Background Paper

Behavioral Health/Primary Care Integration Models, Competencies, and Infrastructure

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National Council for Community Behavioral Healthcare

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This Background Paper on Behavioral Health/Primary Care Integration has been prepared under the auspices of the National Council for Community Behavioral Healthcare. It is a work in progress, reflecting the participation of NCCBH staff, NCCBH consultants and external reviewers. Comments are welcomed and should be directed to the NCCBH offices at Suite 320, 12300 Twinbrook Parkway, Rockville, MD 20852 or www.nccbh.org.

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Introduction

The purpose of this National Council for Community Behavioral Healthcare (NCCBH) discussion paper is to provide an overview of integration thinking to date and to propose a conceptual model for how Behavioral Health (mental health and substance abuse/addiction) services and Physical Health services can be integrated to improve services for consumers and achieve improved health outcomes.

Our intent is to clearly articulate what is meant by integration and to reduce confusion or over-simplification, which could lead to unintended consequences for existing public sector systems and the populations they serve. This paper is one mechanism for NCCBH members and their colleagues to understand the larger context of integration. We hope they will move forward, educating within their communities as well as participating in partnership/collaboration opportunities and advocacy on behalf of public sector consumers in the context of integration.

Why Pursue Integration?

Because it is the right thing to do: The NCCBH vision statement provides the foundation for our work: *We are committed to creating and sustaining healthy and secure communities, achieved through a system that holds the needs of consumers paramount, regardless of their ability to pay. Vital to this commitment is a network of organizations and advocates promoting services of unparalleled value.*

NCCBH members primarily serve public sector consumers, those with severe and persistent mental illness or serious emotional disturbance—the needs of this population are often overlooked in primary care and integration planning. We must assure that their needs as well as the needs of the broader community are appropriately addressed.

Because many people in the broader community now receive their behavioral healthcare in a primary care setting, and the gap between the medical and behavioral healthcare systems must be bridged: As noted by Robin Dea and many other commentators, there is "*evidence that many, if not most, people coming into primary care are being treated for psychosocial problems, not organically based medical disease…evidence of medical cost offsets from treating behavioral health problems presenting as physical health problems in the primary care setting…the assumption that if adequate detection of early stage psychiatric illness took place in primary care, there would be some prevention of patients going to more severe episodes of major psychiatric illnesses…and primary care is where most people who have behavioral health problems are in fact seen*."[i]

Some of the important findings from the research field include:

- The Epidemiologic Catchment Area (ECA) Study and articles based on this survey data, reported the finding that about 50% of care for common mental disorders was delivered in general medical settings.[ii] However, many subsequent studies have shown that these disorders may be undiagnosed or under-treated.[iii]
- Screening systems, treatment guidelines and provider education in primary care are necessary but not sufficient steps to ensure a difference in outcomes.[iv]
- Collaborative and stepped care has been shown to achieve outcomes that are better than "usual care".[v]

Because there is the opportunity for quality improvement of care within the primary care and specialty behavioral healthcare settings: Studies have shown that many people with depression stop taking their medications before the minimal time required to effectively treat an episode of depression. Patients at Group Health Cooperative who initiated medications for depression with their primary care physician and received targeted stepped up care and relapse prevention support were significantly more likely to adhere to adequate dosages of medication and to demonstrate a greater decrease in depressive symptoms.[vi] Application of research findings such as these through adoption of evidence-based practices

in both primary care and specialty behavioral health (BH) settings will result in better outcomes for consumers.

With the publication of *Priority Areas for National Action: Transforming Health Care Quality*[vii], the Institute of Medicine's 2003 follow up to *Crossing the Quality Chasm: A New Health System for the 21st Century*[viii], a major opportunity and challenge has appeared for the public mental health system. The *Quality Chasm* recommended the systematic identification of priority areas for national quality improvement; *Priority Areas* proposes twenty areas for transforming health care nationally. Included in this list are **major depression** (screening and treatment) and **severe and persistent mental illness** (focus on treatment in the public sector). Their inclusion as priority areas, as well as the findings in the Interim Report from the President's New Freedom Commission on Mental Health, with its observation that the system is "fragmented and in disarray—not from lack of commitment and skill of those who deliver care, but from underlying structural, financing and organizational problems"[ix] suggests that the time for new strategies is at hand.

Because many people being served by public behavioral health services need better access to primary care: A rationale less frequently articulated for integration is that the specialty BH system, especially the public sector focusing on the severe and persistent mentally ill adult population (SPMI) and seriously emotionally disturbed (SED) children, serves a disabled consumer population with healthcare needs that are frequently under-addressed due to difficulties in obtaining medical services. Most state Medicaid waivers related to coverage for physical healthcare have focused on enrollment of the TANF population into Medicaid managed care plans, leaving the disabled Medicaid population unable to adequately access care, or in better situations, reliant on "safety net" providers—community health centers (CHCs) or county delivered health services.

Because community health centers serve people who need better access to behavioral healthcare: These "safety net" providers serve a broader scope of patients than just the Medicaid population. But many states have implemented mental health Medicaid waivers that focus the public mental health system on the SPMI/SED and Medicaid populations, with minimal levels of support for non-SPMI/SED or uninsured populations. Often there is not a good match of target populations between the two systems. If the Medicaid mental health program also has a highly managed service authorization and payment methodology, there may be additional barriers to reimbursement for mental health services. This has led to frustration for "safety net" healthcare providers because they have difficulty obtaining behavioral health services for their non-SPMI/SED or uninsured patients. In a recent survey of CHC medical directors, 80% indicated that cost is the main barrier to behavioral health care for their uninsured populations.[x] The recent financing and development of behavioral health services in CHCs addresses this frustration and is just the latest in a series of efforts to acknowledge that a large proportion of the population gets their behavioral health services in primary care.

Because behavioral health clinicians are a resource for assisting people with all types of chronic health conditions: Yet another reason for integration is the potential contribution of BH clinicians regarding behavioral and lifestyle change: providing interventions targeted at better management of chronic disease, supporting and "leveraging" the time of primary care providers through disease management programs. Disease management activities focus on: early identification of populations at-risk for costly chronic disease (e.g., asthma, diabetes); care interventions that utilize evidence-based practices; education-intensive orientations that focus on both patient and provider; care management and a coordinated approach across multidisciplinary treatment teams; and, a method for systematic data collection that measures clinical and cost-effectiveness. Large organized healthcare systems such as Northern California Kaiser-Permanente implement their major disease management programs with specifically assigned nurses as care managers and educators. However, many physicians in individual or group practices do not have access to this level of support unless they are in the network of a health plan with active disease management programs. In markets where primary care and multi-specialty groups have accepted capitated risk, disease management approaches will be especially value-added.

Because there are changes underway in the financing of both healthcare and behavioral healthcare systems: We are in a time of significant public policy activity regarding financing of the

national healthcare system and the uninsured population. As we approach the 40th anniversary of the founding of the community mental health center movement, the dialogue has returned us to our public health beginnings—serving the needs of a population.

The Health Resources and Services Administration (HRSA) Primary Care Integration Initiative is currently being implemented across the country. The HRSA initiative includes: identification of system issues related to integration and the development of related strategies; development of a service manual for CHC behavioral health services; development of BH intervention models for CHCs; and grants for establishing BH services in existing CHCs. Newly funded CHC sites will be expected to provide dental, mental health and substance abuse services, either directly or by subcontract arrangements. CHCs are in the process of decision making about building their own BH services or contracting for BH services, as they prepare their grant applications. (The NCCBH website, www.nccbh.org, has a Primary Care Integration Resource Center with more details about the HRSA process.)

At the same time that HRSA is putting new BH resources into CHCs, reports are emerging from many states indicating that the public mental health system is funded at somewhere around half the level that is needed. In the private sector, the relentless downward pressure on behavioral health PMPMs has also reduced overall system resources, shifting cost from the private sector to the public sector. [xi] Reports such as these were released prior to the current fiscal crisis in state Medicaid programs; rather than addressing the shortfalls, there are significant new reductions in BH services in many states. And, the implementation of managed care methods for Medicaid have made it difficult for some community based BH providers to continue to enact their mission of serving the needs of the population, regardless of ability to pay.

The implications for system-wide duplication and competition for the scarce resources of BH staff and funding, as well as the opportunity to improve consumer access to both health and behavioral healthcare services, suggests that **collaboration is a priority at the national, state and local levels**. Good public policy will work at sustaining, supporting and requiring collaboration between the two "safety net" systems of community mental health centers and community health centers. The conceptual model proposed in this paper can become the basis for HRSA grantees to work with their partners in the public mental health system to fully define working relationships and collaboration on behalf of consumers of care.

In summary, the reasons for integration are grounded in the desire to improve access to both primary care and behavioral health services; ensure that there are evidence-based practices as well as consistent communication and coordination of clinical activities (especially medication management—a key concern of consumers) among the providers serving any single individual; wed the skill sets of primary care physicians and BH clinicians in order to better manage chronic health issues; and, participate in and shape the public policy debate regarding how services should be organized, delivered and financed in ways that ensure that needs of public sector SPMI/SED consumers and the broader community alike are met.

Sounds Like Integration Is A Good Idea—What's Getting In The Way?

People have been talking and writing about integration for over ten years—how far have we come, and how far do we have to go?

Many integration initiatives and research reports have focused on depression because of the broad scope of the problem (more than 19 million Americans each year) and the degree to which it is under-recognized and under-treated in primary care settings. A recent scan of stakeholder experts conducted for SAMHSA reported mixed findings regarding BH/Primary Care integration for treatment of depression.[xii] (A complete summary of the findings can be found in Attachment B.) The stakeholder survey findings are daunting, because they rightly identify the very fabric and complexity of our nation's healthcare purchasing and delivery system as the source of both the barriers and the solutions to integration. Or, as noted by Mike Quirk and his colleagues at Group Health, *"Simply because integration is a good and fundamentally strong idea does not mean that somehow, on its own merit, it would be able to compete*

with the habit-based nature of 'regular care'…To achieve real and substantial change, you need corporate sponsorship, local impassioned leadership, a plan that is accepted by all the relevant players, a system of scheduling progress markers and accountability for achieving them." [xiii]

If this is the case for the relatively well-researched arena of depression within the general healthcare system and population, how can we move forward and also talk about the needs of other populations? How can we contribute to the national dialogue? Our proposed approach is to begin with development of principles for integration and a model for clinical practice. Principles provide the foundation for thinking about integration. A conceptual model will look at the populations to be served and how clinical service integration would vary depending on their needs.

Throughout, we need to remember a few of the major lessons from the research and dialogue to date:

- Many consumers would prefer to have their care coordinated or delivered in a primary care setting, where they perceive stigma as less of an issue.
- Taking research findings from pilots to widespread implementation requires substantial attention to model fidelity and evidence-based or emerging practices. Outcomes related to these services will tell us which emerging practices are most effective—measurement is critical.
- Financing mechanisms must support the work; otherwise integration is not sustainable.
- Grounding our efforts in the Surgeon General's Report on Mental Health will keep us focused on closing the gaps in access to and effectiveness of care, as well as the need to overcome stigma and assure culturally competent services.

Principles for Integration

Detailed principles have been developed based upon the NCCBH's Principles for Behavioral Healthcare Delivery, specifically those focused on Linkage and Integration.[xiv] Ideas have also been derived from principles articulated at the Surgeon General's Working Meeting on The Integration of Mental Health Services and Primary Health Care[xv], by the American Association of Community Psychiatrists, by the Washington Community Mental Health Council, as well as by other sites around the country.

The principles are organized under the headings listed below. A full set of the principles can be found in Attachment A.

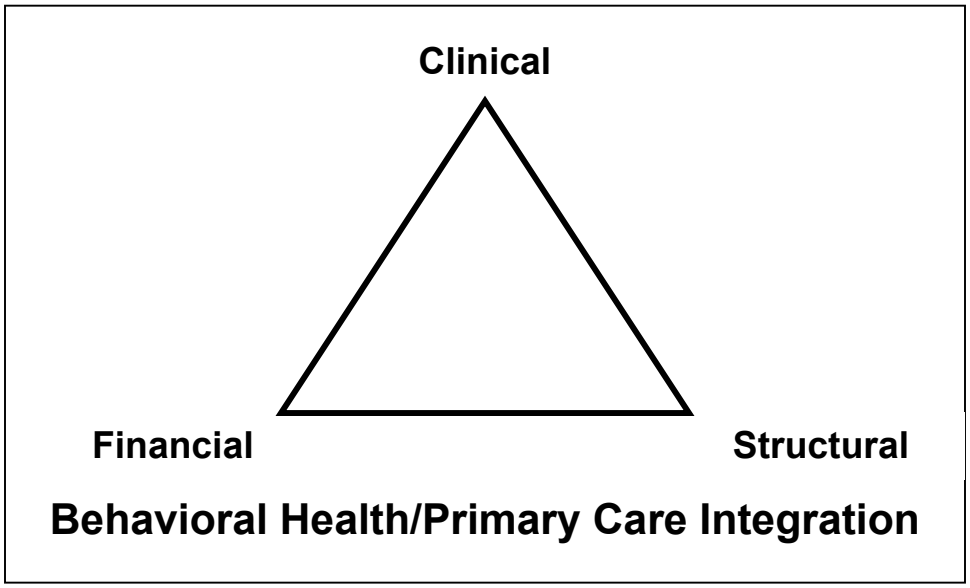
1. Focus on Consumers and Their Families
2. Promote Health, Overcome Disparities, and Address Chronic Illness
3. Standardize Quality and Outcome Measures for Use in Research and Practice
4. Promote Collaboration and Co-location
5. Redesign Financing, the Regulatory Environment and Contracting Methods
6. Develop Best Practice Service Delivery Models
7. Invest in Training
8. Assure Information Technology

Defining Integration

Integration is an omnibus concept, defined in many ways. There can be financial, structural and/or clinical practice integration. Integration that is financial (benefit packages, "carve-ins", shared risk pools or other incentives) or structural (services delivered under the umbrella of the same organization, BH specialty services co-located with primary care services) does not necessarily assure clinical integration. However, **clinical integration can be difficult to achieve without financing mechanisms and structures or infrastructure that support the collaborative effort**.

For example, recent implementation of parity legislation in California has created financial integration, in that all health plans must cover mental health services for specified diagnoses. However, six of the eight major health plans in California now utilize managed behavioral healthcare organizations to separately

manage the parity mental health benefit—these "carve outs" create both financial and structural separateness.[xvi] Clinical integration may or may not be present, dependent on the local arrangements among mental health and physical health care providers. Across the country, aside from a few well-publicized and funded efforts, most clinical practice integration is "person dependent", not systematically designed into the process of delivering care in either the primary care or behavioral health setting.



Clinical integration—what is experienced by the consumer in relationship to the providers—is the goal. To achieve that goal, it is important to be clear about which integration mechanisms are being selected and why.

Ken Minkoff has suggested that the mechanisms promoting the goal of clinical integration include:

- Clinician integration: dually trained clinicians or interdisciplinary teams
- Clinical practice integration: formal collaboration and consultation mechanisms, required screening practices, collaboration practices built into service protocols
- Programmatic integration: incorporating health education into psychiatric rehabilitation or incorporating BH interventions into diabetes management
- Physical integration: Co-location of services in either direction
- Structural integration: BH and primary care services under a common administrative authority, which can create standards for collaboration and clinical integration
- Fiscal integration: MH and primary care services under a common funding stream which can potentially be utilized to promote any of the other activities

In regard to these mechanisms, he notes:

- Keeping the focus on clinical integration as the goal is important.
- There is no one ideal methodology for promoting clinical integration; structural and fiscal integration may present disincentives and difficulties in promoting clinical integration, compared to the flexibility of independently collaborating front line providers.
- While clinical integration is desirable, it must be balanced against competing priorities within the system—from a consumer perspective, for example, regarding choice and privacy.
- Fiscal integration does not naturally promote clinical integration, without attention to the issues of clinical practice and program design. Furthermore, much integration needs to be designed as a routine practice within each funding stream so that it can be easily accomplished within any singly funded setting.
- The best approach to achieve clinical integration varies, and has to be matched to the needs of consumers, the setting and system they are in, and the specific problems they have.

- Given this variability, the choice of integration mechanisms from the list above will vary as well, and the design of a system for integration will incorporate a framework for designing the right model to match the needs of the most clients within that framework.[xvii]

The American Association of Community Psychiatrists[xviii] has recommended that behavioral healthcare providers incorporate a systematic program for interfacing or integrating with primary care provider organizations in their communities. Such a program should include, at a minimum:

- Effective means of bi-directional communications with PCPs
- Determination of what information is most essential to share
- Adoption of appropriate confidentiality and consent protocols

Consideration of additional integration and co-location models should be based on:

- An environmental scan of the resources and capacity of behavioral health services and their local/federal regulatory context
- Assessment of primary care needs for primary care based behavioral health, including definition of who should be served, at what level of services, through what pathway of care
- Development of systemic understanding and support from administrative and clinical leadership
- Determination as to whether the primary care based behavioral health clinicians should be employed by primary care or contracted from the behavioral health provider, and what level of staffing is required (skills, disciplines, capacity)

Doherty, McDaniel and Baird have noted that the extent of collaboration in any given case is a function of the nature of the case itself, the collaboration skills of the providers, and the collaboration capacity of the health care team and setting.[xix] (See Attachment B for a summary of their observations.) Their hierarchy assumes that the greater the level of systemic collaboration, the more adequate the management of very demanding cases is likely to be, but does not prescribe an optimal model for all health care settings. While it can be seen as a developmental model, it need not be a linear progression. Another way of using their concept of levels of collaboration is to make integration consumer driven, activated by the needs identified in the clinical assessment process. Given the resource intensity of full collaboration, the system may be better able to support collaboration if there is a matching between need and level of integration. Thus we suggest the Four Quadrant Model for a population-based approach to determining methods and models of integration.

The differences between primary care and behavioral health languages and cultures have been identified as barriers to successful integration—these language and culture differences are clinical, structural and financial. All three aspects need to be considered in developing models and in local planning and implementation.

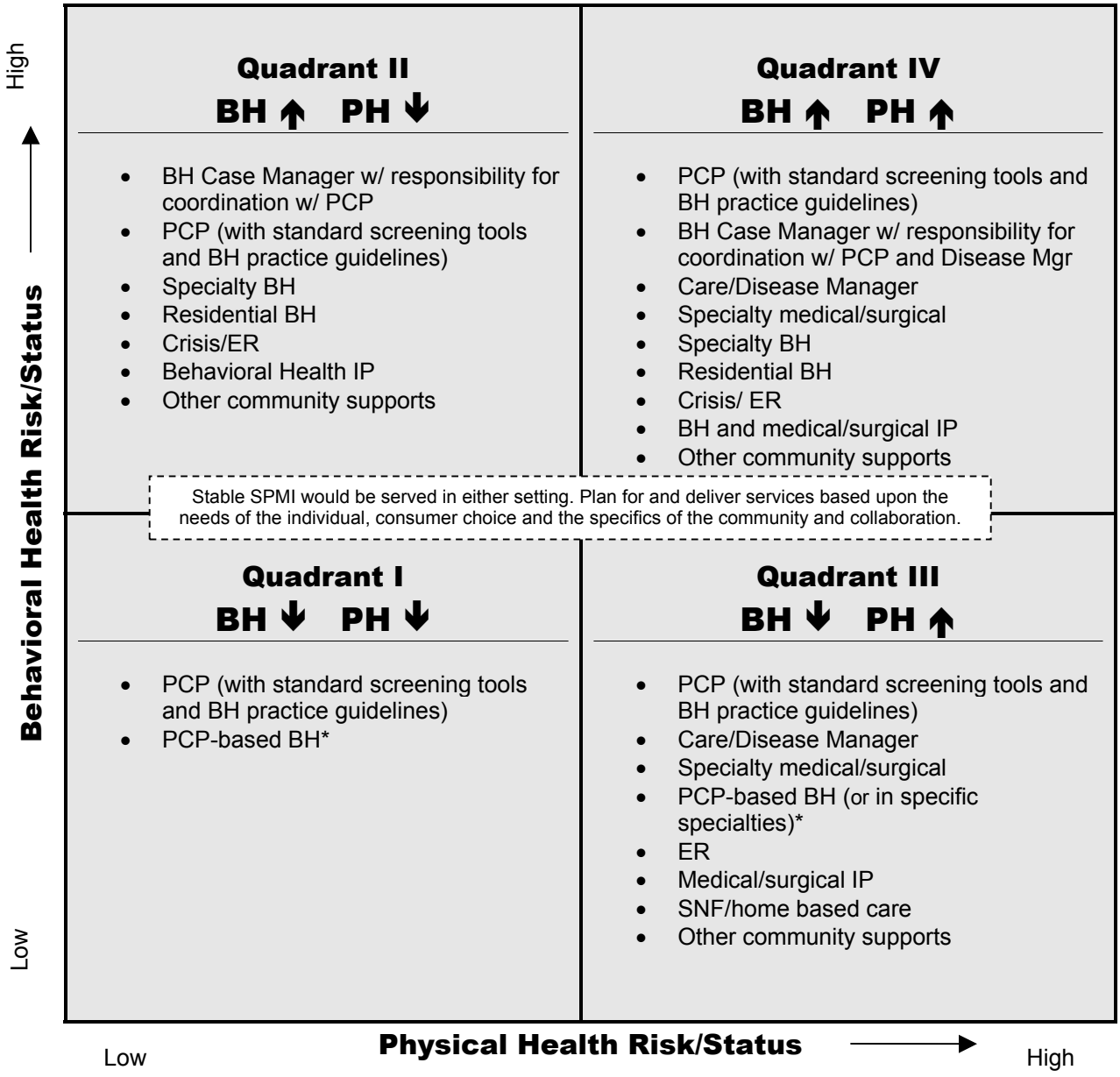
The Four Quadrant Clinical Integration Model

Our proposed model for the clinical integration of health and behavioral health services starts with a description of the populations to be served. This Four Quadrant Model builds on the 1998 consensus document for mental health (MH) and substance abuse/addiction (SA) service integration, as initially conceived by state mental health and substance abuse directors (NASHMHPD/ NASADAD) and further articulated by Ken Minkoff and his colleagues.[xx] Their model for a Comprehensive, Continuous, Integrated System of Care (CCISC) describes differing levels of MH and SA integration and clinician competencies based on the four-quadrant model, divided into severity for each disorder:

- **Quadrant I**: Low MH-low SA, served in primary care
- **Quadrant II**: High MH-low SA, served in the MH system by staff who have SA competency
- **Quadrant III**: Low MH- high SA, served in the SA system by staff who have MH competency
- **Quadrant IV**: High MH-high SA, served by a fully integrated MH/SA program

The Behavioral Health/ Primary Care integration model that follows assumes this competency-based MH/SA integration concept within the behavioral health (BH) services offered and builds on the MH/SA integration model to describe the subsets of the population that Behavioral Health/ Primary Care integration must address.

The Four Quadrant Clinical Integration Model



*PCP-based BH provider might work for the PCP organization, a specialty BH provider, or as an individual practitioner, is competent in both MH and SA assessment and treatment

Each quadrant considers the behavioral health and physical health risk and complexity of the population and suggests the major system elements that would be utilized to meet the needs of the individuals within that subset of the population. The Four Quadrant model is not intended to be prescriptive about what happens in each quadrant, but to serve as a conceptual framework for collaborative planning in each local system. Ideally it would be used as a part of collaborative planning for each new HRSA BH site, with the CHC and the local provider(s) of public BH services using the framework to decide who will do what and how coordination for each person served will be assured.

The use of the Four Quadrant Model to consider subsets of the population, the major system elements and clinical roles would result in the following broad approaches:

Quadrant I

Low BH-low physical health complexity/risk, served in primary care with BH staff on site; very low/low individuals served by the PCP, with the BH staff serving those with slightly elevated health or BH risk.

The PCP provides primary care services and uses standard BH screening tools and practice guidelines to serve most individuals in the primary care practice. Use of standardized BH tools by the PCP and a tracking/registry system focuses referrals of a subset of the population to the BH clinician. The role of the primary care based BH clinician is to provide formal and informal consultation to the PCP as well as to provide BH triage and assessment, brief treatment services to the patient, referral to community and educational resources, and health risk education. BH clinical and support services may include individual or group services, use of cognitive behavioral therapy, psycho-education, brief SA intervention, and limited case management. The BH clinician must be competent in both MH and SA assessment and service planning. The PCP prescribes psychotropic medications using treatment algorithms and has access to psychiatric consultation regarding medication management.

The consumer of care, by seeking care in primary care, has selected a “clinical home”. Consistent with appropriate clinical practice, that should be honored. The primary care and specialty BH system should develop protocols, however, that spell out how acute behavioral health episodes or high-risk consumers will be handled. This will also lead to clarity regarding the “clinical home” of consumers with SPMI who are currently stable, which should be based upon consumer choice and the specifics of the community collaboration.

Quadrant II

High BH-low physical health complexity/risk, served in a specialty BH system that coordinates with the PCP.

The PCP provides primary care services and collaborates with the specialty BH system to assure coordinated care for individuals. Psychiatric consultation for the PCP may be an element in these complex BH situations, but it more likely that psychotropic medication management will be handled by the specialty BH system. The role of the specialty BH clinician is to provide BH assessment, arrange for or deliver specialty BH services, assure case management related to housing and other community supports, assure that the consumer has access to health care, and create a primary care communication approach (e.g., e-mail, v-mail, face to face) that assures coordinated service planning, especially in regard to medication management.

Specialty BH clinical and support services will vary, based upon state and county level planning and financing; some localities may encompass the full range of services offered by specialty BH systems including:

Specialty MH Services

- 24/7 crisis telephone
- Mobile crisis team
- Urgent care walk in clinic
- Crisis respite facilities
- Crisis residential facilities
- Crisis observation 23 hour beds
- Locked sub-acute residential

- Inpatient (voluntary and involuntary)
- Dual diagnosis inpatient
- Hospital discharge planning
- Partial hospitalization
- In-home stabilization
- Outreach to homeless shelters
- Outreach to jail/corrections
- Outreach to other special populations
- Individual/family treatment /counseling
- Group treatment/counseling
- Dual diagnosis treatment groups
- Multifamily groups
- Psychiatric evaluation/consultation
- Psychiatric prescribing/management
- Advice nurse (medication issues)
- Psychological testing
- Services for homebound frail or disabled
- Specialized services for older adults
- Brokerage case management
- 24/7 intensive home /community case management (ACT teams)
- School-based assessment and treatment
- Supported classroom
- Stabilization classroom
- Day treatment (adult, adolescent, child)
- Supported employment /supported education
- Transitional services for young adults
- Individual skill building /coaching
- Intensive peer support
- After school structured services
- Summer daily structure and support

Specialty SA Services

- Sobering sites
- Social detoxification/residential
- Outpatient medical detoxification
- Inpatient medical detoxification
- Pre-treatment groups
- Intensive outpatient treatment
- Outpatient treatment
- Day treatment
- Aftercare/12 step groups
- Narcotic replacement treatment

Residential Services

- Boarding homes
- Adult residential treatment
- Child/adolescent residential treatment
- Transitional housing
- Adult family homes
- Treatment foster care
- Low income housing (dedicated to BH consumers)

Supports For SPMI / SED Populations

- Representative payee/financial services
- Time limited transitional groups
- Parent support groups
- Youth support groups
- Dual diagnosis education/support groups
- Caregiver/family support groups
- Youth after school normalizing activities
- Youth tutors/mentors

The BH clinician must be competent in both MH and SA assessment and service planning. A specific standard of practice should be adopted that defines the methods and frequency of communication with PCPs. Note that this quadrant is where most public sector BH consumers currently can be found.

Quadrant III

Low BH-high physical health complexity/risk, served in the primary care/medical specialty system with BH staff on site in primary or medical specialty care, coordinating with all medical care providers including disease managers.

The PCP provides primary care services, works with medical specialty providers and disease managers (e.g. diabetes, asthma) to manage the physical health issues of the individual and uses standard BH screening tools and practice guidelines to serve most individuals in the primary care practice. Use of standardized BH tools by the PCP and a tracking/registry system focuses referrals of a subset of the population to the BH clinician. The role of the primary care or medical specialty based BH clinician is to provide BH triage and assessment, consultation to the PCP or treatment services to the patient, referral to community and educational resources, and health risk education. BH clinical and support services may include individual or group services, use of cognitive behavioral therapy, psycho-education, brief SA intervention, and limited case management. The BH clinician must be competent in both MH and SA assessment and service planning. The PCP prescribes psychotropic medications using treatment algorithms and has access to psychiatric consultation regarding medication management.

Depending on the setting, the BH clinician may also serve as a health educator regarding lifestyle and chronic health conditions found in the general public (diabetes, asthma) or conditions found in at-risk populations (Hepatitis C, HIV). These population-based services, as articulated by Bob Dyer, would include: patient education, activity planning; prompting; skill assessment; skill building; and, mutual support.[xxi] In addition to these disease management services, the BH clinician might serve as a physician extender, supporting efficient use of physician time by problem solving with acute or chronic patients, as well as working with patients on medication compliance issues.

Quadrant IV

High BH-high physical health complexity/risk, served in both the specialty BH and primary care/medical specialty systems; in addition to the BH case manager, there may be a disease manager, in which case the two managers work at a high level of coordination with one another and other members of the team.

The PCP works with medical specialty providers and disease managers (e.g. diabetes, asthma) to manage the physical health issues of the individual, while collaborating with the BH system in the planning and delivery of BH clinical and support services, which include those listed in Quadrant II. Psychiatric consultation is a key element in these most complex situations. The role of the specialty BH clinician is to provide BH assessment, arrange for or deliver specialty BH services, assure case management related to housing and other community supports, and collaborate at a high level with the healthcare system team. The BH clinician must be competent in both MH and SA assessment and service planning.

In some settings, BH services may be integrated with specialty provider teams (for example, Kaiser has BH clinicians in OB/GYN working with substance abusing pregnant women). With the extension of disease management programs into Medicaid health plans, there is the likelihood of coordinating with disease managers in addition to healthcare providers. The BH clinician and disease manager should assure they are not duplicating tasks, but working together to support the needs of the consumer. A specific standard of practice should be adopted that defines the methods and frequency of communication.

Application of the Model to Various Populations

The examples used in the diagram of the Four Quadrant Integration model are for adult populations; the same template can be used to create models that are specific for children and adolescents, or older adults, reflecting the unique issues of serving those populations (for example, the role of schools and school based services in serving children). Older adults, particularly, have been shown to utilize primary care settings for psychosocial, non-organic somatic complaints and to be underrepresented in specialty BH populations—research suggests they are willing to receive BH services in a primary care setting and that targeted interventions can make a difference in depression symptoms.[xxii xxiii]

Ethnic, language and racial groups also have unique issues in receiving language and culturally appropriate behavioral health services. Primary care based BH services can improve access for these populations and lead to appropriate engagement with BH specialty services as needed. For example, the Bridge Program in metropolitan New York has been successful in reaching the Asian-American community via their primary care settings.[xxiv]

There are also differences between rural and urban environments and among regional markets in terms of the resources available and ease or difficulty of access to services.[xxv] The Four Quadrant Integration model provides a template for considering the resources locally available and developing alternative methods of coordination (for example, telemedicine) that may be required when specialty care (either physical or behavioral health) is delivered in another community.

The Four Quadrant Clinical Integration model is not diagnosis specific; it looks at degree of clinical complexity and risk/level of functioning. Further, the evidence-base is at different levels of development in each of the Quadrants. The model is intended to provide a conceptual construct for how to integrate

services. Diagnosis specific guidelines (such as those developed by Northern California Kaiser-Permanente) should be used to provide detailed guidance for the scope of the primary care provider, the primary care based BH provider, and the specialty BH provider.

Building on the Evidence Base

Depression Research and National Initiatives

The impetus to improve behavioral health and primary care integration has been given considerable energy as the result of research focused on depression and how it is identified and treated in primary care.

There are a number of well-researched and financed initiatives using sophisticated clinical models to implement the findings of the research. Much of this work is well known within the research and general healthcare community but has not been closely tracked by the public mental health community**.** We need to learn about these models, not only because they are important for integration efforts with primary care, but also because **there are evidence-based practices that we should be implementing in our specialty BH delivery systems.**

The **National Program Office for Depression in Primary Care** (a Robert Wood Johnson funded project located at the University of Pittsburg Medical School) has developed a clinical framework, or Flexible Blueprint, for best practice. It is based on the chronic care model developed under The Improving Chronic Illness Care Program (also a Robert Wood Johnson funded project) and was modified after a review of published interventions used to treat depression, interviews with a variety of primary care physicians, mental health specialists and other experts in the field, and selected site visits to view elements of the chronic care model in action.

The Flexible Blueprint is comprised of six basic components encompassing key provider, health system, community, and patient factors.

- **Leadership (**also referenced as **Organization of Health Care)** in an organization is one of the essential components for initiating and sustaining any program.
- **Decision Support** refers to the implementation of practice guidelines and protocols.
- The **Delivery System Design** is the structure that is created to implement all aspects of decision support.
- The **Clinical Information System** serves as the underpinning for maximizing continuity of care.
- **Self-Management Support** programs for consumers encourage empowerment and assist them in dealing with their illness.
- **Community Resources** should be available to consumers and their families to assist in sustaining the effectiveness of treatment.

The BH reader, accustomed to working within a recovery orientation, may initially feel some discomfort with the emphasis on chronic care, so it is important to note that this initiative is grounded in improving how healthcare systems respond to and provide support and empowerment for people who have chronic health conditions. The research basis shows that the “informed, activated consumer” interacting with a “prepared, proactive practice team” achieves the best outcomes.

The six components of the Blueprint have guided the development of protocols, tools and organizational strategies relevant to how primary care providers identify needs and do their work, not specifically just for depression but also for other conditions such as diabetes and asthma. These components are also very relevant to the way in which public mental health systems organize themselves to do their work. The Blueprint promises to be a vehicle for improving communication across systems by providing a common taxonomy for how services are organized and delivered.

The **Health Disparities Collaboratives** are part of a multi-year national initiative to implement models of patient care and change management in order to transform the system of care for underserved

populations. The Institute for Healthcare Improvement (IHI), with support from the Bureau of Primary Health Care (BPHC), has provided leadership for the collaboratives and recently produced training manuals to help health centers improve care for their patients with chronic illness. CHC grantees with new BH programs will be expected to participate in the Depression Collaborative and implementation of the key concepts in the Depression Manual. Specialty BH providers who want to partner with CHCs should plan on implementing these models of care. (The Depression Manual can be accessed through the NCCBH website.) The key change concepts found in the manual include:

- **Organization of Health Care/Leadership**
  - Make sure senior leaders and staff visibly support and promote the effort to improve chronic care
  - Make improving chronic care a part of the organization's vision, mission, goals, performance improvement, and business plan
  - Make sure senior leaders actively support the improvement effort by removing barriers and providing necessary resources
  - Assign day-to-day leadership for continued clinical improvement
  - Integrate collaborative models into the quality improvement program

- **Decision Support**
  - Embed evidence-based guidelines in the care delivery system
  - Establish linkages with key specialists to assure that primary care providers have access to expert support
  - Provide skill oriented interactive training programs for all staff in support of chronic illness improvement
  - Educate patients about guidelines

- **Delivery System Design**
  - Identify depressed patients during visits for other purposes
  - Use the registry to proactively review care and plan visits
  - Assign roles, duties and tasks for planned visits to a multidisciplinary care team. Use cross training to expand staff capability
  - Use planned visits in individual and group settings
  - Make designated staff responsible for follow-up by various methods, including outreach workers, telephone calls and home visits

- **Clinical Information System**
  - Establish a registry
  - Develop processes for use of the registry, including designating personnel to enter data, assure data integrity, and maintain the registry
  - Use the registry to generate reminders and care planning tools for individual patients
  - Use the registry to provide feedback to care team and leaders

- **Self- Management**
  - Use depression self management tools that are based on evidence of effectiveness
  - Set and document self management goals collaboratively with patients
  - Train providers and other key staff on how to help patients with self management goals
  - Follow up and monitor self management goals
  - Use group visits to support self management

- **Community**
  - Establish linkages with organizations to develop support programs and policies
  - Link to community resources for defrayed medication costs, education and materials
  - Encourage participation in community education classes and support groups
  - Raise community awareness through networking, outreach and education
  - Provide a list of community resources to patients, families and staff

For more information on primary care depression research and model development, please visit the NCCBH website, www.nccbh.org, Primary Care Integration Resource Center, which also includes information on The MacArthur Initiative on Depression and Primary Care at Dartmouth and Project IMPACT at UCLA.

The Challenge of Implementing Evidence-Based Practices

The Flexible Blueprint and the Depression Manual both address a significant finding: "Practices that have been demonstrated to be effective by clinical services research could improve the lives of many people if they were widely adopted in routine healthcare settings…However, studies of the impact of practice guidelines suggest that publication and distribution of guidelines is not enough to change the practice of clinicians." Torrey and his colleagues, in their review of the literature regarding efforts to change clinical practice, note that training and education alone is insufficient, sustained change requires a restructuring of the flow of daily work, and focused restructuring may not be sustained following a period of intervention unless there is continued feedback. They conclude that the supports required to establish and maintain a desired practice include: "clearly voiced administrative support for change before training; initial clinical training using didactic methods, observation of practice and written materials; ongoing weekly supervision by an expert, based on written principles and practices; follow–up visits by a program expert with feedback on implementation; and feedback on services and outcomes…To succeed, the system of care must have adequate resources and be reasonably organized, and the efforts of multiple stakeholders must be aligned to support the practices".[xxvi]

The specialty BH system has an opportunity to join with CHCs in using these structured tools to improve depression care in primary care and in the specialty BH setting. However, the literature suggests that careful planning, stable financing and infrastructure are needed in order to be successful over the long term.

Financing Issues

It is not surprising that large scale BH/primary care integration models developed first within staff model HMOs such as Kaiser, HealthPartners and Group Health—the financing stream is less of a barrier, although internal negotiations are still required to identify the resource base for integration. For the rest of the healthcare delivery system, minimal progress has been made on resolving issues of financing. Where the state has structured the Medicaid program into a carve-out, or when the consumer does not meet state target population definitions or is uninsured, there are barriers to be resolved. Similarly, the private sector continues to "vote with their dollars for carve-outs", [xxvii] and the dialogue about parity is often framed within the assumption that managed care carve-outs are a key piece of implementation, borne out by the recent experience in California. Major purchasers have not shifted to support integrated care.

Given the variability of financial and structural arrangements for the purchase and delivery of physical healthcare and behavioral health in both the private sector and the public sector, the NCCBH has created a model for clinical integration with the intent that, if the stakeholders can agree on what the clinical model should be, a negotiation grounded in state and local financial and structural arrangements can proceed in support of a shared clinical vision.

Stakeholders will need to assure adequate resources to ensure success of a shared clinical vision. Screening and identification, extension of access to those not now served, and coordination of clinical services are cost additive for the overall healthcare system. There is a widespread belief that integration and provision of coordinated services, if broadly implemented for entire populations, will not only improve quality, but also reduce the overall cost to the system; however, there is not sufficient current documentation regarding the cost/benefit effect.[xxviii] This means that each integration effort will have to establish the quality improvement basis for initial implementation, and assure that there is tracking of both quality and cost outcomes to make the case over time.

Depending on the focus of the integration effort within the Four Quadrant model, there are specific observations that can be made regarding financing mechanisms.

Quadrant I

Low BH-low physical health complexity/risk, served in primary care with BH staff on site; very low/low individuals served by the PCP, with the BH staff serving those with slightly elevated health or BH risk.

Most sites report the importance of both formal (staff meetings that include case conferencing) as well as informal (curbside consultations) methods of communication between physicians and BH clinicians in order to create something other than side-by-side practices.[xxix] In one setting, 92% of consultations between BH clinician and PCP were unscheduled consultations lasting under 5 minutes.[xxx] However, state level decisions regarding Medicaid codes and claims management processes often result in electronic edits that reject a claim submitted by a BH provider if there is also a claim submitted by the PCP on the same day.

The recent (2002) adoption of CPT codes for behavioral health services in primary care was intended to address the issue of primary care based services delivered in coordination with PCP services. These codes establish a method for billing when the consumer has Medicaid or other health insurance. The codes have been adopted by Medicare and are being implemented by intermediaries. Adoption by Medicaid and private sector plans is proceeding on a state-by-state basis.

CPT Code	Service Description
96150	Behavior assessment, clinical interview, behavior observations, psycho-physiological monitoring; face to face, 15 minute intervals
96151	Re-assessment
96152	Behavior intervention; face to face, 15 minute intervals
96153	Group intervention (2 or more patients)
96154	Family intervention with patient present
96155	Family intervention without patient present

The new CPT codes do not necessarily address all the issues that arise regarding provision of both BH and PCP services on the same day. Among the tools in Attachment C is an overview of billing rules, coding and modifiers that can assist providers in analysis of the payment environment. Each state has different Medicaid rules. After analysis of the environment, providers should initiate a Medical Director level conversation with Medicaid and private sector plans regarding the planned approach.

The Health Resources and Services Administration (HRSA) Primary Care Integration Initiative as well as the expansion of CHC sites provide new financing and an important local opportunity for community mental health providers to collaborate with CHCs. **The opportunity for collaboration is now; CHCs are in the process of decision making about building their own BH services or contracting for BH services**. Effective operational integration can be achieved via both methods of staffing,[xxxi] but the implications for system-wide duplication and competition for the scarce resources of BH staff, as well as the opportunity to improve consumer access to both health and behavioral healthcare services, suggests that collaboration should be prioritized.

Collaboration requires hard work on the part of both systems. Even organizations that incorporate both traditional community mental health and CHC services under the same roof have had to work at resolving reimbursement issues. Cherokee Health Systems is an example of this type of organization; their experience is that, while the new CPT codes for behavioral health services in primary care are a very important step toward being able to bill for primary care based services, the more streams of revenue and diversity of funding sources there are, the more creatively the two systems can work together.

Quadrant II

High BH-low physical health complexity/risk, served in a specialty BH system that coordinates with the PCP.

The specialty BH system is funded to provide specialty BH services (of course, there is the question of whether the funding is adequate—reports have emerged from many states prior to the current Medicaid fiscal crisis, indicating that the public system is funded at somewhere around half the level that is needed; in the private sector, the relentless downward pressure on PMPMs has also reduced overall system resources). [xxxii] That said, the issue here is to assure that there are effective means and methods of bi-directional communications with PCPs. In most public MH systems, collateral contacts are reimbursable as a part of case management services; MBHOs may or may be not reimbursing for this time. Any major system-wide effort at improved communication should estimate the impact of consistent communication regarding all active consumers and the methods for addressing that impact.

Quadrant III

Low BH-high physical health complexity/risk, served in the primary care/medical specialty system with BH staff on site in primary or medical specialty care, coordinating with all medical care providers including disease managers.

The discussion above regarding Medicaid and private sector plans and their claims management processes as well as the new HRSA grant funding is relevant to this population group. In addition to providing BH services for psychiatric diagnoses (in which case the clinician must be a billable member of the panel of providers for the patients' health plan), the BH clinician may also be providing disease management and health education services (in which case the clinician might bill as a mid-level provider under the auspices of the physician).[xxxiii] Dyer describes a business model for provision of BH services to primary care groups—contracting to offer services within the practice, documenting and billing from within the practice. [xxxiv] Providers who want to focus on this population need to develop the capacity to support these types of relationships in settings where there are few disease management services provided for use by physicians.

Quadrant IV

High BH-high physical health complexity/risk, served in both the specialty BH and primary care/medical specialty systems; in addition to the BH case manager, there may be a disease manager, in which case the two managers work at a high level of coordination with one another and other members of the team.

Again, the specialty BH system is funded to provide specialty BH services, but in serving this population, an even higher level of collaboration is needed. The impact of this level of collaboration may be better managed if BH clinicians serving this population have caseloads and team mechanisms that are similar to those for Assertive Community Treatment (ACT) teams. Financing models for this population have tended to be programmatic in nature (for example, targeted outreach and BH services for the HIV/AIDS population). The population in Q IV tends to comprise the 20% that utilizes 80% of system resources—due to their level of disability, there may not be dependable funding streams supporting them, and they may be identified in other systems such as criminal justice. The goal of serving people at this level of intensity is to support their eventual step down to a less intensive level of care.

Competencies and Infrastructure

Currently, of the 373 providers responding to a NCCBH survey, only .3% report they are active in serving primary health care consumers.[xxxv] The implications of this for clinical and infrastructure development are significant—there is much to be done. On the other hand, for most (68%) of these same providers, public sector consumers account for 80% or more of those they serve—over 70% serve SPMI/SED and know the needs and best practices for these populations. There is much that we can build upon.

When the public behavioral health system is functioning at its best, it brings significant strengths to the development of collaborative relationships with primary care. These include:

- Experienced providers of services to the "safety net" population, with knowledge of the high risk, chronic populations and complex disorders
- A broad array of BH services and referrals/linkages to community supports
- Strong case management models delivered by diverse staff
- Serving as an access point to eligibility for specialty BH services, with advocacy and enrollment available
- Psychiatrists who understand the range of psychopharmacologic issues, from dosage to off label uses
- Services that are not only facility based, not only medical model, but based in the community, incorporating the connective tissue of supports and services
- Acute care and crisis intervention capacity, the "first responders" to the community
- Multi-agency relationships and strong collaboration with other systems (schools, criminal justice, child welfare)

These strengths, however, do not take the system to the level needed to be effective at primary care integration—we need to learn from organizations that have actually implemented and sustained integration.

Strosahl (a leader in Group Health's integration work) has made a number of important points about designing and installing primary care based integrated delivery systems:

- *Integrated primary care behavioral health products, to be feasible must…*
  - *Be transferable to any delivery system model or setting*
  - *Be largely cost neutral in delivery system impact*
  - *Be affordable to purchase, install and operate*
  - *Have demonstrated clinical efficiency*
- *Proper installation involves attending to…*
  - *Program design*
  - *Administrative and operations processes*
  - *Clinical practice and training*
  - *Financing mechanisms*
  - *Program evaluation*
- *Properly installed, an integrated delivery system should…*
  - *Be grounded in population-based care*
  - *Deliver consistent primary mental health care services*
  - *Utilize both horizontal and vertical integration strategies*
  - *Work in a variety of practice settings*
  - *Have a consistent operations infrastructure*
  - *Be capable of independent growth and maintenance*

Strosahl also emphasizes the importance of "*product fidelity*"—assuring that evidence-based practices are implemented consistent with the interventions that have produced the research results.[xxxvi] This is consistent with knowledge about best practice implementation and has implications for protocols, policies, procedures, manuals, training, and documentation, as well as the planning and design work needed to implement evidence-based models.

In a related analysis, Peek and Heinrich at HealthPartners developed the concept of clinical, operational and financial road maps for integrating medical and behavioral care into a biopsychosocial system.[xxxvii] They note that healthcare systems operate simultaneously in these three worlds (clinical, operational and financial), but that each world has its own internal logic and language. While people are hired for their expertise in a specific world, they need to learn the logic and language of all three—"*if an action fails to meet the requirements of one of the worlds, it will ultimately fail in all three*". Among their many useful concepts for developing collaboration that unites professionals of all different disciplines is the idea of shifting from "*working as a 'soloist' to working as an 'ensemble-i*st'." They note that what unites musicians is not "*their chosen instrument but their shared musicianship*" and go on to observe "*we as health care professionals must speak meaningfully about good **providership**, just as musicians speak of good **musicianship***". They illustrate with some mottos that became part of building a common culture of "*good providership*":

- *Most difficult patients started out merely as complex*
- *The right kind of time at the beginning of a case saves time over the life of the case*
- *Patients, providers, and families can't do their part in care plans they don't understand and embrace*
- *Watch the team score, not just your own score*

Similarly, at Kaiser, certain shared ideas were the basis for planning and implementation of primary care integration:

- *Get it right the first time—accomplish as much as possible at any individual visit and minimize return appointments or referral steps.*
- *Frontload expertise—assure a high level of clinical expertise early in the treatment process.*
- *Leverage physician time—create a relationship between the patient and the team, rather than just between the patient and the physician.*
- *Outreach—encourage patients to be involved in their own care and use tracking mechanism that minimize "falling through the cracks".*
- *Consumer driven access—minimize gate-keeping functions and enhance patient education.*

This expertise about successful implementation of integration models in organized healthcare systems is a starting point for the more difficult task of integrating care in community systems that are often fragmented. We have some reports from the real world of public sector implementation—the NCCBH is indebted to the individuals who presented within the Behavioral Health/Primary Care Integration track at our 2003 Conference in Denver, providing us with real world examples of how they have been implementing integration. They represent varying segments of the Four Quadrants, and are at different points in their process of development. Shared samples of their tools are provided in Attachment C.

Staff Skills

The literature and our presenters agree—providing BH services in a primary care setting (either Quadrant I or III) uses a different interventional model than that generally employed in public BH services. The practice culture of primary care requires:

- Consultative behavioral interventions
- Fast pace of brief interactions
- High volumes of persons seen (an average PCP sees 130 patients per week)
- Immediate access, visibility and availability, where interruptions are OK
- New vocabulary
- Different documentation and tracking systems

According to our presenters, the skills, orientation and characteristics needed to be successful while providing BH services in a primary care setting include:

- Finely honed clinical assessment skills (both MH and SA)
- Cognitive behavioral intervention skills
- Group and educational intervention skills
- Consultation skills

- Communication skills
- Flexible, independent and action orientation
- Solution rather than process orientation
- Prevention orientation
- Team and collaboration orientation
- Clinical protocols and pathways orientation
- Focus on impacting functioning, not personality
- Behavioral medicine knowledge base and/or interest in medical issues
- Experience with the SPMI and SED populations and how the public BH system works
- Understanding of the impact of stigma
- Strong organizational and computer competency
- Bilingual and culturally competency in serving the major population groups seen in the primary care clinic

These BH clinicians are from a variety of disciplines: Ph.D. psychologists, Master's level therapists, and Advanced Practice nurses. In addition to the characteristics listed above, those who provide Quadrant III services must have additional knowledge and skills related to chronic disease and the best practices of disease management (see Attachment C: Tools/Practice Guidance for more detail).

Documentation

The documentation methods to be used will vary depending on the business model that is adopted for placing a BH clinician in the primary care setting. If the BH clinician is an employee of the clinic, the documentation becomes a part of the medical chart (in most instances in a separate segment of the chart so the notes can be quickly located as well as be protected from inadvertent release). If the BH clinician is the employee of a BH provider organization, providing services through a contractual agreement, Dyer recommends consideration of a "staff rental" model, in which the BH clinician works under the direction of the physician and documents in the medical chart. In this model, billing is done using medical rather than BH codes, by the clinic rather than the BH provider. In another model, billing is done by the BH provider organization using BH codes, so documentation is within the BH system. The decision about business model and staff "ownership" should be made after considering all possible revenue streams, both medical and BH, in order to determine the most stable and advantageous revenue mix. (Attachment C tools provide more detail.)

Whether the documentation becomes part of the medical chart or the BH provider organization chart, there is consistent agreement regarding brief, immediate documentation. This will require BH providers, who often have extensive documentation requirements related to their public financing, to develop alternate methods of documentation for primary care based services, in which most of the consumers seen are unlikely to be covered by public BH funding sources. BH clinicians will not be able to function responsively within the primary care culture if they are expected to carry over the bureaucratic paperwork requirements of most public sector BH systems.

Working Environment

Organizations providing integrated BH services in a primary care setting are very conscious of the degree to which the allocation of physical space and support resources adds to the success of integration or serves as a barrier. Ideally, BH staff are located in offices within the primary care area—an "open door" style is part of the primary care culture. Behavioral consultations may often occur in medical exam rooms. Clerical support is the same as that for PCPs. Access to computers with clinical databases and disease management registries is critical—one component of the best practice Flexible Blueprint is a Clinical Information System that supports tracking and clinical communication. Staff interact informally in break rooms, at nursing stations, and in the hallways. There are shared reception and common areas for consumers. The BH clinician is part of the team and ongoing care delivery.

What Are The Implications For Behavioral Healthcare Organizations?

How can behavioral health providers determine their future work in regard to the Four Quadrant model? Some organizations may already be operating in all four quadrants, others may only be operating in one. There are differences between comprehensive BH providers and those providing niche or specialized services such as residential treatment, as well as differences between general population needs and SPMI/SED needs.

Here is an initial analysis for various types of provider organizations:

- All BH providers should be operating in Quadrant II—assuring coordination with primary care for their consumers. There is considerable variability in current practice. Frequently this variability has been driven by payor requirements. In the future, a standard protocol for communication and coordination should be developed and provider organizations should assure fidelity to the protocol.
- Niche BH providers should be in Quadrant II and may also be operating in Quadrant IV, depending on their area of specialty. A decision to enter into provision of Quadrant I services will be a business decision based on local market analysis and consistency with mission. Niche providers may also want to consider affiliation strategies.
- Comprehensive BH providers should be operating in Quadrants II and IV. In addition, they should be creating partnerships with primary care providers and pursuing all funding methods to support Quadrant I primary care based BH clinicians. Initially, BH providers will want to focus this effort on collaboration with CHC and public health "safety net" providers. Over time, the collaboration should be expanded to other primary care providers serving the Medicaid population
- A decision to enter into provision of Quadrant III services—primary care based BH, disease management and physician extender roles—will be a business decision based on local market analysis and consistency with mission.

This discussion paper was developed to provide an overview of integration thinking to date and to propose a conceptual model for how Behavioral Health (mental health and substance abuse/addiction) services and Physical Health services can be integrated to improve services for consumers and achieve improved health outcomes. The Attachments to the paper provide supplementary information regarding principles, observations regarding integration to date, and tools from presenters at the NCCBH 2003 Conference.

The National Council for Community Behavioral Healthcare is engaged in the national dialogue regarding integration, and encourages its member organizations to develop related dialogues at the state and local level, especially in regard to collaboration among the "safety net" providers. To that end, NCCBH will offer state and local trainings regarding integration, as well as assessment tools that look at the state level policy and financing environment as well as individual organizational capacity.

Finally, the NCCBH website, www.nccbh.org, has a Primary Care Integration Resource Center with linkages to other important documents and resources. As further information and resources become available, they will be posted in the Resource Center. We encourage you to share your experience and ideas with us

Attachment A: NCCBH Principles for Integration

Detailed principles have been developed based upon the NCCBH's Principles for Behavioral Healthcare Delivery, specifically those focused on Linkage and Integration. Ideas have also been derived from principles articulated at the Surgeon General's Working Meeting on The Integration of Mental Health Services and Primary Health Care, by the American Association of Community Psychiatrists, by the Washington Community Mental Health Council, as well as by other sites around the country.

The principles include detailed bullets under each of the headings listed below; these drafts are under discussion by various constituencies and are intended to contribute to the national, state and local dialogues currently underway. Ideally the dialogue will result in the adoption of a set of shared principles between the behavioral and physical healthcare systems.

1. Focus on Consumers and Their Families
2. Promote Health, Overcome Disparities, and Address Chronic Illness
3. Standardize Quality and Outcome Measures for Use in Research and Practice
4. Promote Collaboration and Co-location
5. Redesign Financing, the Regulatory Environment and Contracting Methods
6. Develop Best Practice Service Delivery Models
7. Invest in Training
8. Assure Information Technology

Attachment B: Observations Regarding Integration

Regier and Bishop enumerated this list of issues in a presentation to the National Association of Rural Mental Health.[xxxviii] Among the conflicting practice traditions they suggest must be addressed are:

- Physical location: separate with historical segregation of SA services from MH services
- Confidentiality and case consultation: open vs. controlled and guarded
- Session focus: physical/somatic vs. emotional
- Documentation: brief and specific vs. elaborate and detailed
- Biomedical model vs. Psychosocial model: reductionist vs. systems view
- Stigma: isolated to certain medical conditions vs. pervasive stereotype of mental illness
- Consent for treatment: informal vs. formal
- Session time frames: 8 minutes vs. 45 minutes
- Process of diagnosis: severity of somatic symptoms vs. DSM-IV criteria
- Liability and litigation: order more tests vs. document everything
- Finances and reimbursement: lack of parity in coverage and referral mechanisms
- Attitude about change: suffering does not equal readiness for change

Doherty, McDaniel and Baird have noted that the extent of collaboration in any given case is a function of the nature of the case itself, the collaboration skills of the providers, and the collaboration capacity of the health care team and setting. Focusing on the system and organizational issues that facilitate or impede collaboration, they described the levels of collaboration achievable in different kinds of settings.

- Minimal collaboration
    - Separate facilities and services with rare communication
    - Most private practices and agencies
    - Can handle routine medical or psychosocial problems with little biopsychosocial interplay and few management difficulties

- Basic collaboration at distance
    - Separate facilities with periodic sharing on common patients
    - Facilities with active referral linkages
    - Providers view each other as resources, but with little sharing of power and responsibility
    - Can handle moderate biopsychosocial interplay where management of both problems is proceeding well

- Basic on-site collaboration
    - Shared facility but separate systems, with regular communication on common patients, occasionally face to face
    - HMO settings, rehabilitation centers, clinics with BH specialists who do primarily referral oriented services
    - Providers appreciate each other's roles, but do not share a common language or understanding
    - Can handle moderate biopsychosocial interplay where face to face interactions to coordinate complex treatment plans is necessary

- Partly integrated
    - Shared facility and limited shared systems (e.g., scheduling, charting), with regular face to face interactions, mutual consultation, coordinated treatment plans
    - HMO settings, rehabilitation centers, hospice centers, family practice training programs
    - Providers have a shared allegiance to a biopsychosocial/systems paradigm, but pragmatics are sometimes difficult
    - Can handle significant biopsychosocial interplay and management complications

- Fully integrated
    - Shared facility, systems, vision and seamless services, regular team meetings to address both patient issues and team collaboration issues
    - Some hospice centers, special training and clinical programs
    - Providers are committed to biopsychosocial/systems paradigm, have a deep understanding of roles and cultures, and make conscious effort to balance power and influence
    - Can handle the most difficult and complex biopsychosocial interplay with challenging management issues

The recent scan of stakeholder experts conducted for SAMHSA reported mixed findings regarding BH/Primary Care integration for treatment of depression:

- ***There is great confusion surrounding the concept of integration—what it means, for whom, and what a 'successful' model looks like. Stakeholders agree that quality improvement of clinical care is the desired goal, but aren't sure how to get there.*** *Stakeholders described several specific models and approaches, but admit that their understanding and experience of success in practice is at best limited.*

- ***Rapid increases in the availability, use, and costs of prescription medications are seen as an important driver for integration across the behavioral and physical healthcare, and pharmacy benefit systems.*** *All stakeholder groups share concerns about quality problems that may relate to medication management and contraindicated prescribing.* ***Consumers see this as a 'number one' concern.*** *Data transfer and confidentiality issues often complicate efforts to identify problems in this area.*

- ***More than half of our stakeholder experts reported that integration or coordination of behavioral and physical healthcare is a 'very important' priority—but most added, 'a priority for me but not for others.'*** *Most stakeholders perceive limited awareness of the importance of integration as an issue, especially among purchasers, who have the market leverage and clout to move markets by demand. For many, they say, concern with cost and other issues tops the list. Integration 'isn't on the radar screen.'*

- ***A small elite of value-based purchasers and purchasing coalitions; large public systems including the VA, Air Force, and a new initiative with HRSA's community health centers; and promising clusters of research and demonstration projects funded in the public and private sectors by the Robert Wood Johnson Foundation (RWJF) are pioneering efforts to integrate care for quality improvement. These groups are setting the standard and marking the pace.*** *Few in number and well resourced, they face growing pressure to demonstrate success—and sustainability.*

- ***Many stakeholders support integration as a concept—but are not clear about the benefits. Lack of information about benefits (and risks) and how to realize, measure, and demonstrate them in practice is a common complaint.*** *The lack of evidence seriously jeopardizes support for implementing and sustaining related models and programs, even among employers and value-based purchasers who currently use integrated delivery approaches.*

- ***Stakeholders in all groups are calling for information about implementation and outcomes.*** *They want research-based evidence about 'what works and what doesn't and how' in implementing successful models that integrate or coordinate behavioral and physical healthcare in practice settings. Stakeholders need* ***evidence that integration is producing positive outcomes,*** *including cost savings for the purchaser and improved quality outcomes for consumers.*

- ***Purchasers who have developed integrated approaches for treating depression and other behavioral health problems emphasized the importance of using specific measures and models, including evidence-based approaches, to guide integration activities.*** *They stressed*

*the importance of accountability from the systems and its stakeholders at every level. Stakeholders who have developed integrated approaches say uncertainty is part of the challenge…**Moving forward is a process: getting specific, using trial and error and formative assessment to guide the course, and taking risks to experiment and innovate.***

- ***Integration or coordination of behavioral health and primary care isn't the answer for everyone, nor is it always possible or feasible.*** *According to stakeholders' observations in the field,* ***models differ in their efficiency and effectiveness, and in diverse organizational and market contexts.*** *At present, little is known about the relative performance of various model types in diverse market settings—and whether or to what extent these models are transferable to different contexts.* ***Stakeholders are calling on the research and demonstration communities for answers to these and other questions.***

- ***Three out of four stakeholders described situations where integration efforts have presented problems for purchasers or consumers.*** *Most problems involved: 1) changing roles, responsibilities and resources, i.e., who has control and accountability, and how dollars are divided; 2) interpersonal issues and professional culture clashes; 3) infrastructure issues such as availability of providers and network adequacy; and 4) data management and confidentiality.*

- ***Stakeholders identified financial and non-financial barriers and leverage points, but admitted having little solid evidence or understanding about how to effectively address these barriers.***
  - ***Financial barriers*** *and core issues mentioned most frequently were 1) Lack of Payment/Funding: Who Should Pay For The Costs Of Collaboration?; 2) Ratesetting/Payment: How Should Rates And Pricing Be Developed?; and 3) Monitoring and Assessing Costs and Benefits: Is Integration Worth The Price?*
  - ***Non-financial barriers*** *and core issues mentioned most frequently were 1) Cultural Resistance: Professional Paradigms, Roles and Relationships; 2) Technical Difficulties: Data Management And Transfer, And Privacy Issues; 3) Purchasers Don't Require It; and 4) Outcomes, Evidence, and Successful Models: Can We Make the Case?*

- ***Stakeholders offered suggestions to 'fix' the system and facilitate opportunities for integration in several areas:*** *1) Changes in Attitude: New Paradigms of Practice; 2) Reimbursement: Pay for Collaboration, Pay and Train PCPs to Treat; 3) Accountability: Use Performance Measures and Metrics; 4) Infrastructure: Data Systems and Resources; and 5) Make the Business Case for Models that Work.* ***Most stakeholders believe that changes are needed on multiple levels.***

- ***Stakeholders across the board identified the need for timely*** *information about advances in behavioral health and integration or care coordination for treatment of depression and related disorders.* ***Many are frustrated by the lack of information and 'real world' research, and disappointed by the absence of timely research and information about innovations and best practices. Stakeholders turn to professional organizations, journals and publications, and individuals as credible sources of information. Many reported that existing channels and content need improvement.***

- ***Contracts are seen as a useful tool for defining benefit preferences—but they must be defined in specific terms, with specific models in mind, and funded appropriately. Public and private purchasers differ in their views about contracts. Private purchasers said they did not want to be 'overly prescriptive.' Public purchasers were more likely to promote rigorous, detailed contracts.*** *Many stakeholders urged use of performance measures in contracts to ensure accountability. They advise prioritizing contract requests and caution, 'Don't take on too much.'* ***Stakeholders in both the public and private sectors hold mixed views about contract monitoring. Many see it as a difficult, time consuming and costly activity. There is a lack of consensus about what should be monitored and how.***

- ***New attention is focused on the use of purchaser incentives—both financial and non-financial—to encourage quality improvement with plans, providers, and consumers.*** *Most stakeholders know little about this emerging area, and look to research and demonstration projects initiated by RWJF and other sponsors to provide needed guidance.*

- ***More information is needed about consumers—those already receiving services, those who are not yet in the system, and those who have dropped out—including their preferences for treatment, care and follow-up. Increasingly, consumers will drive demand for services—including pharmaceutical treatments. And, while several stakeholders noted that an empowered consumer who knows his/her treatment options is important for success, few professionals seem to be focused on engaging or developing tools to encourage more active consumer participation in models of treatment and recovery. The changing rules and roles of professional collaboration take center stage for many.***

- ***There is a lack of common understanding of several key concepts among stakeholders:***
  - ***Cost offsets—****whether and to what extent they can be realized through integrated models; how to measure and identify cost offsets and their relative efficiency in different models of clinical care;*
  - ***Parity—****many stakeholders see this as an opportunity to increase access to behavioral health care, others express concern about whether and to what extent purchasers and plans will be able to manage benefits to ensure appropriate utilization. Both perspectives see integration as a result: part of the solution—and a management necessity.*
  - ***Financial and non-financial incentives—****these are seen as a solution, but few stakeholders understand what they are and how they operate, or have experience using them.*

- ***Market leverage appears to play a significant, though poorly understood role in moving markets to integration or coordination.*** *Stakeholders identified several types of market factors that affect integration efforts: resource availability; market regulation, culture and custom; dominant market player; market consolidation and competition; and community norms and issues that 'fall through the cracks. At every stakeholder group and interface opportunity, most agree 'It's all about leverage' at the community market level.*

- ***Many of the historical obstacles to integration identified by stakeholders have been or are being addressed. Innovation and experimentation are underway in areas ranging from clinical models to financial and non-financial incentives, IT systems development, and performance measurement and monitoring across and within systems. Stakeholders call for knowledge development and information dissemination in these areas to create the business case—and the political will—for integration or quality improvement.***

Attachment C: Tools

State Level Principles /Collaboration Proposals

- Washington Community Mental Health Council. *Guiding Principles for Integration: Mental Health and Primary Health Care*
- Missouri Coalition of Community Mental Health Centers. *Proposal for Collaborative CHC/CMHC Primary Healthcare/Behavioral Health (PCBH) Model*

WASHINGTON COMMUNITY MENTAL HEALTH COUNCIL
600 Stewart Street, Suite 520 • Seattle, WA 98101 • 206.628.4608

GUIDING PRINCIPLES FOR INTEGRATION: Mental Health and Primary Health Care

Why Guiding Principles?

- Both state and federal level policy directives increasing call for integration of mental health and primary health care
- To create a best practice framework with which to approach integration planning, development and implementation
- To ensure a focus on client care and opportunities for improved outcomes within integration initiatives
- To establish guidelines to ensure that in the broader integration discussion, mental health, a small piece of the overall healthcare pie, does not get overlooked (particularly mental health care for those with severe and persistent mental illnesses)
- To provide a roadmap for thinking and talking about the complex, and often ill-defined topic of integration, with key points on which to focus

Ways in Which the Principles Can Be Used

1. As a client-centered entrée to networking and planning discussions with potential partners, policymakers and funders
    a. Primary healthcare partners
    b. State level policy makers who may be developing integration initiatives, Requests-for-Proposals
    c. Local policy makers involved in community-level integration and collaboration efforts
2. As a yardstick for use in responding to proposals, assessing and developing possible integration models, and for developing working agreements with partners:
    a. Are/how are these elements represented by the principles addressed in proposals, models and working agreements?
    b. Use principles as a springboard for goal development
3. For consideration in a variety of integration configurations – the principles are currently written in terms of mental health/primary care integration, but could be adapted for use with other integration combinations (mental health/chemical dependency, children's services, mental health/developmental disabilities)

WASHINGTON COMMUNITY MENTAL HEALTH COUNCIL
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GUIDING PRINCIPLES FOR INTEGRATION

Mental Health and Primary Health Care

Developed by Ann Christian, Policy Analyst
Adopted 12/05/02

Introduction

Improved integration of health and mental health care presents many opportunities for increased access to care and enhanced clinical outcomes. These include:

- Broader access to health and mental health care
- Improved communication among healthcare providers leading to better care coordination and fewer clinical errors
- Enhanced patient and family satisfaction
- Opportunities for mutual teaching and learning across healthcare disciplines

In light of these potential benefits, and given current state and federal integration initiatives, the Washington Community Mental Health Council has adopted the following principles to guide development, implementation and evaluation of integration models.

Principles

1. Integration can be accomplished successfully through clinical, structural and/or financial avenues. It is important to articulate and appropriately evaluate which avenue(s) will best accomplish expected outcomes.
2. Desired outcomes of integration need to include:
   ⇒ Increased access to care ("No wrong door" experience for consumers)
   ⇒ Improved patient/consumer health/mental health status & clinical outcomes
   ⇒ Improved patient/consumer satisfaction
   ⇒ Improved cost management and cost savings
   ⇒ Administrative simplification
3. Best practices, evidence-based treatment and existing knowledge should guide program development.
4. Integrated programs should incorporate the best of existing community systems, avoiding duplication or redevelopment of effective services and infrastructure.
5. Consumer, family member and advocate input, preferences and feedback should be an integral part of integration planning, implementation and evaluation.
6. Levels of mental health care should be clearly defined and addressed in program models:
   ⇒ Three distinct levels - general population-based care, specialty mental health care, and long-term care/community support should be addressed in the overall model
   ⇒ Models should identify how each level of care will be provided within or outside the integrated program
7. Health and mental health care integration processes should include clear definitions, expectations and measurable outcomes:
   ⇒ Identification of problem(s) to be solved, specific target population(s) and indicators of success
   ⇒ Articulation of proposed integration model, specifying type of integration (clinical, structural and/or financial) and targeted level(s) of care
   ⇒ Tracking of cause and effect of strategies, interventions and resulting outcomes
8. Pilot integration projects must incorporate an evaluation component in order to document and generate a body of integration knowledge.

NOTE: Many of these principles can be (and are encouraged to be) applied and/or adapted to integration efforts beyond mental health and primary care

DRAFT

PROPOSAL FOR COLLABORATIVE CHC/CMHC PRIMARY HEALTHCARE/BEHAVIORAL HEALTH (PCBH) MODEL

I. Purpose

The purpose of the PCBH collaborative agreement is to develop and implement a model designed to provide integrated primary care and behavioral health services for the general medical population. The proposed model is designed to (1) reduce health disparities ; (2) improve health outcomes in high risk populations; (3) improve collaboration between primary care and behavioral health practitioners; and (4) maximize the broad base of expertise and resources available within the CMHC and CHC systems.

II. Guiding Principles

1)There is a need for both specialty behavioral health services for persons with more severe behavioral disorders and behavioral health interventions among the general medical population. There will always be the need for both integrated and specialty settings in which to serve distinct populations.

2)Required health and behavioral health expertise exists within the respective CHC and CMHC systems. Each system has safety net designations for overlapping geographic areas. Each system also has specific care standards, accreditation, certification and licensure requirements, and supporting infrastructures which provide broad based access to a full range of expertise and care within their respective systems.

3)Primary care/behavioral health integration can be viewed as an opportunity to expand behavioral health services to move mainstream populations and has the added benefit of enhancing public awareness of mental health issues and broadening the advocacy base for both health and mental health services.

4)Both CHC's and CMHC's have an inherent responsibility to be effective stewards of public resources within their communities. Precious public resources can be maximized through collaborative arrangements designed to build specialized capacity within the respective systems of care as opposed to duplicating one another's services.

III. Proposed Service Model for Health Center

The integrated primary care/behavioral health model proposed is a **behavioral health consultant model** designed to address the following critical clinical and service delivery issues within primary health settings:

1)50% of the individuals who receive mental health care seek services from a primary care or family practice physician.

2)Psychosocial stress is a major factor in triggering physical illness and exacerbating existing chronic illnesses.

3)Many individuals seeking medical services report symptoms that may be psychosomatic, i.e., physical complaints without an identifiable medical basis. In these instances, an underlying behavioral or emotional condition can increase unnecessary medical utilization, and the patient is often not referred to appropriate treatment.

4)Many primary care physicians—faced with increased administrative demands and time constraints—are ill equipped to manage patients who present with mental health or substance abuse related issues.
5)Sub-clinical and clinical depression is frequently misdiagnosed or under diagnosed in general medical populations.
6)Substance abuse problems often go unrecognized but trigger or exacerbate conditions such as accident-related injuries, gastritis, diabetes and hypertension, liver abnormalities, and cardiac problems.
7)Depression is a frequent complication of cancer, post-cardiac surgery, diabetes, post partum, and in the treatment of any chronic and debilitating physical illness.
8)Emotional factors are thought to play a role in triggering asthma attacks, and exacerbations of autoimmune diseases (lupus, sarcoidosis, multiple sclerosis).
9)Depression and substance abuse screening and referral are essential components in a primary care setting. However, medical staff has little time or expertise available to perform these functions.
10)Group oriented behavioral interventions have been found useful in addressing emotional factors in chronic and acute disease, improving adherence to medical regimens.

The CMHC would employ a behavioral health consultant to provide expertise and support to the team of medical providers in managing the care of primary care patients. In most instances, this role precludes ongoing traditional behavioral health services by the consultant. However, this role might vary, depending upon the specific setting and population served.

In addition to providing direct expertise and support to the medical team, the consultant will be able to:

1)Directly link clients identified with more serious mental health needs to either general or specialty CMHC services
2)Draw upon other available expertise and resources within the CMHC, including necessary psychiatric consultation, specialized youth and adult expertise, and 24 hour crisis response.

The following CMHC service components are proposed:

IV.Core Services

1)**Mental health and substance abuse screening, triage, or liaison services (new service codes)** Initial screening (30 minutes or less) to determine if a referral to appropriate level of mental health service is indicated.
2)**Behavioral Health Consultation** Intake assessment designed to evaluate level of functioning, diagnosis, risk and stress factors, and service needs.
3)**Behavioral Health Follow-up Visit** Occurs in relation to a visit with a medical provider. The focus is to support behavioral change or treatment initiated by the medical provider.

V.Optional Services (where funding permits)

1)Brief, symptom focused therapy

2)Behavioral medicine interventions (i.e., stress management, relaxation techniques, smoking cessation, obesity management, lifestyle modification.)
3)Psychoeducational groups: Disease-specific groups utilizing behavioral interventions, skill building and health education.
4)Psychiatric consultation for primary care physicians
5)Relapse prevention
6)Medical adherence enhancement: Behavioral intervention designed to improve adherence to medical regimens recommended by the medical provider.
7)Telephone consultation.

VI. Provider Credentials and Supervision

Advanced Practice Nurse or licensed social worker, psychologist or counselor with direct access to a psychiatrist or other specialists.

In addition, behavioral health staff must demonstrate competency in:
1)Behavioral medicine interventions
2)Team work and the ability to understand physician and patient needs.
3)A succinct communication style and the ability to translate key behavioral principles to primary care staff
4)Delivering effective services within the time constraints of a primary care setting

VII. Location

Services will be provided at primary care clinic. If specialized behavioral health services are indicated (e.g., Community Psychiatric Rehabilitation), direct linkage will be made to the CMHC.

VIII. CHC Services to CMHC Clients

It is proposed that a similar model, employing CHC staff to provide expert "Health Consultation" to CMHC teams serving the more severely disabled clients would provide significant benefit to improving the overall health status in addressing critical health issues of the SMI and SED populations served.

The consultant model proposed would build the required capacity to address critical behavioral health and physical health needs within the CHC and CMHC Systems without duplicating services, or the necessary specialized system infrastructures required to support them. The model should be designed to maximize the funding available across systems to the extent possible using interagency agreements and sub-contracts as appropriate.

Practice Guidance

- Kaiser Permanente Northern California. *Skill Summary for Depression*
- Cherokee Health Systems. *Prime MD Patient Questionnaire, Pediatric Screening Tool*
- San Mateo County Mental Health Services. *Program Description with Referral Examples*
- Criterion Health Inc. *Behavioral Technologies in Disease Management: A New Service Model for Working with Physicians*

Example of Skill Summary

Major Depression (Uncomplicated)

History
Patients may report prior history of depression, somatic complaints (headaches, abdominal pain), sadness, crying spells, worsened medical or functional status, fatigue or sleep disturbance, apathy, irritability, anxiety, sexual complaints, recent negative life events, and/or alcohol or drug abuse. Family history of substance abuse, bipolar disorder or major depression is often present.

Exam
Depression is manifested in a variety of ways. There are no definitive physical findings. Patient may appear disheveled, sad, indecisive, and slow to respond or, alternatively, may appear agitated, unaccountably nervous or labile.

Diagnosis
1. At least one of the following two symptoms must be present for at least two weeks: depressed mood and/or markedly diminished interest or pleasure in almost all activities.
2. Additionally, at least four of the following must be present (three if both symptoms mentioned above are present): sleep disturbance; fatigue; loss of energy; significant weight loss or weight gain when not dieting; psychomotor agitation or retardation; feelings of worthlessness or inappropriate guilt; diminished ability to think or concentrate; recurrent thoughts of death, recurrent suicidal ideation, suicide attempt or specific plan to commit suicide.

Significant weight loss or weight gain is usually indicated by a loss or gain of more than 5% of body weight over a month. Symptoms of depression can be indicated by either subjective account of the patient or by evidence that the symptoms are apparent to others.

A variety of general medical conditions may directly cause mood symptoms. These conditions include neurological conditions (e.g., Parkinson's disease), cerebrovascular disease (e.g., stroke), metabolic conditions (e.g., vitamin B12 deficiency), endocrine conditions (e.g., hyper - and hypothyroidism), auto-immune conditions (e.g., SLE), viral or other infections (e.g., hepatitis, HIV), cardiovascular conditions, and certain cancers. Suggested screening labs in most cases: TSH, CBC, and random glucose.

Other differential diagnosis includes substance abuse (alcohol, sedatives, hypnotics, anxiolytics, and stimulant drugs). Some medications may cause depressive symptoms (corticosteroids, high doses of reserpine, cardiac medications, oral contraceptives, anticancer agents).

Tell the Patient
- Depression is a common disorder affecting up to 15 percent of people in the United States some time during their lives.
- Depression includes not only sad mood but also (patient's) symptoms, including physical symptoms.

- One of the factors that research has associated with the symptoms of depression is a chemical imbalance. In order to help correct this imbalance, antidepressant medication is sometimes prescribed.
- In addition to medication, changes in life style, activities, and thinking patterns may help with treatment of depression. A combination of psychotherapy and medication has the best outcomes.

Recommend behavioral changes:
- Increased exercise
- Increased pleasurable activities
- Increased social interactions
- Attending educational class on depression
- Positive self-care (e.g. following structured daily routine, eating well)
- Eliminate alcohol and other drugs of abuse
- Postpone major life decisions

Treatment
Diagnosis and management of uncomplicated major depression without suicidal ideation is appropriately treated within APC, in consultation with the Behavioral Medicine specialist.

Antidepressants
- For retarded depression, with patient showing low energy, fatigue and apathy, use SSRIs - Prozac (10-80mg) or Paxil (10-50mg).
- For sleep disturbance, rule out agitated depression. If not present consider using Trazodone (50-350mg) or other sedating antidepressant as adjunct.
- For pain management, use low dose of desipramine (Norpramin) or nortriptyline (Pamelor) – 10-25mg tid.

Psychotherapy
- Primary Care physician should provide empathy and support
- Referral to the Behavioral Medicine Specialist should be considered. Cognitive Behavior Therapy and Interpersonal Therapy have proven to be helpful.
- Referral to Health Education should be routine.

When to Refer to Psychiatry
- If member presents with suicidal ideation, plan or intent, refer to Psychiatry immediately. If the patient is unable to promise not to harm himself/herself, then a crisis situation exists and the patient needs immediate evaluation by Psychiatry. In this situation, unbroken contact with the patient is required. Law enforcement or security intervention may be appropriate.
- If member is unresponsive to treatment.
- If non-medication approach is preferred by member.
- With more severe depression, or history of recurrent depression with poor inter-episode recovery.
- Patient history or family history of bipolar disorder.
- Member prefers being seen by a psychiatrist.

Patient Resources –

- Depressive and Bipolar Support Alliance (http://www.dbsalliance.org)
- See book and pamphlet list supplied by Health Education

Provider Resources

Clinical Practice Guideline for Depression in Adult Primary Care

Red Flags:

- History of Bipolar Disorder – antidepressants may be contraindicated – see skill summary for *Bipolar Disorder.*
- If suicidal ideation is present, see above under *When to Refer to Psychiatry (#1)* and see separate skill summary for *Suicidal Ideation.*
- If substance abuse is present, see skill summary for *Chemical Dependency.*

PATIENT QUESTIONNAIRE: PRIME-MD

Patient Name: _____Date: _____

1. Over the **LAST TWO WEEKS**, how often have you been bothered by any of the following problems?

	Not at all 0	Several Days 1	Several half the days 2	More than day 3	Nearly every
a. Little interest or pleasure in doing things					
b. Feeling down, depressed, or hopeless					
c. Trouble falling/staying asleep, sleeping too much					
d. Feeling tired or having little energy					
e. Poor appetite or overeating					
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down					
g. Trouble concentrating on things, such as reading the newspaper or watching television					
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual					
i. Thoughts that you would be better off dead or of hurting yourself in some way					

2. If you checked off **ANY** problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Total Score: _____

Date of Visit: Chart #: Last Name:

For each question please circle either Yes or No:	
Yes or No	During the last ***month*** have you often been bothered by little interest or pleasure in doing things?
Yes or No	During the last ***month*** have you often been bothered by feeling down, depressed or hopeless?
Yes or No	In the last ***year***, have you ever drunk or used drugs more than you meant to?
Yes or No	Have you felt you wanted or needed to cut down on your drinking or drug use in the last ***year*****?**
For Provider:	
PrimeMD- <5 = mild; 6-10=moderate; 11-15=major; >15=severe	
A & D 0-1= none to low; 2-3 = minimal; >4 moderate to high. (Do not count first 2 questions in box.)	

Cherokee Health Systems
Together...Enhancing Life

Integrated Health Care Improves Quality, Effectiveness and Efficiency in the Pediatric Clinic
William Allen, Ph.D.
Vice President, Children's Services

When a child faces any type of health problem, it impacts every area of the child's functioning. Whether it is diabetes or depression, the child is impacted physically, emotionally, educationally, socially and spiritually. Treating the problem requires treatment for the whole child. If we think of the child as an integrated system, then health care should be provided by an integrated system.

At Cherokee Health Systems, we provide comprehensive health care by combining the skills of physicians, psychologists, social workers, developmental specialists, physical therapist, dentists and others. Quality of care is improved when as integrated team treats health problems comprehensively,

Most children who have behavioral and emotional problems first show up at the pediatrician's office. In this setting, emotional problems are often overlooked. Even if the doctor screens for emotional problems, getting the child and family into treatment is fraught with barriers. There are waiting lists, insurance issues, paperwork demands and communication blunders that can be overwhelming.

Even if the child faces a problem that is typically considered strictly "medical," emotional development is impacted. To successfully treat any health care problem we must teach coping techniques while we modify behavior and thoughts. We must consider and modify ways the child thinks and feels about his health in order to make treatment more effective. In many conditions, from obesity, to diabetes, to irritable bowel syndrome, we must modify eating patterns, develop and maintain medication and exercise habits, create expectations about the course of treatment and assist with strong feelings of sadness and worry.

In an integrated care setting, the team routinely screens all children for emotional, behavioral, developmental and stress-related problems. This allows us to identify problems earlier, when they are more successfully and more efficiently treated. Using one team to provide the entire range of services facilitates treatment. Many of the barriers are eliminated when the child is treated in a holistic, integrated fashion. When health care services are coordinated, care is more intensive and cost-effective. Symptoms are more likely to improve.

A common example involves a child who sees the physician because of vague stomach and head pains, as well as irritability and oppositional behavior. During the initial appointment, the child sees a behaviorist and physician, who identify significant stressors in the child's life. The family

agrees that the stressors and emotional responses should be addressed. Before they leave, they have an appointment, in the physician's office, to see a behaviorist for more in-depth discussion. As the behaviorist works with the family the physician is informed about issues and progress and contributes medical interventions as necessary. The original symptoms can be treated at the source, leading to faster and more complete symptom relief.

The integration of care does not occur automatically. It takes strong administrative support. It takes blending the cultures of a wide variety of professions. It takes diligent financial wrangling. It takes a lot of thought and effort, and the ability to question current thinking. However, the benefits of integrated health care make the journey essential!

Cherokee Health Systems
Together...Enhancing Life

Standard Primary Care Screening Forms for
Emotional and/or Behavioral Problems in Children

Below you will find suggested forms to use when screening children for emotional and behavioral referrals. These forms can be completed by a parent in less than ten minutes. These forms can also be completed during a parent interview conducted by a service provider.

Use clinical judgment! If you have concerns about a child's mental health, refer to the Behaviorist. Use cutoff scores only in combination with professional judgment.

Birth to 18 Months
The Infant Development Inventory (IDI) is used during the first 18 months of a child's life. This checklist can be given to parents to fill out, although some will need help reading the instructions or completing the back side of the form. The nurse can give the form to a parent with some simple instructions. Ask the parent to put a few comments in the boxes on the front. Ask parents to circle skills the child shows, to mark off skills the child does not show, and, per the instructions, to put a "B" beside the things the child may be just beginning to do. Using the "B" may be the hardest part of the instructions for parents; so parents may need some explanation here. Tell them to use a "B" if the child has just started doing a skill or if they have only done it once or twice lately.

Interpretations should be done combined with your observations of the child to try to establish validity of the scale. You may need to look over specific items and ask a few questions or interact with the child. To use a cutoff score, you can compute the child's age in months and then compute a 70% level as the cutoff period. You can compute 70% of the child's age and draw a line across the chart. If a child has one or more below the 70% cutoff, you should think about a referral. Children under the age of 3 can get a developmental screening from our behavioral staff here at Cherokee Health Systems.

Remember to use this combined with your clinical judgment. If you are really worried about a child's development, please refer them to the Behaviorist.

18 Months through Age 5
The Child Development Review (CDR) can be completed by a parent in a few minutes. There are 6 open-ended questions, 26 checklist items, and a rating chart on the back. Review the 6 open-ended questions and try to judge the information by indicating:

1) No apparent problem
2) Possible problems (interview parent for more information)
3) Possible severe problem (because of severity of problem or number of problems, a mental health referral may be warranted)

For the checklist items on the CDR, it is rare for parents to report 8 or more serious concerns. Concerns are likely to be greater when more items are checked. For the chart on the back, children should be rated at or above 75% of their age, or they may have developmental problems. A development evaluation may be warranted.

Age 6 Years through 18 Years

The Pediatric Symptom Checklist includes 38 items rated never, sometimes or often. Assign one point for items rated sometimes, two points for items rated often. It is unusual for children to score over 28 points. Concerns are likely to be greater when more items are checked. Use clinical judgment! Refer when in doubt!

Primary Care Interface/FSST

Supervisor: Cheryl Walker M.F.T.
573-2630

Primary Care Interface

Supervisor: Cheryl Walker M.F.T.
573-2630 PONY MLH 501

Primary care Interface Mental Health staff work with clients referred by Primary Care Providers whose primary care treatment is negatively impacted by the presence of emotional or mental illness.

All interface staff provide:
*Information and Referral
*Linkages between agencies
*Screening and referral to the Mental Health Access Team
*Assessment, diagnoses and brief treatment

To refer a client to the Interface Clinician please fill out the Inter-agency Referral form. Please include the following:
Name, age, sex, language, medical record number, social security number or attach medical sticker and confirm phone number and address with client.

Write observations or patient's stated symptoms of mental illness.
Indicate if there is a history of treatment for mental illness.
Indicate if there is current or previous substance abuse.
Symptoms should be frequent and are starting to impair daily functioning.
*Please be sure there is not a medical cause for the symptoms.
*Please be sure that the client's symptoms are not secondary to active substance abuse.

Examples of referrals with adequate information

28 y-o male complains of suicidal thoughts, previous history of attempt no current plan. Patient has been treated at Fair Oaks for one year. Patient has been asked if he would be willing to talk with Mental Health clinician and said yes.

33-year-old female with remote history of substance abuse complains of lack of sleep, nightmares, anxiety, crying, feeling frightened, hopeless with loss of interest in her normal activities. She reports this has been going on for several weeks.

29 y-o male with diabetes and wt loss current Wt now below 100 pounds, client has been in treatment three years. There is no substance abuse. MD and diabetes clinic have provided multiple education regarding his illness during last three years. His wife reports that she is very worried and he complains of weakness. He has asked to see a counselor to try and understand why he is not taking better care of his health.

40-year-old patient recently diagnosed with life threatening illness. He is angry, sad, anxious and afraid and not following up with necessary treatment; Public Health Nurse education and follow

up, did not improve his follow up with treatment. He is willing to talk to a Mental Health Therapist.

25 year-old patient with symptoms of panic complains of many recent episodes of extreme fear, which are starting to limit her activities. No history of substance use or abuse.

Child with school behavior problems that appear to be ADHD. MD needs help to gather more information about home and school behavior.

Samples of referrals with incomplete information

Patient shows up in the waiting room with "Return Appointment" form that has Interface clinician's name and phone number on it.
Patient telephones the Interface Clinician and says the Provider gave her/him the clinician's phone number

What is missing? The Interagency Referral Form is missing. Additionally, both interventions are unsuitable because they do not facilitate the client's access to Interface.

Depression Evaluate and provide tx nec
Evaluate depression vs adjustment D/C
Depression vs anxiety patient would like therapy not just drugs is on Paxil.

What is missing? These referrals do not list the symptoms that concern the Primary Care Provider, the initials is not clear.

*Patient wants counseling assess and advise.

What is missing: Interface staff needs to know the details of the concern. Symptoms or critical issues that need mental health treatment are missing. How are the symptoms impairing functioning?

*Patient complains of marital discord wants couples counseling.
Interface is unable to provide marital counseling

*Patient relates domestic violence, assess, refer and advise.

What is missing: Has a referral to DV community resource been given to the client? Is this on going or a crisis? Is it safe to contact the client at home or did you ask her to contact Interface? Are there mental health symptoms that need treatment?

*Patient worried about child's behavior at school he is fighting with other children, her older children are also having problems possible gang behavior, assess and advise.

What is missing: What is the child's name, what are the parent's mental health symptoms that are a barrier to parenting?

*Female patient with history of substance abuse (crack Cocaine), last use 2 wks ago, with depression started on anti depressant today. Assess and advise.

What is missing: Did you make a referral to AOD? Do you want Interface to link the client to AOD for assessment and referral to treatment? Is the client a reliable historian about substance use? Does the client want help with substance abuse?

Patient has multiple medical problems, which limits her ability to work. She states she has had an increasingly difficult time coping with family, stress, limitation in work, etc. Assess and advise.

What is missing: What are the symptoms of her stress and difficulty coping. Is it having nightmares, crying, sleeping all day?

Seriously Mentally Ill Symptoms
Refer to Access Team 1-800-686-0101

The Interface Team recommends that you first consult with your Interface Clinician.

History of long psychiatric treatment with hospitalizations for serious mental illness with or without psychotic symptoms.

Psychotic symptoms that are not related to a substance use/abuse, medical or degenerative cognitive condition.

History of severe depression with history of hospitalizations and suicidal ideation and unable to manage in Primary Care.

Severe Panic Disorder. Patient unable to leave home except to come to medical appointments.

Child in special education several months and continues to fail in school.

Behavioral Technologies in Disease Management:
A New Service Model for Working with Physicians

By Robert Dyer, Ph.D.

Definition of Disease Management

The concept of disease management is quite young and currently evolving. The two most common definitions, which seem to capture the essential efforts around disease management, are as follows:

Disease management is a systematic approach designed to minimize degenerative symptomatology in patient's suffering from chronic diseases requiring significant lifestyle related accommodations.

Or

Disease management is an integrated system of interventions and assessments designed to optimize quality of life, clinical and economic outcomes with specific disease states.

The essential elements included in these definitions are:
- Targeted disease syndromes; most often related to chronic lifestyle syndromes.
- An organized approach to intervening; implies a multi-disciplinary approach-physician, educator, pharmacy, etc.
- Desired results that improves quality of patient life and functioning; implies less invasive or less expensive medical resource utilization.

The Need: Incidence and Impact of Chronic Illness

Traditionally, behavioral health treatment has been associated with syndromes such as anxiety, depression and substance abuse. These are areas commonly classified under the headings of mental disorders. While growth and common deployment of behavioral technologies has been occurring in these areas, there have been additional efforts underway in the traditional venue of physical medicine. Combining the developments in behavioral and physical medicine will provide practitioners with exceptional tools and patients with improved recovery.

Individuals suffering from chronic illnesses that affect their lifestyle have much to gain by receiving behavioral technologies aimed at helping them manage their symptoms. Efforts to assist changes in diet, lifestyle and activity, developing habits of compliance on appropriate medication management and cognitive restructuring are all the domain of the behavioral technologies. Successful programs impacting these necessary lifestyle modifications represent reduced symptomatology, decreased pain and suffering, increased functioning abilities, decreased work absences, fewer hospitalizations and less overall medical expenses. It would seem everyone would desire their medical interventions to strive for these goals.

Specific syndromes that best respond to lifestyle changes in order to minimize symptomatology (or improve quality of life) are the targets for behavioral disease management initiatives. While

a case can be made for very broad applications of the technology, this paper suggests focusing on a few, high incidence illnesses which directly benefit by disease management efforts. The syndromes targeted are: adult onset diabetes, chronic obstructive pulmonary disorders, hypertension and chronic pain conditions such as arthritis.

A 1988 Price Waterhouse study comparing the monthly treatment costs of our target syndromes paid by insurers can provide a sense of the monetary magnitude of disease management:

- Hypertension $266
- Diabetes $491
- Asthma $585

The average monthly commercial treatment cost for chronic behavioral health disorders is $180. Behavioral technologies have demonstrated the ability to reduce the cost of each of these syndromes. As each of these syndromes is discussed, the application of behavioral technology is identified with related costs.

Diabetes: While only slightly more than three per cent of the population is diagnosed with diabetes it represents 14 per cent of all health care costs. Forty per cent of diabetes treatment cost is estimated to be inpatient costs associated with difficulties in lifestyle management. (Also note that the American Diabetes Association estimates there is one person with undiagnosed diabetes for every one diagnosed.

Chronic Obstructive Pulmonary Disorder (COPD): Asthma and emphysema impact five per cent of the population and represent ten per cent of all health costs. Pediatric asthma difficulties represent 40 per cent of all pediatric inpatient admissions. Episode costs of COPD care are among the highest of all disorders and, significantly, the need for inpatient care is related to unstable lifestyle.

Pain: Pain related issues significantly impact the functioning (absenteeism, disability) of twelve per cent of the population. Arthritis alone accounts for twelve per cent of all office visits by the elderly.

Hypertension: Fifteen per cent of the population is diagnosed with hypertension. This is the single most frequent diagnosis, which represented over 27 million people in 1996. Over fifty per cent of people diagnosed are medically out of care within twelve months. Of those in care, less than fifty per cent are following the prescribed medical plan.

Pediatric impulsivity and depression: Attention deficit disorder syndrome is a syndrome the author adds to this list of chronic lifestyle related issues. It is one that impacts pediatricians and family physicians in a worrisome way. The U.S. Office for drug Enforcement notes that one in seven children are receiving prescription medication for behavioral or psychiatric reasons. Over seven per cent of latency age boys receive medication for attention deficit disorder alone. Five per cent are medicated for depression. We know the majority of children identified with ADHD or depression will be treated for these disorders for many years, i.e. they are "chronic" conditions. The most common stolen and illegally sold prescription drug is Ritalin. The need for

an organized support system to educate and encourage appropriate medication utilization is obvious and strongly supported by pediatricians and family physicians.

A survey of HMO plans found four per cent of plan members who utilized care accounted for over thirty per cent of all health care costs (Terry, 1998). COPD, diabetes, pain and hypertension accounted for approximately half of that total amount. Over 43 million Americans suffer from chronic lifestyle related diseases.

Value Health Sciences (1995) reviewed medical claims and determined the following:

Financial Impact of Chronicity of Need:
People who use Medical Services vs. Cost of Services

% Covered Lives	% Medical Expenses
5%	60%
45%	37%
50%	3%

In other words, five per cent of all covered lives cost sixty per cent of all expenses paid for care. Clearly, targeting resources to assure maximum success for this five per cent has the greatest potential for impact.

By comparison all mental and addictive disorders combined (over 300 diagnoses) result in eight per cent of the population receiving care in one year and medical expenditures accounting for eight per cent of all healthcare costs.

Current System: Pressures on Primary Care

We are at a point in healthcare where the funding is once again creating (and limiting) what interventions are available.

The sad fact is that funding methodologies, more than technology, have been the impediment to behavioral interventions in physical medicine (and conversely, the motivator of growth of traditional mental health services). Biofeedback and self- control regimens have a long and rich tradition of providing assistance to individuals with physical symptomatology. Biofeedback receives little or no reimbursement from major insurers. Similarly the use of health educators or office assistants for skill building or medical compliance regimens has received little financial support. The lack of support by insurance companies has restricted broad application of behavioral technology. HMOs or pharmaceutical companies who have direct financial benefits currently drive most disease management initiatives. Insurance executives acknowledge the need and even the results of existing programs, but voice concerns of "opening" funding categories for fear of being "exploited" by providers. Most major coordinated disease management programs are separately funded and identified as exceptions by insurers.

Capitation payments in managed care contracts change the traditional incentives to providers. In traditional fee for service payment systems incentives are placed on applying the most expensive providers and procedures possible (i.e. those with the largest profit margins). No financial

incentives exist for "curing" people when providers only get paid for seeing patients and get paid more if the patients need or want more.

Capitation pays a fixed amount with minimal regard to how much care is accessed. This has led to problems of under treatment, i.e. "drive-by deliveries", etc. There is also an incentive for the patient's health. Physicians have a financial stake in doing whatever makes people be as healthy as possible to minimize their overall need for care.

The dominant model of managed care involves insurance plan members accessing all care though a primary care physician. This "gatekeeper" delivers basic care and "prescribes" specialty care as needed. Physician groups are managing financial resources at their own financial risk. They want the most cost- effective solutions, as they get to keep the savings.

Acceptance of Disease Management

The acceptance of disease management in the era of managed care is best exemplified by the utilization of disease management programs by Health Maintenance Organizations (HMOs).

HMOs are taking the overall financial risk for delivering care to broad populations. They want integrated systems that insure cost effectiveness. They have embraced the concepts of disease management:

Of 282 HMOs, seventy five per cent offered at least one disease management program. Sixty per cent offered disease management programs for up to four conditions. The beneficiaries of programs offered are moderately to severely ill plan members.

Per cent of HMOs with Disease Management Programs

75% HMOs offer at least one disease management program
60% offer two to four programs
57% offer Asthma programs
50% offer Diabetes programs
50% offer High Risk pregnancy programs
23% offer Congestive Heart Failure programs
20% offer Breast Cancer programs
17% offer Depression programs
17% offer Cholesterol programs
15% offer HIV/AIDs programs

Lovelace Health systems of Albuquerque, NM identified thirty conditions that accounted for 80 per cent of their total costs. They targeted sixteen of those as having significantly improved episodes with disease management programs:

- Diabetes
- Low back pain
- Pediatric asthma

- Birth episode
- Breast cancer
- Stroke care
- Depression
- Knee injuries
- Chronic cardiac illnesses
- Peptic ulcer disease
- Congestive heart failure
- Hysterectomy
- Attention deficit disorder
- Hypertension
- Adult asthma
- Alzheimer's disease

Consistently, disease management programs post from twenty- five to forty per cent medical savings results. A list of sample results finds a consistency in the decreased of total cost resulting in an overall medical savings of disease management participants (see Padgett, 1997 for representative sampling of programs and their results for a wide diversity of syndromes). The results most often extend beyond simple financial savings, for example; Value Health, in conjunction with Eli Lilly has created a diabetes disease management program. Their site patient impact targets are:

- 50% reduction in lower extremity amputations
- 70% reduction in episodes of ketoacidosis
- 50% reduction in end-stage renal disease
- 60% reduction in diabetes related blindness
- 40% reduction in lost work days

As can be seen, significant financial savings accrue for such programs and, additionally, these results mean very impressive gains for a patient's quality of life.

Lifestyle Modification: Medical Non-Compliance

Physicians have long recognized that their recommendations to patients about changes in diet, activity and basic cognitive approaches to illnesses have not resulted in much success though the years. Human nature just doesn't allow easy replacement of long-standing; well-practiced maladaptive habits with unfamiliar new behaviors just because someone suggests it would be a good idea. Thirty years of research suggests medical non-compliance rates for medication taking; diet and activity prescriptions exceed fifty per cent across many diverse syndromes. For example, patients seen by primary care doctors stop taking their antidepressant medication at a rate exceeding sixty per cent within six months of initial prescription (Katon, et.al., 1992).

What we know about Primary Care Need and Want

The American Medical Association abstracts medical practices in the United States (AMA, 1999). We know the following about the practices of over 250,000 independently practicing primary care physicians:

Time spent:
89% Office based
9% Hospital based
2% Other

Physician activity:
107 office visits per week
16 hospital visits per week
7 nursing home visits per week
2 house calls
9 uncompensated/ discounted services per week
47 billed hours of care per week

How organized:
36% practice solo
12% one partner
34% 3 or 4 partners
17% practice in settings with over 4.
(The AMA Survey does not count employee physicians, which is around one third of total physicians.)

Why people see primary care physicians:

Respiratory issues (15%)*
Blood pressure/ hypertension (8%)*
Exams/ progress reports (3%)
Pain (2%)*
Skin related (2%)
Gastric (2%)
Cardiac (1%)

Age impacts visits significantly:
What follows are most frequent reasons people over 75 years old saw their physician:
Blood pressure (12%)*
Arthritis (12%)*
Respiratory (8%)*
Cardiac (5%)
Diabetes (4%)*
Gastric (2%)
Skin related (1%)
(* Target syndromes of this paper.)

Average visits to physician per person in a year:

2.8 visits per year

Primary Care Disposition of office visits:
72% prescribed medication
49% leave with return visit planned
29% referred for internal "counseling"
15% for diet
10% exercise counseling
5% referred to other physician
4% referred to other non-medical personnel
4% cholesterol reduction
3% smoking cessation
2% for physiotherapy
2% for family/personal (**This is traditional referral out for Mental Health!)**
<1% for alcohol/ drug counseling
<1% for family planning

Per cent of office visits believed by PCPs to be "psychological" in nature:

30% of office visits

The most frequent outpatient billings were for:
The Medstat Group™, of Ann Arbor, MI reviewed medical claims in 1995 and found the following to be the most frequent outpatient billings:

- Allergic rhinitis
- Essential hypertension*
- Back disorders*
- Respiratory symptoms*
- Joint dislocations
- Abdominal and pelvic symptoms
- Neurotic disorders*
- Lipid disorders.

The outpatient care episodes with the most expensive episode costs were:

- Respiratory symptoms*
- Abdominal and pelvic symptoms
- Neurosis*
- Back and disk disorders*
- Hypertension*.

(* Target syndromes of this paper.)

In 1997, Spectrum Health, Inc. of Bellevue, WA conducted a survey with Seattle area primary care physicians. Highlights include:

Primary Care Physician Observations:

- 71% of office visits were for follow-up to chronic conditions.

- Over 70% stated the preferred mode of treating chronic pain would include lifestyle management.
- Over 70% stated the preferred mode of treatment for asthma would include lifestyle management.
- Almost 90% stated preferred mode for treating diabetes would include lifestyle management.
- Well over 80% stated the preferred mode for treating hypertension would include lifestyle management.
- Less than 30% of the time in all follow-up visits was patients suffering these disorders seen by anyone other than a physician.
- Over 70% did not offer lifestyle management services in their practices.

What Physicians want:
Relative to the use of physician extending personnel, Physicians wanted:

- 57% someone to process charts for them.
- 43% someone to see chronic patients in prescribed protocols.
- 43% someone to process prescriptions.
- 43% someone to verify managed care benefits.
- 29% someone to process lab results.
- 21% someone to process referrals out of practice.
- 14% someone to help follow- up with patients.
- **86% would like to add revenue to their practice by providing lifestyle management services.**
- 60% stated if physician-extending services generated increased revenues, it would result in increased utilization.
- **Over 80% were interested in adding a "qualified health educator and care coordinator" to their practice.**

(Yurdin, 1997)

Physician Extending

An hour of primary care time costs on average $196. The need for lower cost solutions to service common issues is widely known. Patient education, functional assessments, skill building, prompting, etc. can and are often performed by "physician extenders". Physician extenders delivered 36% of all office-based care procedures performed. (Over 264,000,000 visits in US in 1996- AMA)

The use of physician extenders seems directly related to size of setting and amount of capitated payment in the revenue mix of the setting.

- 64% of physicians in staff model HMOs have physician extenders.
- 23% of physician groups contracting for risk have extenders.
- 16% of medical groups with no risk contracts have extenders.
- 6% of solo practitioners have extenders.
- Overall, 28% of PCPs employed extenders.

(Grandinetti, 1999)

A Behavioral Model of Disease Management

As can be seen from patient needs and physician desire the demand is strong to have an organized approach to assisting lifestyle modification to accommodate minimizing the symptomatology of chronic illnesses. What follows are the essential features of an organized approach embracing the best findings of today's behavioral technologies.

Business model

What is proposed is a model where behavioral providers organize a systematic approach that is offered as a contract to medical groups, in much the same manner as many medical groups purchase medical laboratory services or physical therapy.

The essential business structure consists of a behavioral health entity to deliver a trained health educator to a medical practice. The health educator will perform a set of services approved by the physicians, document those services and report the performance results of those interventions in exchange for payment.

The value added to the physicians' practice includes state of the art information about improving medical compliance and lifestyle accommodation to the target syndromes. This implies the health educator will document in the physicians medical record, working as a practice extender to the physician.

The target practice for entering into such a contract will probably have four or more primary care physicians in a single location. This size will support a full time presence for a "physician extender" (hereafter called a "health educator").
Make no mistake, the business model must directly attend to how contracting for the services will either:
Make revenue for the practice,
Decrease expenses for the practice; or
Decrease financial risk for the practice (and therefore decrease expenses).

Targeted syndromes

The target syndromes that align themselves for a common approach include:
Adult onset diabetes
Attention deficit disorder
Chronic obstructive pulmonary disorder (especially asthma and emphysema)
Chronic pain (especially arthritis)
Depression
Hypertension

Note: a pediatric subset of ADHD, depression and pediatric asthma bundle nicely to fit adequate demand for full time relevance to any multiple pediatrician or mixed pediatric/ PCP practice.

The scope of offerings must bundle similar systemic approaches for at least three syndromes to achieve impact worthy of contracting in an outpatient practice. In an open full time medical practice it must be assumed that only around twenty per cent of all easily identifiable eligible

patients would be referred to the on site program. A significant volume must be available to create the ongoing demand for the services.

Packaging
In order to train and assure consistency in application by the health educators it is necessary to make a common system in which the processes and resources have a common "look and feel" across syndromes. Intervention protocols and patient education materials must be non-controversial and subject to editing by the practitioners to reflect the standards of the physician.

Any inserted intervention must be compatible with the practice. Finding an efficient way to communicate between the health educator and physician is essential. Since we are proposing, "selling" this model to physicians a brief way to show the relevance as well as essential features of the "product" is also essential. Written, editable materials are necessary. At least the following materials should be available to the interested physician:

- **Indications for and contra-indications for the disease management program;**
- **Intervention protocols for each syndrome;**
- **A set of "prescriptions" for each decision point in care, i.e. points where care significantly increases in intensity;**
- **Functional lifestyle assessments for each syndrome;**
- **Patient education materials; and**
- **Health Educator training materials**.

While many interesting and potentially powerful findings are emerging from the field of alternative medicine it is strongly recommended that all materials initially presented reflect the least controversial aspects of attending to the syndrome as possible. All necessary materials can be generated from primary American Medical Association sources (J.A.M.A., New England Journal of Medicine, etc.) or the major trade associations representing the syndromes (American Diabetes Association, American Lung Association, American Heart Association, etc.). Modifications reflecting the experience of the physician or health educator can be modified into the interventions later as jointly identified and agreed.

It is imperative that the health educator does not surprise the physician by saying or doing significant interventions without those being disclosed and approved. The health educator works under the auspices of the physician. They must be in sync with each other. (Also, it is important to note that behavioral health professionals are stereotyped as liberals, "soft and fuzzy", in order to overcome potential stereotypes it is wise to insure your materials reflect science and a logical, linear approach to assisting the physician.)

Intervention Essentials
The essential services being sold reflect the major findings from research on improving medical compliance, replacing maladaptive habits and adult learning. The model for a potent behavioral intervention that emerges includes at least the following components:

Functional Assessment
Assessment tools need to exist for at least three separate purposes**:**

1. **Initial lifestyle assessment**. Questionnaires need to sample how diet, activity, medication taking habits and current syndrome symptoms (frequency and intensity) impact level of functioning. This provides structured feedback about appropriateness for services as well as benchmarks for later comparison.
2. **Skill building assessment**. As specific issues are identified, performance samples are used to chart progress towards a (new) habit acquisition or identify behavior that hinders progress.
3. **Evaluation**/ impact sampling. At pre- set times the results of the intervention need to be globally sampled. This is both critical symptom and patient perceptions of services monitoring. Frequency and intensity of key symptoms along with perceptions about services received need to be taken to develop population trends that can be reviewed to improve overall offerings.

Patient Education

Participants need reference material. The patient education materials present basic information about the disease. This would include major symptoms, course of illness, common treatment regimens and realistic expectations for life changes with the progress of the illness.

Materials need to be very readable, charts and graphics increase interest. Adult education material finds value in creating characters that act as guides or examples through the entire episode of care, i.e. the materials are presented with story-like anecdotes happening with common characters to make the points or show applications of the material.

By design most patient education can be conducted in a group context. By practice it is often not practical to wait for groups to form to begin care.

Skill Building

The essence of the intervention is building a new set of behaviors. That may be:

- Changing diet;
- Changing schedule;
- Increasing or changing activity or physical regimen;
- Changing or creating reliable medication taking routines; and
- Changing internal self-talk about disease (or limitations), etc.

The diagnosis often immediately signals a need for significant changes in a person's life. In essence old habits must be stopped and new ones developed; which is never an easy proposition. Replacement requires understanding the need, knowing what new behavior the patient is to do, when the patient is to perform it and then performing it reliably and often.

The milieu for maximizing change includes:

- Present the situation calling for new behavior;
- Present the sequence of behaviors in which the behavior to replace occurs;
- Present the new behavior to implement;
- Personalize the application;
- Have participants determine when, where and how this situation is applicable;
- Practice the new behavior;
- Perform sequence of behaviors in front of peer for feedback and support;

- Troubleshoot. Question ease and appropriateness of intervention, vest "buy- in" from participants;
- Plan "homework" when new behavior can be utilized;
- Live life and practice;
- Contact patient and prompt (remind, "nag") support for new behavior; and,
- Debrief and reinforce steps at next meeting.

As with the patient education materials, readability, graphics, common characters, etc. all help with written materials. For improved compliance it is desirable if people leave each meeting with something concretely "in their hands" to remind them of their commitment to new behaviors.

Ideally, all skill building activities can be performed in a group context. Group feedback and public commitments increase veracity of new behaviors.

Prompting
People need support to develop new habits that are life changing. The health educator creates a schedule for support. Calling to check on new habit development. Potentially coming for home visits to help people practice in their real world setting.

Phone calls can work wonders. A kind word, a reminder, joint strategizing to overcome the inertia of change-all can improve outcomes. Calls are planned and results are documented.

Care Coordination
Helping physicians attend to those aspects of health care, which exist outside the practice, adds great value and potentially discovers major ways of increasing compliance.

The health educator summarizes all out of practice care the patient's receive. A brief review can identify patterns that have improved or negatively impacted functioning. Other specialist's may have changed medications or given supportive care that impacted behavior; only by seeing these interventions over time can results be identified.

Mutual Support Facilitation
Following assessment and skill building maintenance can be improved significantly by having patients support each other. The technology around mutual support groups is very available. The National Institute for Mental Health has an excellent technical publication on establishing such systems. People learn from each other and provide support that seems to promote growth. Having a group of people a little further along the "learning curve" that can anticipate and provide encouragement for surmounting the trials associated with inserting new behavior into a lifestyle provides a powerful addition to the treatment paradigm. Groups most often have been single disease focused. That does not seem necessary and mixing can add an aspect of generalizability to the situation that seems to help some people.

Groups need to be ongoing. Use of dedicated helpers for people newly in the group (a la "sponsors" or "guides") can improve initial group meeting attendance. Encouragement (or

discouragement) of after hour contacts between group members needs to be openly determined. It will happen so it's best to manage it.

Central Support/ Account Management
Many behavioral health practitioners have experienced the phenomenon of inserting a junior clinician into a medical practice only to have the clinician accept an offer to become a member of the medical group practice. To retain their central value to the behavioral health organization there must be activities and resources of value that occur on a regular basis. This allows the health educator to maintain an ongoing relationship and stay connected with the behavioral health practitioners.

Once a health educator and physician start working together the working relationships become automatic. There exists a need to have support, training, materials updates and performance evaluations, which are apart from the medical practice. Quality assurance functions require sampling the health educator's performance and documentation.

Performance updates
Centrally maintaining updates on information, updating patient education, assessment and treatment protocols is a major value to provide.

Regularly scheduled training and potentially providing on site training or one time "clinic" services can go a long way to providing value to the medical practice.
Semi-annual assessments of performance with displays of new materials and trouble shooting of communications will increase direct communications between the physician "client" and the "account manager" at the "home" office.

Documentation
Progress notes must be written for all patient contacts. Because the basis for delivering the service is under the auspices of the physician's practice, documentation fits into the physician's record.

The basis of the services is medical, not psychiatric. Medical records are brief, terse and conform to the problem oriented medical records requirements of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Services are "prescribed" by the physician. Insurers and state licensing requirements dictate whether or not the health educator can sign alone or whether all notes must be co- signed or approved by the physician (or contract supervisor).
The reimbursement aspects of service delivery must work for both fee-for-service and capitation billing. In a capitated environment documentation may be unique to the practice, i.e. payers don't dictate the standards). In a fee-for-service system documentation follows the requirements outlined in the American Medical Association's International Classification of Disease Ninth Revision (ICD-9) Year 2000.

Pricing
A simple system for pricing must exist to be attractive to the physician. Most medical groups are not used to value purchasing. They are most comfortable "buying time", paying a fixed amount for procedures, like they are paid.

In fee-for-service environments having the supplier receive a fixed percent of revenues collected is a common payment method. Pure fee-for-service payment environments are rare. Mixed capitation and fee-for-service payment is more common. (Capitation payments are around one-third of the average physician's income.) Developing a pricing policy that works for both again supports a procedure pricing system.

Generally speaking pricing will peak out around seventy dollars per hour, or alternatively, no more than seventy per cent of all revenues collected. The point in both methods is that the physician's practice must keep a significant amount of revenues generated or they will simply replace your service with one of their own without regard to the additional benefits your services offer.

Personnel and Infrastructure
The requirements for organizing a set of services such as these include the following:

Medical consultation
Protocols and patient education materials should be reviewed by medical specialists in the areas of focus, e.g. pulmonologist, cardiologist, endocrinologist, etc. The reviews can be of completed work and are not ongoing as much as periodic.

Health Educators
Mental health trained personnel; nurses or educators with training, can provide the health educator role. Experience has utilized a wide diversity of personnel; the issues have more to do with scope of practice, training and supervision. Since it is best to encourage practice within the agreed to materials the functions are best thought of as a technician's activities and in some ways that suggests lesser-trained personnel.

Marketing
The utility of such services are quite clear to practicing physicians. The ease with which physicians will organize such a role into their practices depends in large part upon timing. Services demand and payment mix determine a practice's interests in such a provider. Your services must be known and the exchanges (contract performance and price) understood to be desirable. Successful venders must be known in medical trade groups and in local practice areas to be viewed as credible and "worth the chance". Physicians want to see the materials and want to know with some sense of certainty that the financial impacts are real.

There exists a bright future for the application of behavioral technologies in assisting people make personal adjustments to chronic, lifestyle related diseases. The model presented here is but one that will definitely emerge with increasing frequency over time in some form in primary care practices. Hopefully, this material will stimulate more development and opportunities for improving the lives of others.

Resources

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Documentation Formats

- Cherokee Health Systems. *Behavioral Health Consultation Note Format*
- San Mateo County Mental Health Services. *Transfer/Discharge Note*

CHEROKEE HEALTH SYSTEMS

BEHAVIORAL HEALTH CONSULTATION

Name: _____ **DOB:** __/__/__ **Case#:**_____

Referral Source: _____

Presenting Complaint: _____
_____
_____
_____

Diagnostic Impression:

Axis I: _____
_____

Axis II: _____
_____

Axis III: _____
_____

☐ **Intake**

☐ **Initial Consultation**

☐ **Re-evaluation**

Current GAF: _____

Mental Status: _____
_____
_____
_____
_____

Follow-Up: _____
_____
_____
_____
_____

Session Notes: _____
_____
_____
_____
_____

Clinician: _____ **Date:** _____

Patient Name: _____

Initial Treatment Plan

Goals with time Frame	Outcome Criteria (objective and measurable)	Interventions
1.	1.	☐ Psychotherapy
		☐ Case Management
		☐ Psychiatric Services
		☐ PCP Consultation
2.	2.	☐ Other

Treatment History:_____

Additional Notes:_____

Clinician: _____ **Date:** _____

Supervisor: _____ **Date:** _____

"CONFIDENTIAL PATIENT INFORMATION: See California Welfare and Institutions Code Section 5328"

SAN MATEO COUNTY MENTAL HEALTH SERVICES

ADULT TRANSFER/ DISCHARGE NOTE

NAME _____ MH# _____

□ Transfer to: _____ □ Discharge to:_____ □ Closed

Current Address: _____Current Phone#:_____

Conservator (name & phone #):_____Rep-Payee (name & phone #): _____

Family Member(s) (name & phone #):

_____

In treatment from (date): _____ to (date): _____ Treatment included: □ Medication Management

□ Case Management, □ Brief individual therapy, □ Group(s) (specify): _____

□ DBT Program, □ Family Support, □ Other (specify): _____

Specialty Programs (name & phone # of contact person): _____

Current Medications (dosage & frequency) : _____

_____

_____

Current Level of Functioning & Living Situation: _____

_____

_____

If client requests services in the future: □ Client could return directly to a region □ Client should be re-evaluated via ACCESS TEAM □ Unable to determine at this time.

AXIS I	**CODE**	**P/S**
AXIS II	**CODE**	**P/S**
AXIS III		
Other Factors Significantly Affecting Mental Health → → → **Circle** Yes, No, or Unknown.		
Substance Abuse (If yes, specify in an Axis I Diagnosis.)	Yes No Unknown	
Developmental Disabilities	Yes No Unknown	
Physical Health Disorders	Yes No Unknown	
AXIS IV List problem(s) making a significant contribution to the client's current disorder.		
AXIS V/GAF → → → → → Enter current level of functioning:		

1. *Staff Signature:* _____
2. *Unit Chief Signature:* _____

Primary Care Clinic Surveys

- Cherokee Health Systems. *Clinic Survey*
- San Mateo County Mental Health Services. *Primary Care Provider Survey*

Dear Clinic Staff,

Attached is a questionnaire designed to help clinic staff

- identify the level of integrated care that is taking place in their clinic currently and
- develop an action plan to integrate care for the next year.

The first step is to go through this questionnaire as a group to assess the integration of behavioral health in your primary care clinic. If you have time before the group meeting please review the questionnaire and answer questions on your own. When the staff meets each item will be discussed and the group will attempt to come to consensus on the level of integration currently taking place at the clinic as well as agree to the level of integration they would like to be experiencing within the next six months.

Several weeks later clinic staff will reconvene to review, modify and finalize a six month action plan. Once the action plan is reviewed and finalized by clinic staff it will be implemented and periodically reviewed.

Thanks for your time,

Parinda Khatri, Ph.D.
Director of Integrated Care

1. CLINIC SYSTEMS-This first section addresses basic clinic systems and logistics.

A. In the box below please check yes or no to indicate if each item listed below describes your clinic at the present time.

	Issue	Item	Yes	No
1.	Location of behavioral health care services relative to primary care services.	Behavioral health and primary care services are located in the same building		
2.	Patients Charts	Patient charts are integrated to include both primary care and behavioral health information and notes.		
3.	Appt Systems	There is one system to make both primary and behavioral health appointments.		
4.	Support Staff	Behavioral health and primary care services share the same support staff.		
5.	Electronic database	A single database is utilized to track patients for both primary care and behavioral health.		
6.	Paper work	Paperwork (e.g. Intake, new patient information, consents) for primary care and behavioral health is collected once from the patient and shared between the two entities.		
	Totals			
	Level *	*Level 1= 0 yes, Level 2= 1-2 yes, Level 3= 3 yes, Level 4=4 yes, and Level 5= 5-7 yes.	Level=	

For items 1-6 please comment below on any of the following questions:

- What are your preferences?
- How it is working for you?
- What changes would you like to see?
- How important is this item to you?
- What do you like/dislike about how it is going?

1. Location of behavioral health care services relative to primary care services.
2. Patients Charts
3. Appt Systems
4. Support Staff

5. Electronic database
6. Paperwork

B. *In the box below please circle the level that most accurately describes your clinic at the present time.*

Issue	Level 1	2	3	4	5
Referral process-The time it takes for a patient to see a behaviorist once the primary care provider has made a referral.	6-12 weeks	4-6 weeks	2-4 weeks	Within one week	One day
Issue	Level 1	2	3	4	5
Availability of behavioral health provider at primary care clinic.	Not available at all.	Available at clinic 1 day a week	Available at clinic 2 days a week	Available at clinic 4 days a week.	Available at clinic every day.

Regarding the referral process and availability of behavioral health provider please comment below:

- What are your preferences?
- How it is working for you?
- What changes would you like to see?
- How important is this item to you?
- What do you like/dislike about how it is going?

Referral process:
Availability of behavioral health provider at primary care clinic:

2. COMMUNICATION AMONG PROVIDERS- This section addresses communication between behavioral health and primary care providers.

A. *In the box below please circle the level that most accurately describes your clinic at the present time.*

Issue	Level 1	2	3	4	5
Communication between behavioral health and primary care providers	Rarely communicate Little or no transfer of knowledge	Periodically communicate via phone and letter.	Regularly communicate by phone and letter, and sometimes face to face.	Regular face-to-face communication. Feedback usually not provided on the same day that patient has been seen.	Regular face-to-face communication. Feedback provided on same day that patient has been seen. Providers participate in regular collaborative meetings. High transfer of knowledge among providers takes place.

Regarding communication please comment below:

- What are your preferences?
- How it is working for you?
- What changes would you like to see?
- How important is this item to you?
- What do you like/dislike about how it is going?

Comments:

THE NATURE OF BEHAVIORAL HEALTH IN THE PRIMARY CARE SETTING
This section addresses the role of providers, delivery of care, patient screening and risk assessment.

A. For each question below please circle the number 1-5 that most accurately reflects your clinic at the present time.

1. To what degree are the behavioral health patients seen in your clinic long-term patients or short-term patients?

Predominately Long-term Patients		Equal Balance of Long vs Short		Predominately Short-term Patients
1	2	3	4	5

Comments:

2. To what degree do the primary care providers in your clinic address behavioral health issues of patients?

Do not address		Often addresses		Always addresses
1	2	3	4	5

Comments:

3. To what degree is the behavioral health provider part of the primary care team?

Not part of the team		Often part of the team		Completely part of team
1	2	3	4	5

Comments:

4. To what degree is the goal to resolve the patient's mental health issues using the traditional psychotherapy model vs to address behavioral health issues with brief interventions and consultations?

Resolve with traditional psychotherapy model	Utilize a mixture of traditional psychotherapy and brief interventions/ consultations	Address behavioral health with brief interventions and consultation.

1	2	3	4	5

Comments:

5. How long are therapy sessions in length?

60 minutes or more		30 minutes		15 minutes or less
1	2	3	4	5

Comments:

6. To what degree are patients receiving long-term behavioral health services here at the clinic rather than being referred to another site.

80%		50%		20%
1	2	3	4	5

Comments:

8. What percent of patients are screened for behavioral health issues in the primary care setting?

0%		50%		100%
1	2	3	4	5

Comments:

9. To what degree are patients with chronic illness (e.g. Cardiac, diabetes) targeted for behavioral health risk assessment and treatment?

Not at all		Often		Always
1	2	3	4	5

If yes, how is it addressed and who addresses it?

Comments:

10. To what degree are healthy lifestyle/behaviors (e.g. tobacco use, stress management) addressed with a behavioral risk assessment and treatment?

Not at all		Often		Always
1	2	3	4	5

If yes, how is it addressed and who addresses it?

Comments:

Regarding items 1-10 please comment below.

- What are your preferences?
- How it is working for you?
- What changes would you like to see?
- How important is this item to you?
- What do you like/dislike about how it is going?

Comments:

INTERFACE MENTAL HEALTH
MENTAL HEALTH SERVICES - SAN MATEO COUNTY

PRIMARY CARE PROVIDER SURVEY

Thank you *for taking the time to complete this survey. Your response will enable Interface Mental Health to serve our providers better. Please fold, staple and put in the* ***PONY (Address is on the back)*** *or Return the survey to your local Interface clinician by 1/30/02.*

General Information

1. I am a ☐ Doctor ☐ N.P. or P.A.

2. I work at ☐ Fair Oaks ☐ Willow/Belle Haven ☐ North/SSF ☐ 39th St.

3. Of the patients I see per week I prescribe psychiatric medication to approximately:

   ☐ less than 6 ☐ 6 to 10 ☐ 11 to 20 ☐ 21+ Patients

4. I see ☐ adults ☐ children ☐ both

5. I currently prescribe the following psychiatric medications: (check all that apply)

	Never	Rarely	Occasionally	Frequently
☐ Anti-depressants				
☐ Anti-Anxiety				
☐ Anti-psychotics				
☐ Mood Stabilizers				

Referral to Interface

For each of the following statements, please check the column that best represents your impression of the Interface Team

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	DON'T KNOW
5. I generally receive appropriate support from Interface.	☐	☐	☐	☐	☐
6. Interface staff provides complete information when returning the Interagency Referral Form.	☐	☐	☐	☐	☐

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	DON'T KNOW
7. I understand the referral process for mental health.	☐	☐	☐	☐	☐

Education and Training

1. I would like to learn more about psychiatric medications.	☐	☐	☐	☐	☐
2. I would like to learn more about anti-depressants.	☐	☐	☐	☐	☐
3. I would like to learn more about medications for the treatment of anxiety.	☐	☐	☐	☐	☐
4. I would like to learn more about medications for psychotic illnesses.	☐	☐	☐	☐	☐
5. I would like to learn more about brief mental health treatment.	☐	☐	☐	☐	☐

13. List your top five priorities for psychiatric training/education in order of preference.

Medication for Anxiety and Depression ☐
Brief Therapy ☐
Case Discussion ☐
Substance abuse ☐
How does Access work ☐
Mental Health Resources ☐

14. Please add any general comments and psychiatric education requests.

_____

_____

_____

_____

Thank you very much for your participation

Staff Requirements

- San Mateo County Mental Health Services. *Job Description (prepared for non-profit community health center)*
- Criterion Health Inc. *Productivity Calculator*

The South County Community Health Center seeks a full time permanent Spanish speaking mental health clinician to provide brief treatment and case management to patients referred by the primary care provider. This clinician will work with clients referred by the primary care provider. Patients with serious mental illness will be referred to San Mateo or Santa Clara County by this clinician for assessment and if appropriate, long term mental health treatment.

Qualifications: Licensed Clinical Social Worker or Marriage and Family Therapist. Unlicensed candidates will be considered if they are registered as a Marriage and Family Therapist Intern or as an Associate Clinical Social Worker and eligible to earn hours for licensure in California. **Supervision** of hours the meet the B.B.S.C. standards will be provided. Training will be arranged.

The ideal candidate will be an experienced mental health clinician who wants to work with primary care providers in a medical clinic. The clinician will have demonstrated expertise, skill and interest in working with a broad range of patients of diverse cultures and backgrounds. The ideal candidate will have solid clinical assessment, diagnostic and evaluation skills. The candidate will have skill in establishing and maintaining productive working relationships with other professionals, collaborative partners and the public. Finally the clinician will be able to make sound decisions based on the exercise of judgment and the consideration of all available information.

South County Community Health Center offers primary adult, pediatric and prenatal care, family planning and women's health, chronic disease case management and dental services.

Immediate need is for the assessment, evaluation and referral or brief treatment of patients referred by their primary care provider.

Short Term Goal for this position: Identify Seriously Mentally Ill patients and link with their County Regional Treatment Team.

Long Term Goals:
Build programs of treatment with community based agencies and clinic staff based on clinical finding and staff input.

Liaison/partner with other community based mental health practitioners to provide on-site groups

Partner with medical staff to provide educational groups that focus on the health impact of behavior.

LCSW/MFT: Salary Range

Criterion Health
Productivity/Workload Calculator

Syndrome	Depression	Anxiety	Relation -ship	ADHD	Medication adherence	Weight loss	Activity adherence
PCP sees per week							
BHP sees per week (@20%)							
½ hour units							

Billing

- Criterion Health Inc. *Billing/Coding Grid and Staff Business Model Summary*
- Practice Management Associates. *Level II HCHCS "H" Codes and Modifiers, Denial Management and Prevention Methods*

Criterion Health Inc.
Billing/Coding Grid and Staff Business Model Summary

	What is the focus of the service being provided?	
Who is providing the service?	**Physical Diagnosis**	**Psychiatric Diagnosis**
Physical Health Independent Practitioner		
Psychiatric Independent Practitioner		
Physical Health Clinician, providing "incident to" services		
MH/SA Clinician, providing "incident to" services		

	In PCP Practice as Primary Health	**As Psychiatric Practitioner Services**
Diagnosis	Physical	Psychiatric *
Authority	PCP prescribes	BH Practitioner
Billing under	PCP bundled services 99201-5, 11-15 series 99078 educational services-group 99401-4, 11-12 prevention interventions 0108 & 0109 for diabetes	MH benefit * 90804-29 series, individual 90853,57 group 90846-49 family 99150-5 codes as come on line
Documentation	In medical chart	BH Practitioner records
Liability	PCP practice (& BHP)	BHP

Practice Management Associates
Effective Billing Practices

New Health Screening CPT Codes

96150 - H & B assessment (e.g. health-focused clinical interview, behavioral observations, psycho-physiological monitoring, health oriented questionnaires, each 15 minutes face-to-face with the patient, initial assessment)
96151 - Re-assessment
96152 - Health and Behavior intervention (each 15 minutes, face to face, individual)
96153 - Group (2 or more)
96154 - Family (w/ patient present)
96155 - Family (w/o patient present)

Consultation Codes

99242 Office consultation -new or est.
- History = expanded problem focused
- Examination = epf
- MDM = straightforward
- Nature of problems = low severity
- Documentation = 3 key elements
- Time = usually takes 30 minutes
- Referring provider must be reported on claim

99243 Office consult
- History = Detailed
- Examination = Detailed
- MDM = Low complexity
- Nature of problems = Moderate
- Documentation = 3 key elements
- Time = Usually takes 40 minutes
- Referring provider must be reported on claim

99244 Office consult
- History = Comprehensive
- Examination = Comprehensive
- MDM = Moderate complexity
- Nature of problems = moderate to high
- Documentation = 3 key elements
- Time = Usually takes 60 minutes
- Referring provider must be reported on claim

99245 Office consult

- History = Comprehensive
- Examination = Comprehensive
- MDM = high complexity
- Nature of problems = moderate to high
- Documentation = 3 key elements
- Time = Usually takes 80 minutes
- Referring provider must be reported on claim

99251-99255

- Initial inpatient consultations for a new or established patient.
- May be reported only once per admission.
- HX-Exam-MDM = same progression as office consults
- Documentation = All 3 key elements
- Time = 20-110 minutes
- Use established consult protocol

99301-99313

- Services provided in nursing facilities (formerly SNF, ICF and LTC facilities).
- If a procedure such as medical psychotherapy is provided in addition to E/M services, this service is also reported.
- Usually provide 1 x month.
- Note: Recent PM in re: psych meds in nursing facilities.

99321-99333

- Used to report services provided to new and established patients in domiciliary, rest home or custodial care facility. (a facility which provides room, board and other personal assistance services, generally on a long-term basis).
- When reporting this code, use modifier SP or MP to indicate single or multiple patients seen.

Multiple Same Day Services

- National Correct Coding Initiative (NCCI) guides
- Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239), when CMS (then HCFA) changed from the "usual and customary" form of payment to the current physician's fee schedule
- It is the Mutually Exclusive section of the NCCI electronic edit process that could "electronically" reject or down-code certain combinations of services a CMHC provides to it's clients
- Versions (manuals) of the NCCI edits are issued quarterly (we are up to version 8.something) and each chapter of the manuals are divided into two sections: Mutually Exclusive Procedures and Comprehensive and Component Procedures. (Bundled and unbundled)
- Three foci:
    - Services that will never be allowable on the same day to the same patient, and therefore should be avoided
    - Services provided on the same day that are allowable with modifier codes but will most likely be questioned by the Carrier

- Services that should pass the NCCI audits without modifier codes

Mutually exclusive, UNLESS, different Dx.
- More than one M0064, 90862, 90872, 90804, 90806, group or family psychotherapy, 99211, 99212, 99213, 99214 or 99215
- Two psychotherapy codes
- Any E/M and M0064 or 90862
- M0064 and 90862
- 90872 and 99211, 90862 or M0064
- 90862 and individual psychotherapy by the same provider
- 90801 and another service on the same day

Should pass NCCI edits w/o modifier:
- Any E/M (99212-99215) and group psychotherapy
- 90862 and group psychotherapy
- 99211 and individual or group psychotherapy
- M0064 and individual, family or group psychotherapy
- 90872 and individual, group or family psychotherapy
- Consultation (9924x) and any treatment code (excludes additional diagnostic services such as 90801 on same day)
- 90804 or 90806 and 90853, if the individual therapy service is reported first on the claim.

Should pass edits w/modifiers:
- E/M and nearly any other procedure, when for a different diagnosis.
- 90853 and 90804, 90806 or 90847, if 90853 is listed first and modifier 51 is used.
- 90862 and 90804 or 90806 when done "incident to", with modifier 51. (Not recommend as a typical procedure when M0064 and 9080x should work alone.
- 90847 (when listed first) and 90804 or 90806 with modifier 51.

CPT Modifiers

-21 Prolonged Evaluation and Management Services: When the face-to-face or floor/unit service(s) provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management service with a given category, it may be identified by adding modifier '-21' to the evaluation and management code number or by use of the separate five digit modifier code 09921. A report may also be appropriate.

-25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service: The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are

not required for reporting by adding the modifier '-25' to the appropriate level of E/M service, or the separate five digit modifier 09925 may be used.

-51 Multiple Procedures: When multiple procedures, other than Evaluation and Management Services, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending the modifier '-51' to the additional procedure or service code(s) or by the use of the separate five digit modifier 09951. NOTE: This modifier should not be appended to designated "add-on" codes.

-59 Distinct Procedural Service: Organizations may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier '-59' is used to identify procedures or other services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or client encounter, different places of service (like another campus or at the client's home, as opposed to your office or agency), treatment for a separate diagnosis (sequential treatment for dually diagnosed persons) not ordinarily encountered or performed on the same day by the same physician.

Level II - HCPCS National codes

H Codes- Alcohol and Drug Abuse Treatment Therapies

- This section is new to HCPCS. Some were created in 2001, 2002, and 2003. These codes are critical to the organization supplying them as they are the only way to describe provide services, post HIPAA.
- For further definition of these codes, please refer to the CMS website at www.cms.gov.

Level II HCHCS "H" codes and Modifiers

H0001	Alcohol and/or drug assessment
H0002	Behavioral health screening to determine eligibility for Admission to treatment program
H0003	Alcohol and/or drug screening; laboratory analysis of specimens for presence of alcohol and/or drugs
H0004	Behavioral health counseling and therapy, per 15 Minutes
H0005	Alcohol and/or drug services; group counseling by a clinician
H0006	Alcohol and/or drug services; case management
H0007	Alcohol and/or drug services; crisis intervention (outpatient**)**
H0008	Alcohol and/or drug services; sub-acute detoxification (hospital inpatient)
H0009	Alcohol and/or drug services; acute detoxification (hospital inpatient)
H0010	Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient**)**
H0011	Alcohol and/or drug services; acute detoxification (residential addiction program inpatient)
H0012	Alcohol and/or drug services; sub-acute detoxification (residential addiction program outpatient)
H0013	Alcohol and/or drug services; acute detoxification (residential addiction program inpatient**)**

H0014	Alcohol and/or drug services; ambulatory detoxification
H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education
H0016	Alcohol and/or drug services; medical/somatic (medical intervention in ambulatory setting)
H0017	Behavioral health; residential (hospital residential treatment program), without room and board, per diem
H0018	Behavioral health; short-term residential (non-hospital residential), without room and board, per diem
H0019	Behavioral health, long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem
H0020	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)
H0021	Alcohol and/or drug training service (for staff and personnel not employed by providers)
H0022	Alcohol and /or drug intervention service (planned facilitation**)**
H0023	Behavioral health outreach service (planned approach to reach a targeted population)
H0024	Behavioral health prevention information dissemination service (one-way direct or non-direct contact with service audiences to affect knowledge and attitude)
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)
H0026	Alcohol and/or drug prevention process service, community-based (delivery of services to develop skills or impactors)
H0027	Alcohol and/or drug prevention environmental service (board range of external activities geared toward modifying systems in order to mainstream prevention through policy and law)
H0028	Alcohol and/or drug prevention problem identification and referral service (e.g., student assistance and employee assistance program), does not include assessment.
H0029	Alcohol and/or drug prevention alternatives service (services for populations that exclude alcohol and other drug use e.g., alcohol free social events)
H0030	Behavioral health hotline service
H0031	Mental Health assessment, by non-physician
H0032	Mental health service plan development by non-physician
H0033	Oral medication administration, direct observation
H0034	Medication training and support, per 15 minutes
H0035	Mental health partial hospitalization, treatment , less than 24 hours
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes
H0037	Community psychiatric supportive treatment program, per diem
H0038	Self-help/peer services , per 15 minutes
H0039	Assertive community treatment, face-to-face, per 15 minutes
H0040	Assertive community treatment program, per diem

H0041 Foster care, child, non-therapeutic, per diem
H0042 Foster care, child, non-therapeutic, per month
H0043 Supportive housing, per diem
H0044 Supportive housing, per month
H0045 Respite care services, not in the home, per diem
H0046 Mental health services, not other wise specified
H0047 Alcohol and/or drug abuse services, not otherwise specified
H0048 Alcohol and/or drug testing: collection and handling only, specimens other than blood
H1010 Non-medical family planning education, per session
H1011 Family assessment by licensed behavioral health professional for state defined purposes
H2000 Comprehensive multidisciplinary evaluation
H2001 Rehabilitation program , per ½ day

Level II - HCPCS modifiers
H9-court ordered;
HA- Ch/Adol.program;
HB-Adult program, non-geriatric;
HC-Adult program, geriatric;
HE-Mental Health Program;
HF-Substance Abuse Program;
HM-Less than bachelor degree level:
HN-Bachelor's level;
HO-Master's level;
HP-Doctoral level;
HQ-Group setting;

Some of the interesting new HCPCS modifiers that may affect behavioral health providers:
Y-No physician or other licensed health care provider order for this item or service;
GN-Service. delivered under outpatient speech/language program;
GO-Service delivered under output OT;
GP- Service del under output PT;
H9-court ordered;
HA- Child/Adolescent program;
HB-Adult program, non-geriatric;
HC-Adult program, geriatric;
HE-Mental Health Program;
HF-Substance Abuse Program;
HM-Less than bachelor degree level:
HN-Bachelor's level;
HO-Master's level;
HP-Doctoral level;
HQ-Group setting;
HR-Family/couple with client present;
HS-Family/Couple w/o client present;
HT-Multidisciplinary Team;

HU-funded by child welfare agency;
HV-Funded state addictions agency;
HW-Funded by state mental health agency;
HX-funded by local agency;
HY-Funded by Juvenile Justice agency;
HZ-Funded by Criminal Justice agency;
TL-Early intervention family service plan (IFSP);
TM-Individualized Education program (IEP);
TR-School-based individual education program (IEP);
Medicaid Level of Care, Defined by each State will go from U1-U9 and UA-UD, with U1 being level 1 and UD describing Level 13.

Denial Management and Prevention Methods

Persistence in appealing denials is often the key to a successful claims recovery strategy. It is also helpful to adjust internal procedures within your organization and provide your staff with training on claims recovery strategies. Common recovery strategies include:

- Spreadsheet to track status of denials and provide feedback to appropriate person.
- Trend denials by CPT/HCPCS code and revenue center.
- Involve the attending MD and ask for his/her input prior to submitting.
- Keep exact duplicates of everything you send.
- Implement tracking by using overnight services or certified mail.
- Review and summarize patient history, treatment, progress and P/C status.
- Address specific denial reasons through process improvement or education.
- Cite how patient met regulatory and/or reimbursement guidelines to payer
- Reference attachments to payer
- Intermediary and carrier guidelines are updated and available to providers and billing staff.
- Include documentation in your organization's Standards of Care policy
- Track results of claims recovery as you Map Payors
- Review your denial rate per quarter at a minimum
- Turnover rate = Opportunity to train, test, re-train all staff members in that department.
- Report claims recovery results to CEO, CFO and CCO (corporate compliance officer)

More Denial Prevention methods

Effective ways to prevent denials include:

- Awareness at all levels (zero tolerance for denials)
- Good documentation
- Accurate procedures
- Staff education
- Front-end resolution

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