This article presents strategies for the delivery of a bio-behavioral collaborative care approach in the primary care setting. Two techniques are briefly described, including the Behavioral Health Consultant model (using Insomnia Treatment as an example), and the Shared Medical Appointment approach (using diabetes as the example).

Introduction
The delivery of behavioral techniques for the management of patient care in the primary care setting is gaining attention. Although several management plans have been proposed, one model that has been successful is the Behavioral Health Consultant (BHC) working along with Primary Care Providers (PCPs) to deliver behavioral health services. Within this model, care can be provided either individually or in groups. I would like to first describe an example of a collaborative bio-behavioral approach to the delivery of care in an individual treatment for insomnia, and then an even more integrated form of collaborative care that is delivered in a group setting (Shared Medical Appointment).

A Collaborative Primary Care Approach to Treating Insomnia
The prevalence of sleep complaints in primary care settings is 50% for occasional insomnia and 19% for chronic insomnia (Schochat, Umphress, Israel, & Ancoli-Israel, 1999). The effectiveness of behavioral treatments for insomnia, coupled with high prevalence of these symptoms, makes insomnia ideal for collaborative behavioral treatment in primary care. While the most commonly offered treatment for sleep problems is prescription medications (e.g., benzodiazepines [Chesson, et al., 1999; Nowell, et al., 1997]), behavioral treatments (e.g., sleep hygiene, stimulus control, and sleep restriction) are just as effective and, in some cases, the effects last longer (Hryshko-Mullen, Broeckl, Haddock, & Peterson, 2000; Lichstein & Riedel, 1994; Morin, Colecchi, Stone, Stood, & Brink, 1999).

Despite positive evidence for efficacy of behavioral therapies for insomnia, PCPs do not usually apply or offer these options. Reasons offered for the inattention to behavioral strategies are lack of training with those techniques, limited appointment time, the expectations of their patients that they will receive medication, and the perception that behavioral treatments are lengthy, complex, and specialized. The BHC model has been used successfully in the Air Force and the Navy for more than 5 years. Collaborating with a BHC allows the PCP to maximize time devoted to patient care by focusing on medical needs while the BHC consults on behavioral and psychosocial issues.

Sleep problems, including insomnia, provide a prime example of the way in which this collaborative management can take place. The PCP first assesses the patient to evaluate his or her medical needs and then consults with the BHC for further assessment of psychological issues and recommendations regarding behavioral management (e.g., stimulus control) of the sleep complaint. Our typical assessment and treatment recommendations are outlined below.

• PCP identifies patients with insomnia symptoms and refers them to BHC

• First Appointment with BHC with BHC (30 minutes)
  • Interview
  • Baseline Sleep Impairment Index (Morin, 1993)
  • One week sleep diary given to patient to return following week
  • Feedback provided to the PCP in the form of both written and face-to-face contact

• Second Appointment with BHC (15–30 minutes)
  • Review sleep diary
  • Discuss recommended behavioral changes, including stimulus control and sleep hygiene
  • Provide patients with handouts and explain procedures in detail
  • Provide feedback to PCP

• Third Appointment with BHC (15–30 minutes)
  • Review sleep diary
  • Teach relaxed breathing, if indicated
  • Provide feedback to PCP
• Fourth Appointment with BHC (15–30 minutes)
  • Evaluate sleep diary
  • Conduct posttesting using the Sleep Impairment Index (Morin, 1993)
  • Provide feedback to PCP, including a discussion of risks of relapse and ideas for encouraging continued compliance with changes in behavior.

In our setting, pre- and postintervention sleep diaries and the Sleep Impairment Index were used to examine the efficacy of this brief, individualized collaborative bio-behavioral approach in two family practice clinics, with 29 individuals reporting significant sleep impairments (regardless of other comorbid conditions). Participants demonstrated an increased mean sleep efficiency from 72.21% to 88.03%; mean sleep onset latency decreased by 25.11 minutes, and scores on the Sleep Impairment Index improved 10.72 points. Overall, we considered this collaborative bio-behavioral intervention in primary care to be effective at reducing symptoms of insomnia, despite the presence of comorbid medical diagnoses in some participants (Isler, Hunter, Isler, & Peterson, 2003).

A Collaborative Primary Care Approach for Group Appointments

Next, I would like to describe what I consider to be the apex of the collaborative bio-behavioral approach between the PCP and the BHC. Shared Medical Appointments (SMAs) bring the strengths of group treatment to the primary care setting; this model offers a cost-effective yet patient-oriented solution for select patients and providers. SMAs comprise 60–90 minutes of exposure to the primary care team (PCP, nurse, technicians, BHC, and documenter) for patients in groups ranging from 6 to 15. SMAs can be homogeneous, grouping patients with a similar diagnosis, or heterogeneous, grouping patients with various diagnoses (Beck, et al, 1997; Noffsinger & Scott, 2000; Noffsinger, 1999a, 1999b).

A diabetes SMA typically begins with the BHC explaining confidentiality, purpose, flow, and length of the appointment. The PCP then begins with the first patient and assesses the important management areas for a typical diabetic patient (e.g., A1C, blood pressure). Since the SMA is in a group setting, the PCP will only have to explain certain concepts in diabetes management once. This is a target-rich environment and brief periods of the appointment will be spent explaining prevention information. During the appointment, the PCP answers medical questions, discusses test results, and renews prescriptions. The BHC addresses topics such as stress management, exercise plans, sleep problems, or how to stick with nutritional goals, all within a paradigm of group support that allows for a true biopsychosocial approach. In addition, the BHC typically monitors practice management aspects of the appointment (e.g., time spent with each patient).

Advantages of SMAs

SMAs have advantages for both the providers and patients. PCPs and BHCs benefit from being able to share information with the entire group at once, thereby resulting in less repetition (i.e., not having to tell each patient the same information) and allowing for a broader scope of prevention information to be delivered. Also, because more patients are seen in less time, provider time can be leveraged by 200%–300%, and patients can be billed for an individual encounter even though they were seen in a group setting. In addition, providers are better able to manage high-risk patients because they can be followed more frequently, and incipient worsening of a condition can be noticed. For the patients, access to care is improved because there are more people seen in each group time slot than would be possible with individual appointments, thus increasing efficiency. Overall, it is a win-win situation with improved patient and physician satisfaction.

Barriers to Initiating and Maintaining SMAs

We have encountered several barriers to the initiation and maintenance of the SMAs, including maintaining the census for the appointments and documentation after the appointments. A designated scheduler and documenter are vital components of the infrastructure that supports the SMAs within the primary care settings. I strongly recommend that a dedicated scheduler be part of the SMA design phase as well as the implementation. We have handled this by having our appointment personnel participate in an appointment before contacting patients so that they have first-hand knowledge of how the SMAs work. Documentation can also be a stumbling block. The last thing that the PCP wants is to see 10 patients and then have to go back and document for the next hour. This can be overcome by having a dedicated documenter participate in the appointment and begin entering the note in the computer as the PCP is interact-
ing with the patient. The goal is for the PCP to be very close to completing documentation by the end of the SMA and probably only have to review and sign the final note.

Other physical and attitudinal barriers may have to be overcome as well. For example, a typical primary care office may have the physical barrier of inadequate meeting room space, which limits the number of patients per group. Attitudinal barriers stem from the culture of primary care being built on individual visits; in other words, in order to conduct SMAs, PCPs have to be willing to try something new. The BHC can offer training in practice management skills and group process for the PCP team since anxieties can sometimes run high due to lack of exposure to these types of appointments. Overall, the effort extended in overcoming these barriers is repaid in the improved efficiency offered by the SMA. In addition, providers who launched the SMA structure have greatly enjoyed the challenges and rewards of administering healthcare within the shared setting.

Concerns Regarding Confidentiality
Concerns regarding confidentiality are frequently raised by the PCP team and mental health providers, but rarely from patients. Our team deals with confidentiality issues and the sharing of medical information by addressing them during all aspects of recruiting patients for SMAs. At the time of the SMA, patients are provided with a verbal description of the group appointment, including what types of information will be discussed. They are also instructed that they can leave at any time if they begin to feel uncomfortable. Lastly, all participants, including those accompanying patients (e.g., spouse, family member, friend), are provided with a written informed consent document for their signature. Of course, all participants are also offered an individual encounter with the PCP on demand or when clinically appropriate. Overall, we have received very few negative comments from patients, and our satisfaction ratings from providers and patients remain very high.

Conclusion
This article describes a collaborative care approach for mental health professionals who are interested in working with primary care providers. The Behavioral Health Consultant model, in which the mental health professional receives referrals from the PCP, offers brief recommendations to the patient, and provides feedback to the PCP is growing in popularity. Giving patients with insomnia the opportunity to consult with a BHC can lead to significant improvements in sleep efficiency and a significant decrease in sleep onset latency. The second example of collaborative care in primary care is the SMA, which is an appropriate choice for delivery of quality care for select patients and providers. Although SMAs take considerable momentum to initiate and maintain, they are a wonderful way for the BHC to consult with the PCP on group and practice management skills. Primary care psychology has progressed markedly in a short period of time, and BHCs will need to continue to use their unique skills, creativity, and adaptability to build the future.

References
