMENT



PSYCHOTHERAPY



POLYPHARMACY
REVIEW

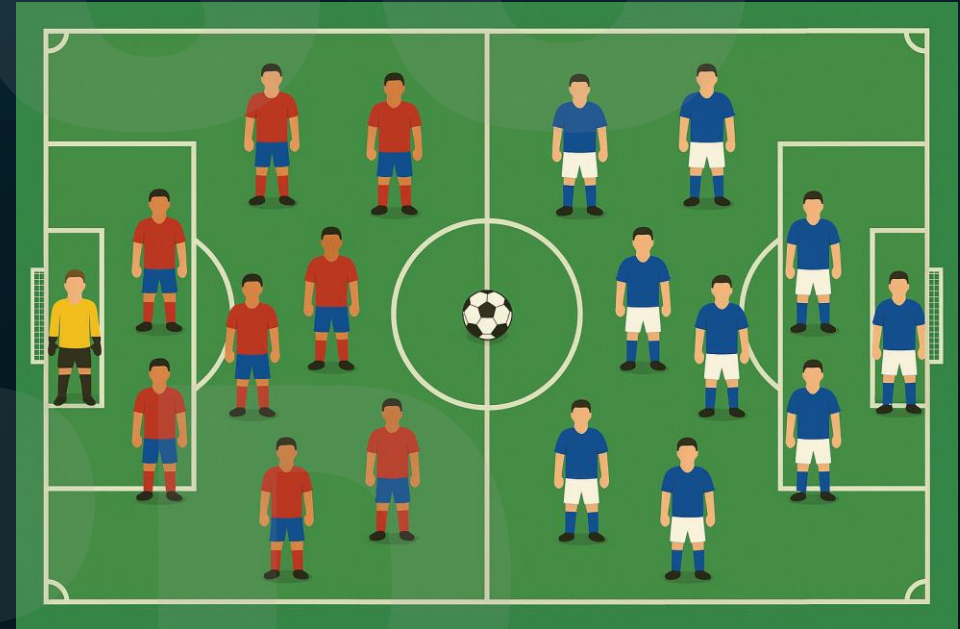
Care
coordination
for ALL...but
it's not that
simple



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



Team Effort or Team *Efforts*?



Why is coordination hard?

Multifactorial challenges



OHSU

*Think of a time when
coordinating care was
challenging...*

CPD

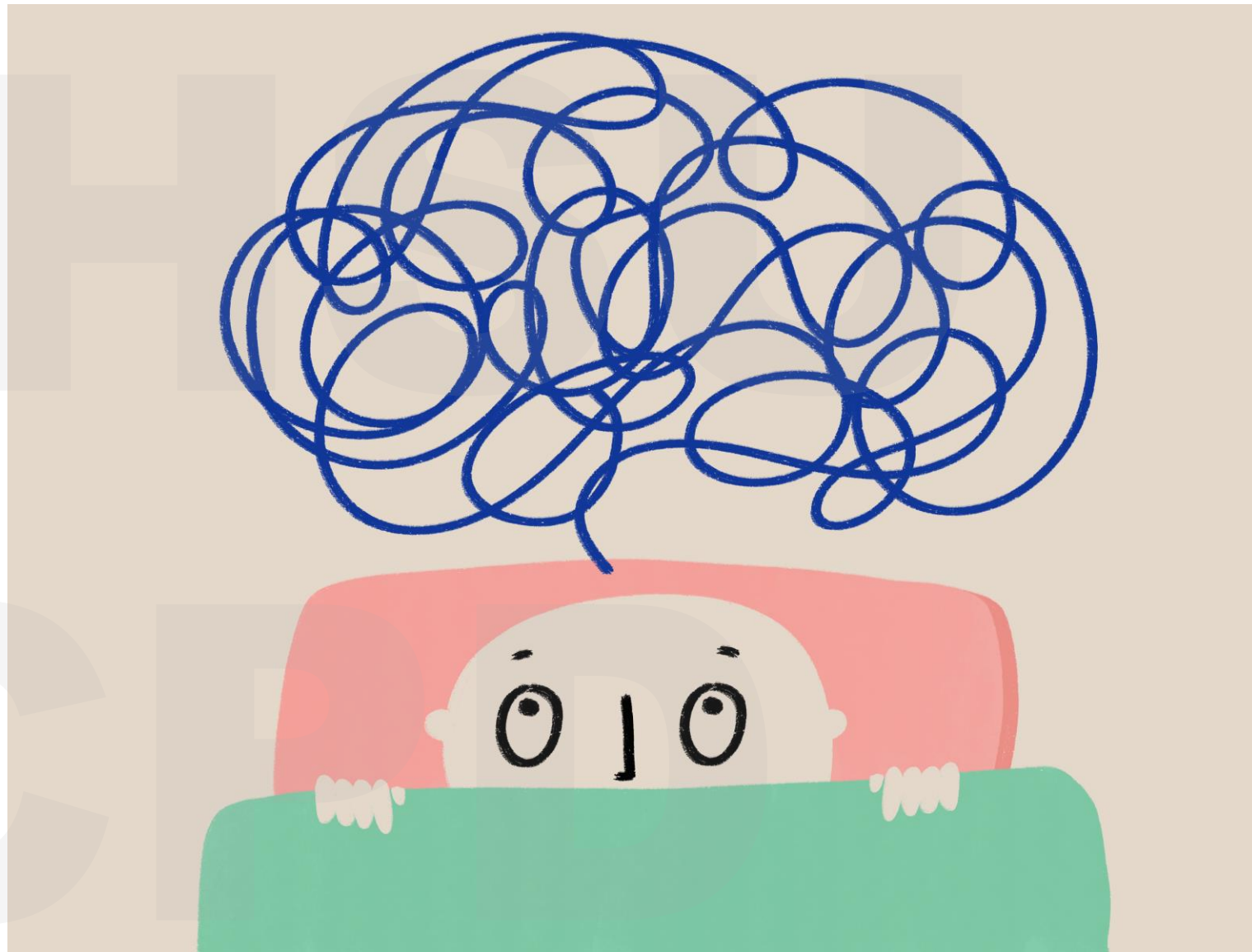
Brain Challenges

Executive
Function is
Impaired!

Problem solving,
planning, follow
through....



Executive Function Challenges + Complex Care...



Insufficient Support and Patient “Blame”

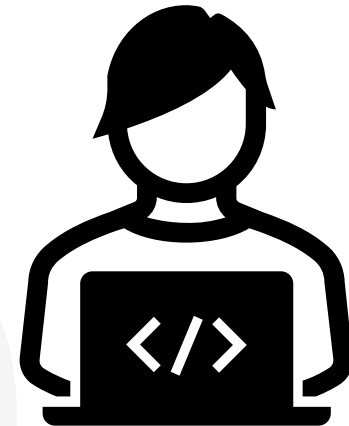
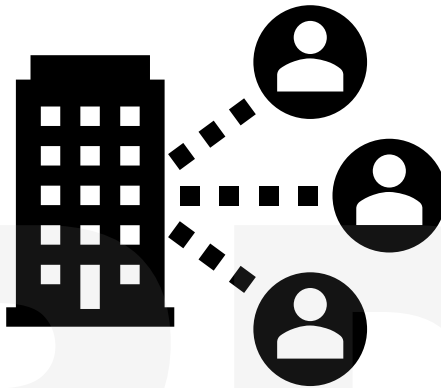
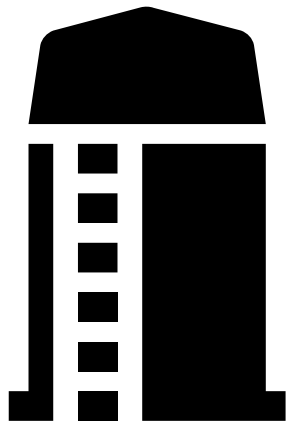
Did you tell your PCP about
the medication we changed
last month?

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

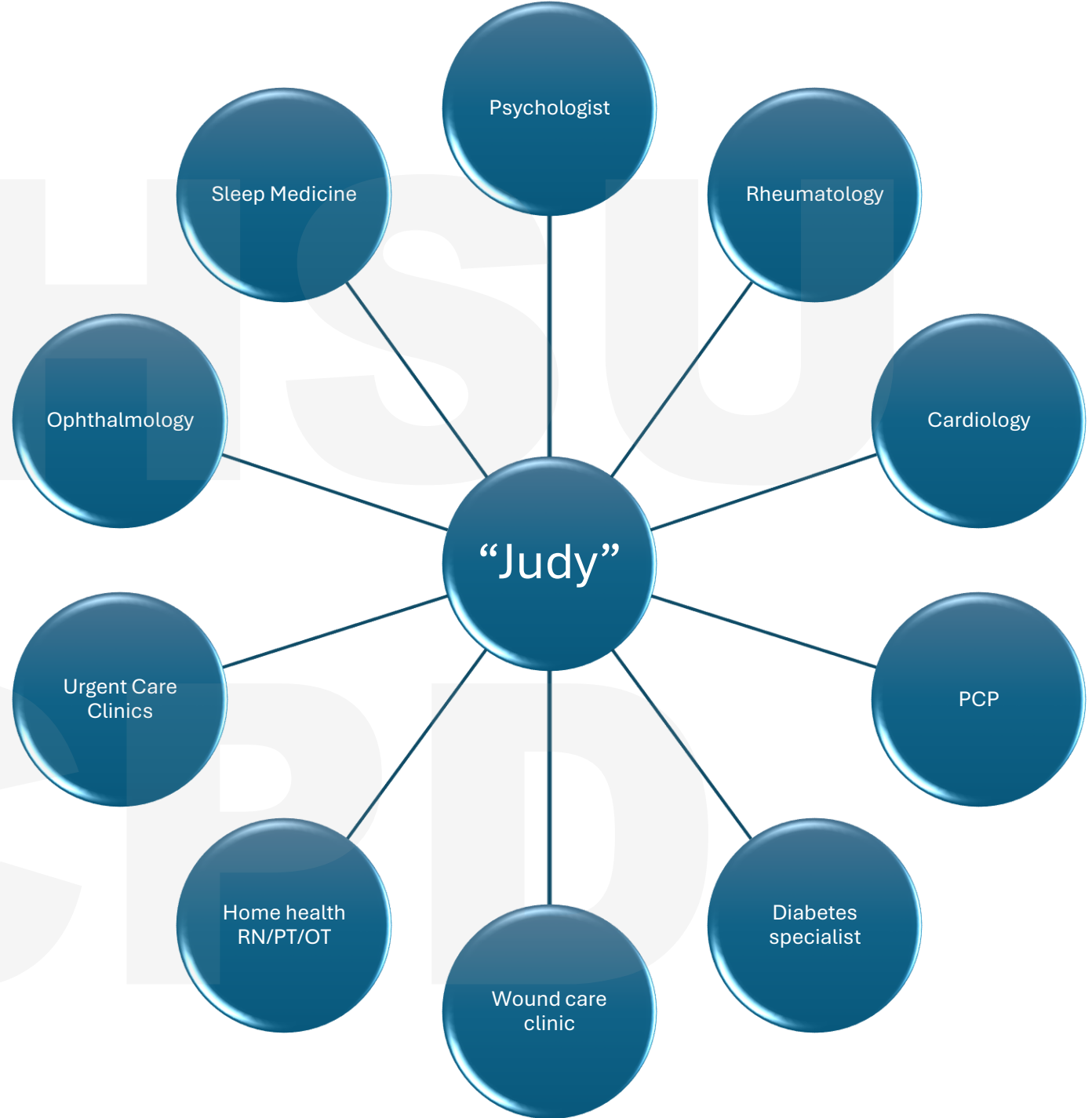
Why haven't you scheduled your
mammogram, DEXA scan,
colonoscopy, and physical therapy
appointments yet?

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

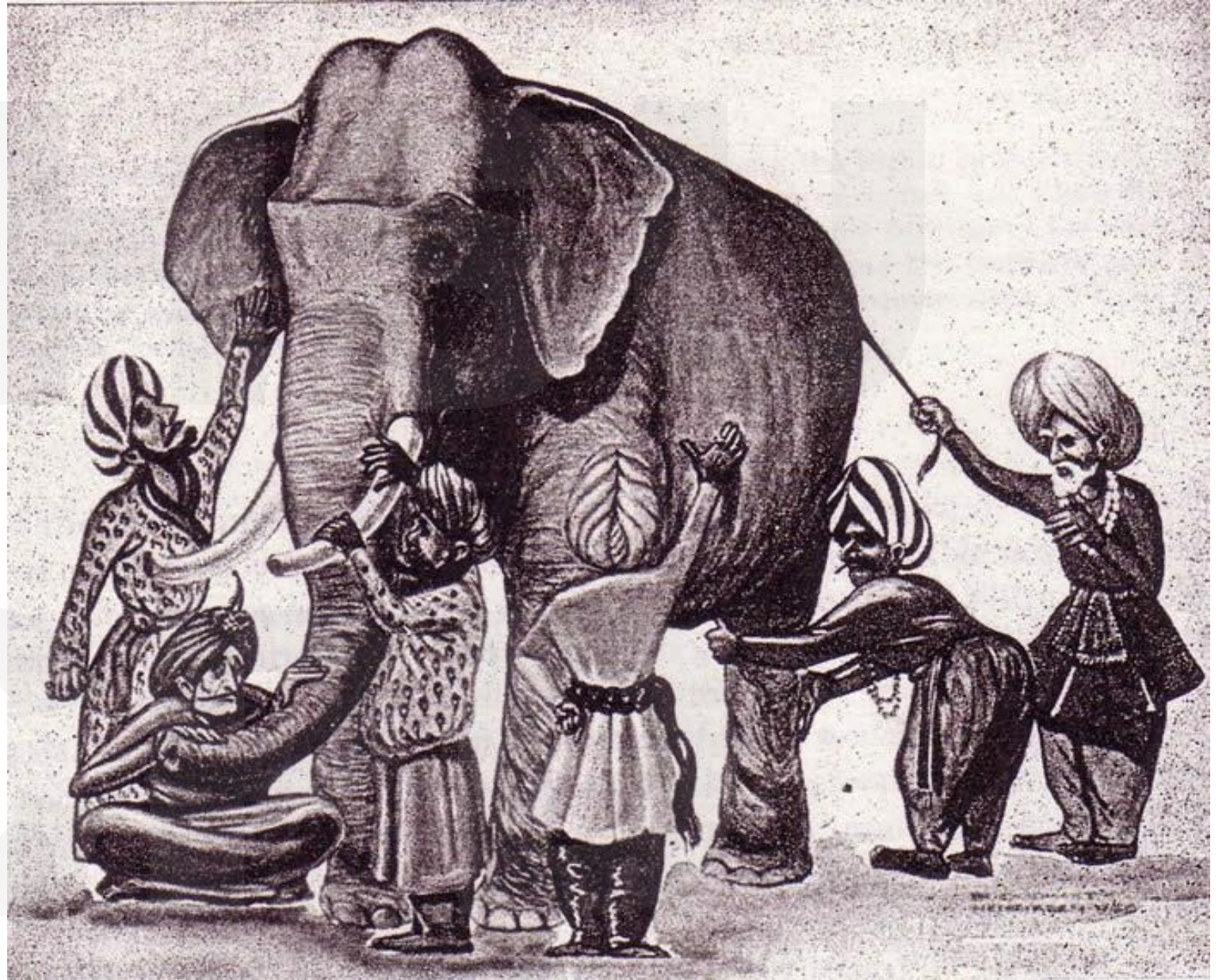
Health System Challenges



Health System Fragmentation



Team Member Perspective Challenges



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

Provider Discomfort Challenges

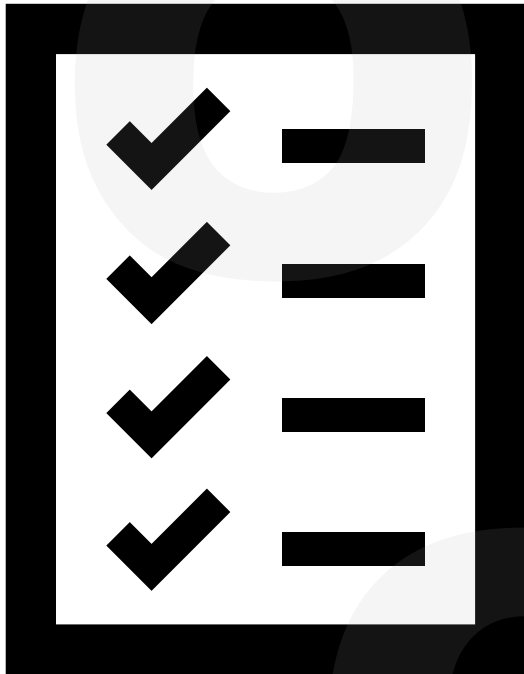
We are really comfortable with the things we're really comfortable with



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

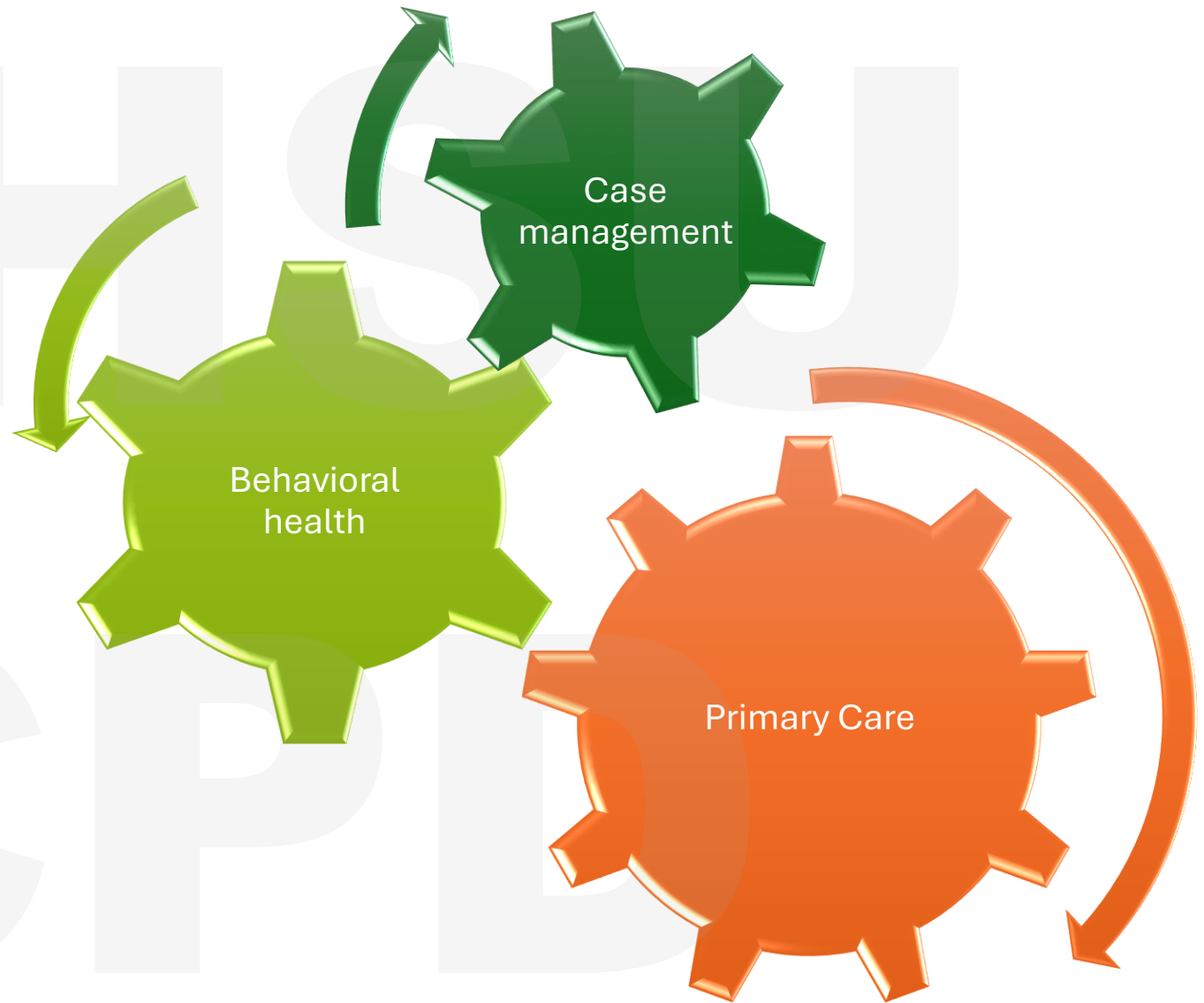
- Consider how well patients care coordinate on their own
- Our system isn't idealized for communication
- We see the same patient but not the same conditions/concerns
- ***For all these reasons, adults with SMI need active care coordination between providers***

How do we make this
better?



Steps to improve coordinating care

The Idealized Solution: Integrated Care





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

Key Features of PCBH and CoCM

Primary Care Behaviorist Model

- Co-located and integrated behavioral health specialist (Primary Care Behaviorist)
- Evidence-based screening with diagnosis by practitioner
- Warm hand-offs to behaviorist
- Evidence-based behavioral treatments customized for primary care
- Treatment duration ≤ 6 sessions (time-limited therapy)

Care Management for Patients With Mental Health Conditions Model

- Co-located and integrated care manager with behavioral health training
- Evidence-based screening with diagnosis by practitioner
- Decision support for complex mental health needs provided by practitioner or psychiatric consult
- Algorithm-based, stepped care with proactive patient follow-up and monitoring
- Treatment duration 3-12 months

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

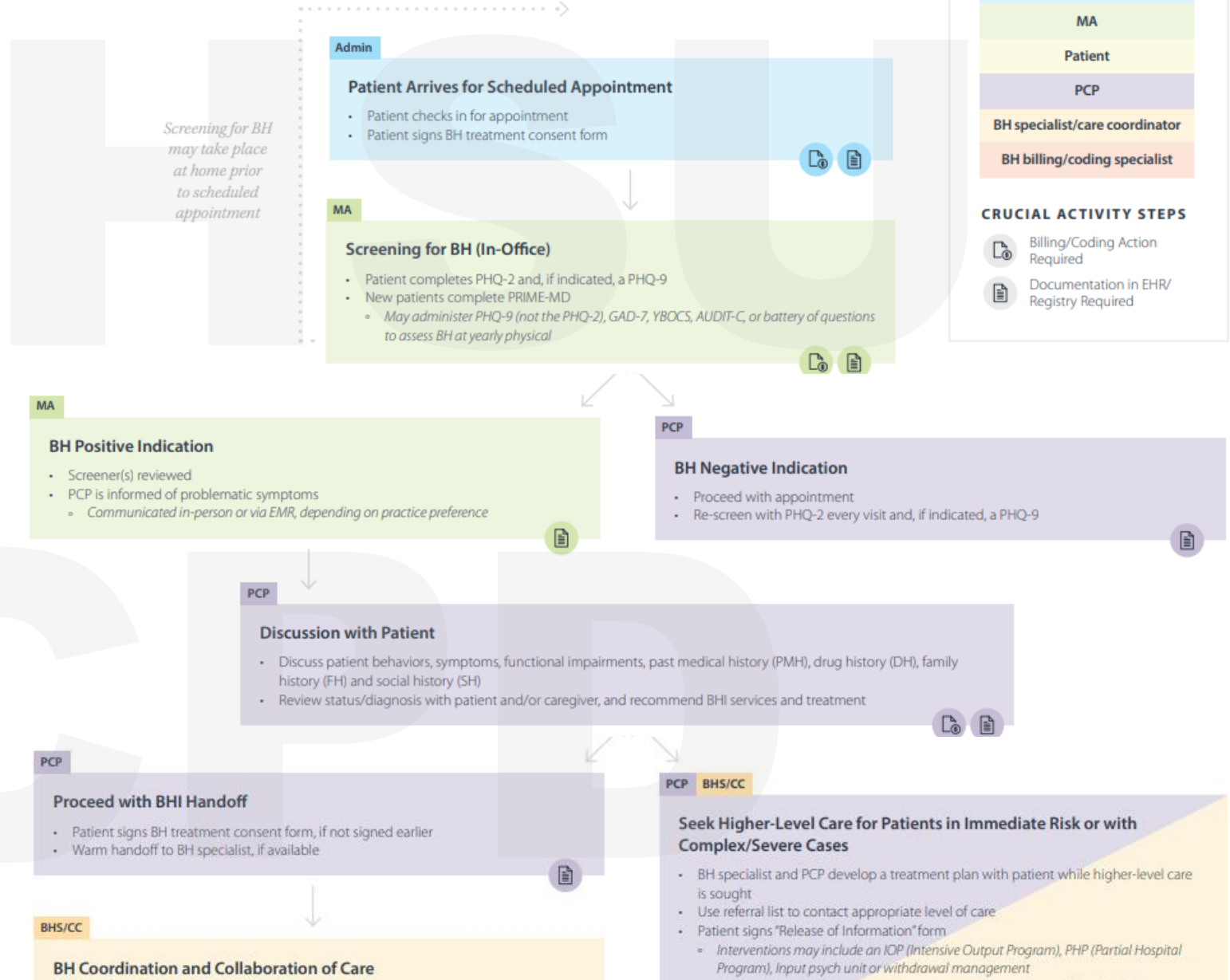
Slide courtesy of Dr. Walt Dawson



AMA: Behavioral Health Integration

BHI Workflow Example:

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



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 Behavior Health Alliance- Patient Centered Primary Care Home Standards
<ul style="list-style-type: none"> On-site referral from Primary Care Physicians for ongoing therapy for patients w/ diagnosed mental health and substance use disorder conditions 	<ul style="list-style-type: none"> Intensive care management for patients with specific behavioral health conditions Primary Care Physician support from a consulting psychiatrist/ Psychiatric Mental Health Nurse Practitioner Registry management and treat-to-target approach 	<ul style="list-style-type: none"> 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
<p>Recommend minimum 1:6 Full-Time Equivalent Behavioral Health Clinician per Primary Care Physician</p>	<p>60-100 patients per 1.0 Full-Time Equivalent Behavioral Health Care Manager (but depends on patient complexity)</p>	<p>30-100 patients per 1.0 Behavioral Health Clinician Full-Time Equivalent</p>

Accessing the IBH Toolkit

Find a Health Center Account **Member Portal** Log Out X f Instagram YouTube LinkedIn RSS

 **LIBRARY**

Fact Sheets: [OPCA 101](#) | [Oregon AIDS Education and Training Center 101](#) | [Oregon FQHC services 101](#) | [UDS Data Visualization – Statewide](#)

General resources: [Health Center Board of Directors Resource Repository](#) | [Health Center Leadership Resource Repository](#) | [Value Based Care Repository](#) | [Health Centers Emergency Preparedness Repository](#) | [Annual Report](#) | [Directory](#) | [Tableau Data](#) | [ACLC Archive](#)

Toolkits: [AsPIRE to EQUITY Document Library](#) | [Oregon Integrated Behavioral Health Toolkit \(PDF\)](#)

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					
<ul style="list-style-type: none"> » 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 	<ul style="list-style-type: none"> » 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 	<ul style="list-style-type: none"> » Proximity may not lead to greater collaboration, limiting value » Effort is required to develop relationships » Limited flexibility, if traditional roles are maintained 	<ul style="list-style-type: none"> » System issues may limit collaboration » Potential for tension and conflicting agendas among providers as practice boundaries loosen 	<ul style="list-style-type: none"> » 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 	<ul style="list-style-type: none"> » 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*



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

What would you do?

63-year-old unemployed IT worker with severe, treatment-resistant depression and no health insurance, seen for free in a community mental health center. Appeared healthy, with normal vital signs in clinic.

- Weekly visits with therapist
- New job as a used care salesman
- Maximum doses of an antidepressant via samples
- Behavioral Health Care Coordinator found him a free medical clinic

Chronic Renal Failure...

...required urgent dialysis!!!



Oregon's Coordination Resources



Care Coordination Services Team



- Coordinates outpatient mental health and SUD w/ physical health care services
- Coordination with primary care and transitions to integrated care settings ⁴⁴

Regional Care Teams (Tri-County Region)





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Coordinated care



Cascade Health Alliance

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Care Coordination Services



[MEMBERS](#) ▾ [PROVIDERS](#) ▾ [ABOUT](#) ▾

UMPQUA HEALTH MEMBERS

Care Coordination Services

Jon'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 (more to come!)



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

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”)

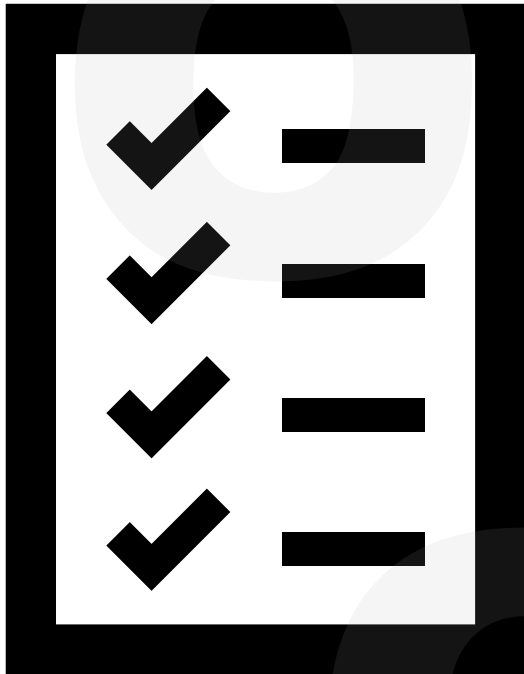


Epic message/Teams message (“I need an answer to this question or advice on this situation in the next 24 hours”)

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”)

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 clients!***

Be the
neck!



Thank you!

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