Multnomah County Department of Human Services
Mental Health and Addictions Services Division

MHASD Healthcare Integration Report

DRAFT 6.22.10

Prepared by:
E. Dawn Creach, MS, Project Manager
Joan Rice, RN, MHASD Quality Manager
David Cutler, MD, MHASD Medical Director
421 SW Oak St, Suite 520
Portland, OR 97204-1817
503/988-5464 x29597

Multnomah County Mental Health and Addictions Services Division
Healthcare Integration Report
Table of Contents

Executive Summary

Recent research tells us that people living with serious mental illness die an average of 25 years earlier than the general population, primarily due to chronic medical conditions. One reason is a lack of access to primary medical care and preventive health services. Another reason is that many psychiatric medications prescribed to treat mental illness increase the risk of medical conditions like heart disease and diabetes. Without access to quality primary care and preventive health services, these conditions go undiagnosed and untreated. The societal cost of caring for people who have both physical and behavioral[1] health problems, many of which can be controlled or prevented, is overwhelming. For people with serious mental illness, Community Mental Health Centers (CMHC) may be the most important point of entry to the healthcare system. Integrating primary care into CMHCs has been shown to increase the overall health and quality of life for this population. Furthermore, services that care for whole-person health are an important part of national and state healthcare reform. Our goal at Multnomah County Mental Health and Addiction Services Division (MHASD) is to develop integrated healthcare services that "put the head back on the body."

MHASD recently produced a strategic plan for 2010 – 2013. The integration of physical and behavioral healthcare is one of four top division goals. MHASD is committed to the *Pledge for Wellness* to promote improved health for people with mental illness and reduce their early mortality. This report presents MHASD's plans to integrate healthcare services so that vulnerable people in our community get the care they need to live healthy lives. The MHASD Healthcare Integration Project began in August 2009 with key objectives to:

MHASD Healthcare Integration Project Goals:

- Understand the current national, state, and local context for integrated healthcare (Section I)
- Study existing national models and evidence-based practices for providing integrated healthcare services (Section I)
- Describe the integrated healthcare services currently available in Multnomah County (Section II)
- Incorporate the recommendations of behavioral health consumers and consumer advocates (Section III)
- Work with local stakeholders to develop recommendations for the integration of behavioral health and primary care services that meet the needs of adults with serious mental illness (Section III)

The MHASD Healthcare Integration Report documents the extensive process of inquiry that led to our final recommendations for delivering integrated care to the people we serve. Understanding "where we are now" is critical for mapping out "where we want to go." We use the information about "where we are" as a community to plan for integrated healthcare capacity in all settings that serve people with serious mental illness. It is important that people with serious mental illness have a Person-Centered Healthcare Home to ensure whole-person care.

In Section I we identify barriers to physical healthcare for people with serious mental illness. We review the recommendations from national experts and describe model programs that have overcome barriers to effectively deliver integrated care. We explore a variety of models ranging from Cherokee Health Systems in Tennessee,

[1] The term behavioral health is used throughout this report as a term that includes mental health, behavioral and lifestyle aspects of physical health conditions, and substance use/abuse.

which is fully integrated both structurally and financially, to partially integrated models like the Navos-Neighborcare partnership in Seattle, Washington. We focus on organizations serving a population similar to our own including public-private partnerships, primary care organizations, behavioral health organizations, governmental entities, and CMHCs. Few national models exist of the fully integrated Person-Centered Healthcare Home for people with serious mental illness, but this report outlines lessons learned from the national and local integration efforts that we can build upon. Section I also examines the new national healthcare reform law and reform efforts in Oregon. We explain how these changes will dramatically impact the behavioral health system. We also explain how integrated healthcare is critical for achieving the basis of all healthcare reform efforts, the Institute for Health Care Improvement's Triple Aim™ to increase population health, enhance patient experience/quality, and control healthcare costs.

There are many integration efforts already underway in our community. Section II details our efforts to understand the scope of integrated healthcare services currently available. Based on this information, we identify areas of strength to build on and places to target improvement efforts. We first examine primary care safety-net Federally Qualified Health Centers (FQHC) in our community that provide integrated behavioral healthcare services. MHASD conducted standardized site visits to six FQHCs – Multnomah County Health Department Westside Clinic, OHSU Richmond Clinic, Central City Concern Old Town Clinic, Outside In, NARA Indian Health Clinic, and Virginia Garcia Hillsboro Clinic – to understand their behavioral health delivery models, integrated billing practices, and the types of services they offer. We also assess elements of the primary care Patient-Centered Medical Home: providing team-based and patient-centered care, the scope of primary care services offered, use of health information technology and safety/quality measures, and providing care coordination and management.

It is clear from our site visits that our community is rapidly expanding the integration of behavioral healthcare into primary care settings. However, we found that the type of behavioral health services offered and how they are delivered varies widely among the clinics. It is unclear if the scope of behavioral health services available in these primary care settings is adequate to meet the needs of people with serious mental illness. We also found that none of the clinics have a registry for identifying people with behavioral health needs or those taking psychiatric medications that increase their risk for medical conditions. Without the ability to identify and track these individuals, there is no way to tell if they are receiving effective care. Three of the six clinics do not feel they have collaborative relationships with behavioral health providers outside of their practice and none have protocols for communicating with case managers external to the practice. Many people with serious mental illness receive their behavioral healthcare and psychiatric medications at CMHCs and receive physical healthcare at FQHC primary care clinics. It is critical for primary care and behavioral health providers to communicate and exchange patient information regularly. However, there is a lack of process mechanisms to facilitate the coordination of care.

MHASD also visited three innovative CMHC programs in our community that provide integrated primary care services onsite. The OHSU Intercultural Psychiatric Program and Central City Concern 12th Avenue Recovery Center have both established a patient exam room and have a primary care provider (PCP) onsite to care for people with serious mental illness who do not have a regular source of primary care. Asian Health and Service Center (AHSC) has a Naturopathic Doctor and interns from the National College of Naturopathic Medicine onsite one day per week. They provide acupuncture and Chinese herbal medicine to treat a range of behavioral

and physical health symptoms and illnesses. AHSC and other CMHCs provide a variety of physical health wellness programs such as chronic disease management, nutrition, and exercise classes. Some also participate in projects focused on outreach and education about breast/cervical/colorectal health and increasing cancer screening rates.

There are also two collaborative Performance Improvement Projects focused on integrated healthcare services in CMHCs. Kaiser Permanente and Verity Integrated Behavioral Healthcare (Verity) partnered to improve the continuity and coordination of care for their mutual enrollees through the use of an Exceptional Needs Care Nurse and standardized patient information forms. CareOregon, LifeWorks NW, and Verity also partnered to provide an embedded nurse at the LifeWorks NW Gresham clinic. The nurse performs health screening, assists clients in establishing care with a PCP, monitors lab requirements, and coordinates care between behavioral health and primary care providers.

The integrated healthcare efforts already underway at CMHCs provide some foundational elements for Person-Centered Healthcare Homes for people with serious mental illness in our community, but there is still much work to be done. When we compare the services available to national recommendations, we find that no CMHCs in our system of care provide the minimum physical health services for their clients.

As part of this project MHASD met with many local stakeholders - behavioral health consumers and consumer advocates, primary care physicians and psychiatrists, and other physical and behavioral health providers. Section III describes their input into this report and our final recommendations for creating integrated healthcare services. Input sessions with behavioral health consumers and consumer advocates produced six key recommendations for integrated healthcare services:

Behavioral Health Consumer and Consumer Advocate
Key Recommendations for Integrated Healthcare:

1. **Ensure there is no "wrong door" for receiving care** – Consumers should have access to behavioral and physical healthcare services at locations of their choice, either in primary care clinics or CMHCs
2. **Establish team-based, coordinated care** – Consumers value and desire long-term relationships with a team of providers; they believe that communication between providers will increase the effectiveness of their care
3. **Honor consumer choices** – Consumers should have a choice of where they receive care, including staying with established providers, and whether or not to share their mental health information with PCPs
4. **Incorporate services to help facilitate receipt of physical healthcare** – Consumers would like longer appointment times with PCPs, "warm hand-offs" when introduced to new providers, availability of on-site blood draws at CMHCs, and peers/advocates/mentors/case managers to help them prepare for and/or attend PCP appointments
5. **Educate providers and consumers** – PCPs need more education about mental health issues, including medication management, interactions between mental and physical health conditions, and be dually-trained for substance use/abuse. Consumers need education about the importance of primary care, how to negotiate the healthcare system, and how to talk to PCPs about medication and health concerns
6. **Create environment of respect and acceptance** – Consumers value being positively acknowledged by all staff and providers, greater tolerance of diversity, and not being judged or dismissed by PCPs

MHASD also held six collaborative meetings with a Verity Provider Review Committee (PRC) subcommittee, which included representatives from five local agencies that provide behavioral health services to people with serious mental illness: Multnomah County Health Department, Central City Concern, Luke-Dorf, LifeWorks NW, and Cascadia Behavioral Healthcare. The goals of the meetings were to 1) identify barriers and potential solutions to integrated healthcare and 2) prioritize and plan for areas of standardization at sites providing integrated healthcare services. The guiding vision of the subcommittee is to overcome barriers to integrated services so that appropriate care is received at the right time and place.

Based on all information and community input presented in this report, Section III concludes with five recommendations for behavioral health services in primary care FQHC clinics. We also make nine recommendations for physical health primary care services delivered in CMHCs. We explain how these are aligned with evidence-based research, national expert recommendations, and local consumer and provider input. We believe these recommendations will result in decreased total healthcare costs over the long-term for adults with serious mental illness. We also believe these recommendations will improve the health and quality of life for people in our community living with mental illness.

Final recommendations in this report will be used to plan for the package of integrated services in the RFPQ planned for Winter 2010. The recommendations are separated into two areas – behavioral health services delivered in FQHC primary care settings and primary care services delivered in CMHC settings. Our overarching vision is to ensure people with serious mental illness have access to Person-Centered Healthcare Homes that care for the overall health and well-being of people at locations that best serve their needs and preferences.

Recommendations for behavioral health services delivered in safety-net FQHC primary care clinics in Multnomah County:

1. Establish standardized elements of the behavioral health delivery model and minimum set of services available in FQHC safety-net primary care clinics

2. Standardize and streamline documentation requirements and patient health information exchange procedures

3. Standardize and simplify billing and coding practices for integrated behavioral health services

4. Establish registry tracking/outcome measurement for 1) all individuals receiving behavioral healthcare at FQHC safety-net primary care clinics and 2) all individuals receiving their behavioral healthcare at CMHCs and physical healthcare at FQHC safety-net primary care clinics

5. Help establish evidence-based wellness programs and Peer Wellness Coaches to help people with behavioral health needs engage in wellness programs/activities

Recommendations for integrated primary care services delivered in Community Mental Health Centers that contract with MHASD to provide services to people with serious mental illness in Multnomah County:

1. Establish primary care providers (physicians or nurse practitioners) onsite in CMHCs that provide services to large numbers of people with serious mental illness

2. Establish embedded Clinical Care Managers within all CMHCs serving people with serious mental illness

3. Establish registry tracking and outcome measurement for all individuals receiving care at CMHCs serving people with serious mental illness

4. Provide point-of-service access to blood draws onsite at CMHCs serving people with serious mental illness to eliminate barriers to regular metabolic monitoring and recommended lab work

5. Establish accountability practices for prescribing providers at CMHCs to 1) ensure appropriate lab work is ordered, 2) review lab results in a timely manner, and 3) make appropriate treatment adjustments and/or coordinate care with patients' PCPs

6. Begin to develop Person Centered Healthcare Homes (PCHH) for people with serious mental illness in Multnomah County by first focusing on: 1) transitioning to team-based and collaborative care structures/operating practices in CMHCs and 2) provide education/training on "Integration 101" topics for behavioral health providers/staff

7. Establish evidence-based wellness programs and Peer Wellness Coaches in all CMHCs serving people with serious mental illness to help consumers engage in integrated health services and wellness programs/activities

8. Establish resources necessary to hire a project manager/grant writer/consultant to help Multnomah County compete for next round of SAMHSA grants for integrated primary care services in CMHCs and to implement the recommendations in this report

9. Fully develop MHASD financial payment model for integrated health services to include fee-for-service, case rate, and pay for performance mechanisms

The national and local movement to integrate behavioral health and primary care services requires Multnomah County MHASD to deliberately plan and invest the resources necessary to address the health disparity for people living with serious mental illness. Furthermore, the sweeping healthcare system changes over the next 5 to 10 years will present extraordinary opportunities for the community behavioral health system. Now is the time for forethought and action. We must simultaneously commit to address the *Pledge for Wellness* (to reduce the 25 year early mortality) and the Triple Aim™ (to increase population health, enhance patient experience/ quality, and control costs) for people living with serious mental illness in our community. The integration of primary care and behavioral health services is indisputably vital for achieving these goals.

MHASD Healthcare Integration Report

Section I:

Introduction,

Conceptual/Contextual Framework,

And Selected National Models

A. Introduction

The National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council released a landmark report in 2006 based on consistent and concerning research findings that people with serious mental illness die an average of 25 years earlier than the general population, primarily due to unmanaged physical health conditions. "The increased morbidity and mortality are largely due to treatable medical conditions that are caused by modifiable risk factors such as smoking, obesity, substance abuse, and inadequate access to medical care" (NASMHPD, 2006). The co-morbid health challenges people with serious mental illness face are compounded by evidence that many psychiatric medications actually cause metabolic disturbances, predisposing people to Metabolic Syndrome, a cluster of risk factors -- high blood pressure, high blood sugar, high cholesterol levels, and abdominal obesity -- that increases risk of heart disease and diabetes (Mendelson, 2008).

The societal and monetary costs of caring for people with co-morbid medical and behavioral health[2] conditions are staggering. Many people in this population are insured by publicly-funded health systems, for example, 49% of Medicaid beneficiaries with disabilities have a psychiatric disorder. Furthermore, among the highest-cost 5% of Medicaid beneficiaries with disabilities, three of the top five most prevalent pairs of diseases include a psychiatric disorder (Center for Healthcare Strategies, Inc., 2009). Many people with serious mental illness are insured by Medicaid and Medicare, referred to as "dual eligibles." The annual cost of care for dual eligibles is estimated at $250 billion; nearly half of all Medicaid and a quarter of all Medicare expenditures (Center for Healthcare Strategies, Inc., 2010).

Despite the evident need for primary care services, there are many individual, provider, and system-level barriers to high quality care for people with serious mental illness. These include:

- Primary care and mental health system fragmentation
- Using the emergency room as the only source of medical care (Levinson, Druss, Dombrowski, & Rosenheck, 2003)
- Poverty and/or lack of health insurance coverage (Druss & Rosenheck, 1998)
- Stigma and discrimination against people with mental illness, e.g. providers often assume patients' complaints are psychological, leading them to be less aggressive in ordering procedures and diagnostic tests (Graber, Bergus, Dawson, Wood, Levy, & Levin, 2000)
- Primary care provider (PCP) lack of knowledge about and comfort with people with serious mental illness (Lester, Tritter, & Sorohan, 2005)
- Problems resulting directly from mental illness, e.g. cognitive limitations, lack of motivation, paranoia, and impaired communication skills (NASMHPD, 2006)
- Weight gain caused by psychotropic medications leads to discrimination, bias, and stigmatization due to being overweight (Puhl, 2010)
- Social isolation
- Sense of powerlessness

The Insitute of Medicine (IOM) states, "Mental and substance-use problems and illnesses should not be viewed as separate from and unrelated to overall health and general health care," and calls for coordinated and integrated care by primary care, mental health, and substance-use treatment providers to be the norm (IOM, 2006).

[2] The term behavioral health is used throughout this report as a term that includes mental health, behavioral and lifestyle aspects of physical health conditions, and substance use/abuse.

People living with serious mental illness may be more comfortable and more likely to receive primary care at Community Mental Health Centers (CMHC) where they already receive behavioral health treatment and have established trusting relationships. Indeed, CMHCs may be the most important point of entry to the healthcare system for people with serious mental illness (Druss, et al., 2008). However, access to and quality of primary care for CMHC patients is typically substandard (Levinson-Miller, Druss, Dombrowski, & Rosenheck, 2003). CMHCs are usually not equipped nor staffed to provide even basic primary care services, and have few incentives to coordinate care with patients' medical providers (Samet, Friedmann, & Saitz, 2001).

The historical separation of the behavioral health system from physical health presents multiple barriers to service integration. However, given recent national focus on controlling healthcare costs and increasing the quality of healthcare, it is imperative to overcome these barriers. "Physical healthcare is a core component of basic services to persons with serious mental illness. Ensuring access to preventive healthcare and ongoing integration and management of medical care is a primary responsibility and mission of mental health authorities" (NASMHPD, 2005). This report represents Multnomah County MHASD's strategic plan for increasing the health of people living with serious mental illness in Multnomah County by achieving systematic integration of behavioral health and primary care services.

What is integrated healthcare?

"It has been defined in many ways, but in essence integrated health care is the systematic coordination of physical and behavioral health care. The idea is that physical and behavioral health problems often occur at the same time. Integrating services to treat both will yield the best results and be the most acceptable and effective approach for those being served. The question is not whether to integrate, but how. Neither primary care nor behavioral health providers are trained to address both issues. Systems that pay for these services typically are set up to pay for them separately. Shifting to integrated health care requires a fresh perspective, new skills and radical changes in service delivery" (Hogg Foundation for Mental Health, 2008).

B. Current Context and Conceptual Framework for Integrated Healthcare

1. Federal Healthcare Reform and National Developments

At the time this report is being written, comprehensive national healthcare reform called the Patient Protection and Affordable Care Act (PPACA) has just been signed into law. It includes four key strategies – insurance reform, coverage expansion, delivery system redesign, and payment reform - to transform the healthcare system in alignment with the Institute for Healthcare Improvement Triple Aim™ (IHI):

- Improve the health of the population
- Enhance the patient experience (quality, access, reliability)
- Reduce, or at least control, total healthcare costs (referred to as "bending the cost curve")

The provisions set forth in the 2,700 page law will have a considerable impact on the healthcare system of the future, the details of which are difficult to forecast at this time. However, the following presents a summary of areas that will substantially affect the behavioral healthcare system and plans for integrated healthcare services presented in this report.

Insurance Coverage Expansion and Parity – The Mental Health Parity and Addiction Equity Act now requires behavioral health services to be offered and covered by insurance companies at parity with physical health services. In addition, the primary pillar of the PPACA will be the significant increase in the number of people

with health insurance coverage. Both of these elements combined will create a precipitous increase in demand for behavioral healthcare services. The behavioral health system will need to expand capacity considerably to meet this demand (NCCBH, 2010):

- Nationwide, over 30 million people (15 million Medicaid-eligible) will gain health insurance including coverage for behavioral health services
- In Oregon it is estimated that an additional 260 FTE will be needed to close 50% of the gap only for the indigent and uninsured people with a serious mental illness/serious emotional disorder
- Insurance expansion (not including impact of Parity Act) will add $15 - $23 billion nationwide in spending for behavioral health services

However, it is important to note that the focus on controlling total healthcare costs will result in increased opportunities only for behavioral health organizations able to demonstrate they provide high-quality, effective, evidence-based care. There will also be increased competition as organizations, including physical health entities, vie for healthcare dollars. Given the increased awareness of the costs associated with co-morbid physical and behavioral healthcare conditions, the demand for integrated services that address whole-person health will be marked.

Accountable Care Organizations - Another healthcare reform concept gaining attention and included in PPACA is the Accountable Care Organization (ACO). Although not fully defined at this time, the central idea is to change the way healthcare is delivered by uniting different healthcare organizations to focus on the common goals of improving health for their patients and managing total healthcare expenses. For example, an ACO might include a hospital, physician group, and CMHC as part of an integrated care system designed to lower costs and improve care. The group would share risks as well as rewards for improving health of their patients, eliminating waste and inefficiencies, and holding down costs. "The ACO is truly the way the federal government is moving health care in our country: a new payment system that mandates integration across the continuum of care" (Jansma, 2010).

SAMHSA Grants for Primary Care in Specialty Behavioral Health Settings – Section 5604 of the PPACA authorizes $50 million for the SAMHSA grant program for providing integrated primary care services in CMHCs. This program was previously funded at $14 million, and funded 13 projects in 2009. These grants will be an important mechanism for establishing robust primary care capacity in CMHCs and addressing the physical health needs of people with serious mental illness.

State Option to Provide Healthcare Homes for People with Chronic Conditions - Section 2703 of the PPACA authorizes $25 million to implement healthcare homes for people with chronic conditions. The wording specifically includes CMHCs as eligible providers and people with mental illness and substance use disorders as eligible participants. It will be important to monitor how this program is developed in Oregon.

Patient-Centered Medical Homes – The PPACA strategies for delivery system redesign and payment reform are conceptualized in the Patient-Centered Medical Home (PCMH) model, which provides comprehensive primary care. The PCMH is a healthcare setting that focuses on team-based care for the whole person via continuous healing relationships and proactive care management/coordination. The characteristics of the PCMH were developed jointly in 2007 during collaborative meetings among the four major primary care associations (American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and American Osteopathic Association (AOA), representing approximately 333,000 physicians). The core characteristics of the PCMH as described by the *Joint Principles of the Patient-Centered Medical Home* include (AAFP, 2007; See Appendix A):

- Ongoing relationships with a team of providers

- Care Coordination and Integration
- Care Management
- Whole Person Care (including behavioral health)
- Focus on Quality, Safety, and Efficiency
- Enhanced Access to Services
- Health Information Technology

Since 2007, the PCMH concept has dominated discussions of healthcare reform and is widely recognized as the delivery system by which improved healthcare quality and cost-savings will be realized. The PPACA heavily incorporates PCMHs, cementing it as the delivery model of the future. There are many PCMH demonstration projects already underway across the United States that provide optimistic results and, although it is outside the scope of this report to provide a comprehensive review of the literature on PCMH quality and effectiveness, highlights are provided below.

Care delivered in PCMHs is consistently associated with (PCPCC; The Commonwealth Fund, 2008):

- Better health outcomes
- Reduction in emergency room visits
- Fewer preventable hospital admissions for patients with chronic diseases
- Reduced mortality
- Improved patient compliance with recommended care
- Reduced or even eliminated racial and ethnic disparities in access and quality
- Increased patient satisfaction
- Increased provider and staff job satisfaction
- Lower costs of care

Traditional fee-for-service (FFS) payment systems are not the ideal method to reimburse for the team-based, coordinated, preventive primary care provided in PCMHs. The new payment paradigm is **value-based purchasing** whereby value is assessed by health outcomes and ability to control total healthcare costs. Many believe that FFS models are headed for gradual extinction in the healthcare system of the future. However, a blended payment model of FFS + case rates/capitation + pay-for-performance (P4P) will be used to pay for care provided in PCMHs for the time being. The timeline and extent to which delivery system redesign and payment reform are enacted will be heavily dependent on the state and local environment (See State of Oregon Healthcare Reform, Page 15).

The National Committee for Quality Assurance (NCQA) developed a certification process for primary care practices to distinguish themselves as a Physician Practice Connections-Patient Centered Medical Home (PCC-PCMH) using three levels of tiered recognition. Recognition as a PPC-PCMH positions practices for increased reimbursement, pay rewards, and entry into high-performing provider networks. However, the standards are widely criticized for not incorporating enough behavioral health measures and concentrating too heavily on information technology at the expense of whole person care and patient experience. Recently, members of the Patient-Centered Primary Care Collaborative Behavioral Health Task Force submitted recommendations for the next version of the standards, with many specific recommendations for incorporating more behavioral health into the PCMH standards. The NCQA is now in the process of revising the standards, including cataloguing all suggestions and gathering input from stakeholders. The new standards are expected to be released in early 2011.

Person-Centered Healthcare Homes - The National Council for Community Behavioral Healthcare (NCCBH) released a report in April 2009 titled *Behavioral Health/Primary Care Integration and the Person-Centered Healthcare Home*, which calls for the bidirectional integration of behavioral health and primary care services (NCCBH, 2009). This includes continued development of behavioral health in primary care settings, as well as beginning to establish primary care capacity in CMHCs to address the 25-year mortality disparity for people with serious mental illness. The report advocates for use of the term "Person-Centered Healthcare Home" (PCHH) instead of "Patient Centered Medical Home" to indicate that behavioral health is a central component of healthcare. It also builds on *The National Wellness Action Plan for People with Mental Illnesses*, which pledges to promote wellness for people with mental illnesses by taking action to prevent and reduce early mortality by ten years over the next ten year time period (The Pledge for Wellness, 2007). The NCCBH report and national experts contend that CMHCs need to take immediate action to implement one of the three following options (NCCBH, 2009; NCCBH, 2010; Jarvis, 2009):

1) Establish a fully integrated Person-Centered Healthcare Home
   A single organization provides full-scope primary care and specialty behavioral health services, and 24/7 accountability for a broad community population, as well as people with serious mental illness. The Cherokee System serves as a national model (See page 18). The fully integrated PCHH would include:
   - Preventive screening/health services
   - Acute primary care
   - Women and children's health
   - Behavioral health
   - Management of chronic health conditions
   - End of life care

   These services are supported by enabling services, electronic health records, registries, access to lab, x-ray, medical/surgical specialties, and hospital care.

2) Establish a focused partnership Person-Centered Healthcare Home
   A CMHC partners with a PCMH primary care clinic to create PCHHs for people with serious mental illness. Explicit role clarification and processes are in place to achieve clinical integration across organizations. The National Council recommends six research-based components that should be included in a focused partnership model:
   1) Medical nurse practitioners or primary care physicians located in CMHCs*
   2) If a medical nurse practitioner is located at a CMHC, there should be a primary care supervising physician*
   3) Embedded nurse care manager in CMHCs
   4) Regular screening and registry tracking/outcome measurement for all individuals at the time of psychiatric visits
   5) Evidence-based practices from the U.S. Preventive Services Task Force (USPSTF) to improve health status of all people with chronic health conditions
   6) Wellness programs

   *The National Council does not recommend that CMHCs hire a medical nurse practitioner directly, without the backup of a skilled primary care physician and a full scope primary care practice.

3) Establish linkages to multiple primary care Patient-Centered Medical Homes
   CMHCs that do not envision providing comprehensive primary care services or a focused partnership PCHH are still responsible for providing a minimum set of services onsite:
   - Identify the current PCP for each client, and when none exists, assist the individual in establishing a relationship with a PCP and accessing care

- Regular screening and tracking at the time of psychiatric visits for all clients receiving psychotropic medications - check glucose and lipid levels, as well as blood pressure, and weight/Body Mass Index (BMI). Record and track changes and response to treatment and use the information to adjust treatment accordingly. Monitoring should be the standard of practice, as recommended by the 2004 Consensus Guidelines (The American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists, and the North American Association for the Study of Obesity, 2004)
- Establish specific methods for communication and treatment coordination with PCPs and ensure that timely information is shared in both directions
- Provide education and link individuals to self-management assistance and support groups

Federally Qualified Behavioral Health Centers – The National Council for Community Behavioral Healthcare (NCCBH) lobbied to include in PPACA a provision that would create a new federal definition for CMHCs called Federally Qualified Behavioral Health Centers (FQBHC). This would parallel the designation of Federally Qualified Health Center (FQHC) primary care clinics and include beneficial financing mechanisms for serving the safety-net population. Unfortunately, this provision was not included in the final law, but the NCCBH will continue to aggressively pursue FQBHC status for CMHCs.

> "The ability to achieve FQBHC designation and the accompanying financial benefits are necessary components for Community Behavioral Healthcare Organizations to be able to adapt to the changes that will occur in the general healthcare system" (Jarvis, 2009).

Given the sweeping changes ahead in the healthcare system enacted by PPACA, and the lack of a FQBHC designation included in the final law, NCCBH policy analysts assert that CMHCs will need to meet a set core competencies in order to continue being an important part of the healthcare delivery system (NCCBH, 2010):

- A full array of specialty behavioral health services
- A well defined assessment process and Level of Care System
- A solid approach to prevention, early intervention, and recovery
- The ability to practice as a team to coordinate care
- Demonstrated use of clinical guidelines
- Measurement systems and tools that measure consumer improvement
- A robust EHR that includes patient registries
- Quality improvement processes and supporting data systems
- Financial systems to manage case rate payments
- Ability to market services in response to increased competition

2. State of Oregon Healthcare Reform

The State of Oregon could be considered a high-change system, ahead of the curve in enacting many healthcare reforms that will compliment and accelerate the PPACA changes in Oregon. The state has already begun work to "bend the cost curve" and recognizes behavioral health as central to overall health and wellbeing.

State of Oregon Department of Human Services Health Services Integration Initiative

Within the Department of Human Services (DHS), the Core Integration Team is working to "systematically organize services in such a way that full integration of mental health, addictions, oral and physical health care is achieved during the next two biennia" (Oregon DHS, 2009). The purpose of the Core Integration Team is to

engage a broad audience to provide input and to review and prioritize key areas that present barriers to integration, as well as providing technical assistance and make recommendations for system changes. DHS also funded three pilot projects in Oregon focused on integrating services for people with serious mental illness.

It is important to note that the DHS state integration initiative plans to incorporate oral healthcare into service integration. MHASD acknowledges the importance of this aspect of overall healthcare, but we do not include plans to integrate oral health services in this strategic plan. Given the prominent mortality gap for people with serious mental illness, priority is placed on tackling the barriers to primary medical care, with the intention to plan for oral health services in the future.

Oregon Health Authority

In June 2009 the State of Oregon passed HB 2009, creating a new Oregon Health Policy Board and establishing the Oregon Health Authority (OHA), charged with streamlining state health services and carrying out a variety of initiatives to contain costs, improve healthcare quality, and improve the health of Oregonians. By July 2011, most DHS and health-related programs in the state will be joined together to form the OHA. The OHA will be overseen by a nine-member, citizen-led board called the Oregon Health Policy Board. Programs that will be consolidated into the OHA include:

- Addiction Services
- Mental Health Services
- Division of Medical Assistance Programs (DMAP)
- Family Health Insurance Assistance Program (FHIAP)
- Oregon Educators Benefit Board (OEBB)
- Public Health Division (PHD)
- Office for Oregon Health Policy and Research (OHPR)
- Oregon Medical Insurance Pool (OMIP)
- Oregon Prescription Drug Program (OPDP)
- Oregon Private Health Partnerships (OPHP)
- Oregon Public Employees Benefit Board (PEBB)

A variety of committees and commissions were established to begin work on the assorted areas identified in the law. Their recommendations and decisions will affect healthcare in Oregon significantly. This report is written in the context of this transition; below is a brief overview of some areas that will affect the long-term plans presented in this report.

The Health Information Technology Oversight Council (HITOC) will oversee public and private statewide efforts in electronic health records (EHR) adoption and develop a statewide system for health information exchange. Oregon will receive more than $21 million in grants over the next four years to help health systems adopt EHRs and develop a system of statewide health information exchange between hospitals, doctors' offices, pharmacies, and other healthcare providers. Oregon Health & Science University (OHSU) and OCHIN will serve as Oregon's Regional Extension Center (REC) to provide technical assistance statewide around EHR implementation and meaningful use.

The Patient-Centered Primary Care Home (PCPCH) Program goals are to develop strategies to identify and measure PCPCHs (a.k.a. PCMHs), promote their development, and encourage populations covered by the OHA to receive care in this new model. The PCPCH Standards Advisory Committee released their final report in February 2010 that includes a 3-tired approach to identify PCPCHs. All indications point to the potential for CMHCs to provide primary care services and be recognized as PCPCHs.

HB 3418 requires the OHA to study the feasibility of alternative payment models for PCPCHs within the Medicaid program and establishes a framework for favorable reimbursement changes for team-based, patient-centered, coordinated primary care services. The Department of Human Services (DHS) is expected to report to the Legislative Assembly by June 30, 2010 on the feasibility of a new payment system for recognized PCPCHs.

3. Summary

In order to address the mortality gap for people with serious mental illness and meet the demands of the emerging healthcare system, it will be imperative for CMHCs to provide some level of integrated primary care services onsite and be able to effectively coordinate care with their patients' primary care providers. Additionally, CMHCs will need to meet a set core competencies in order to continue being an important part of the changing healthcare delivery system.

This report is produced in the context of significant and historical healthcare system transformation at both the state and federal level. Although we cannot predict exactly how the various changes will ultimately affect the behavioral health system, we hope this report provides an indication of the trajectory, and positions Multnomah County to navigate these changes to best meet the needs of our citizens.

C. Selected National Models of Integrated Care

1. Fully Integrated Person-Centered Healthcare Home

Cherokee Health Systems – Tennessee (NCCBH, 2009; Freeman, 2007)

Cherokee Health Systems provides both full scope primary care and specialty behavioral health services; it is widely believed to be the ideal model of a fully integrated PCHH. Integrated and collaborative care processes are built into Cherokee's program and core mission. Cherokee is integrated structurally and financially, which supports the focus on clinical integration.

A behavioral health consultant (BHC) is an embedded, full-time member of the primary care team. A psychiatrist is available for consultation and medication management, generally by telephone. The BHC provides consultation to PCPs and delivers brief, targeted interventions to patients to address psychosocial concerns, behavioral and lifestyle aspects of physical conditions, and substance use issues in the primary care setting.

For patients requiring specialty behavioral health services, there is a PCP embedded in the specialty behavioral health team. PCPs are committed to team-based care, a holistic approach, and are comfortable with and knowledgeable about behavioral health issues. The community is aware that people are treated for all types of problems at Cherokee, reducing the stigma of seeking behavioral health treatment.

Impact of BHC on Subsequent Service Utilization**:**

- 28% decrease in medical utilization for Medicaid patients
- 20% decrease in medical utilization for commercially--insured patients
- 27% decrease in psychiatry visits
- 34% decrease in psychotherapy sessions
- 48% decrease in mobile crisis team encounters

2. Primary Care Capacity in Specialty Behavioral Health Settings

Navos/NeighborCare Partnership – Seattle, WA

MHASD conducted a site visit to the Navos/NeighborCare program in Seattle, WA in February, 2010. Navos is a behavioral health organization and NeighborCare is an FQHC primary care organization. The two entities established a partnership to provide bidirectional integration of behavioral health and primary care services. BHCs from Navos provide behavioral health interventions in NeighborCare's primary care clinics and a Family Medicine physician provides primary care for patients with serious mental illness at one of Navos' CMHCs. The goal for the site visit was to identify critical components of their partnership model that facilitate primary care for people with serious mental illness. Below is a summary of identified critical components that make the partnership work**:**

Passion - The primary care doctor, psychiatrists, RNs, and administrators are extremely passionate about working with people with serious mental illness, and place a high priority on their physical health.

Common values/vision/goals - Both Navos and NeighborCare's constant focus is increasing access to primary care for their clients with serious mental illness. This provides the common bond for their relationship, and

guides everything they do. For example, there is limited contracting between the agencies. Arrangements are fairly informal and the trust between them is evident.

RN Care Manager - Perhaps the most critical element of their model is the RN care manager. She is very detailed and determined, and provides the "glue" between patients' behavioral and physical healthcare. She is often the person communicating between patients' psychiatrist and PCP.

Economies of Scale - The program operates on a small scale, which allows them to manually work around barriers to integrated care. They are currently trying to work out the details for how to expand the program and realize they will need to automate and streamline the care delivery in order to increase the number of people they serve.

Staff Involvement in Care - The care delivery model does not provide true team-based care, i.e. the PCP is not an embedded member of the behavioral health team. The RN care manager provides the connection between the behavioral health providers and the PCP, and pulls together all patient information. RNs on the Navos' Program of Assertive Community Treatment (PACT) team also play a central role, as they provide the client assessment to determine whether or not a person needs to see a PCP. However, we did not get the impression that they have a shared treatment plan, team meetings, or jointly-developed patient goals (for example).

Care coordination and communication – Enhanced care coordination is facilitated by the PCP's willingness to take calls anytime from the RNs at Navos, although the PCP remarked that calls during the night or other inconvenient times has not occurred often. The other critical aspect of care coordination and communication is the Navos RN care manager, who takes responsibility for making sure patient information is flowing between the behavioral health staff and the PCP.

Relationships and patience – Patients with serious mental illness may take longer to establish a relationship with and trust the PCP, and may not allow the PCP to examine or treat them until after a few appointments. Foot care services are an important element in this respect because it often serves as a draw for people with serious mental illness that need, seek out, and value that service. Once they are there, the PCP can start establishing a relationship with him/her, and eventually start treating other physical health problems.

Flexibility and adaptability – The program makes adjustments and changes to their model as they go along, learning from experience what works and what does not.

Financial Structure - The partnership is financially feasible for two main reasons: 1) All of Navos' clients are covered by Medicaid and have many health problems, which keeps the PCP busy and able to bill for many services, and 2) NeighborCare's status as an FQHC makes this a favorable payor mix. However, as they plan for expansion the financial feasibility is unclear, and must be worked out in order to expand.

Adherence to National Council for Community Behavioral Healthcare Recommendations – NeighborCare/Navos provide regular screening and registry tracking/outcome measurement using a secure web-based Care Management Tracking System (CMTS) developed by the University of Washington. This is the same system used for the IMPACT project (University of Washington) and the NCCBH integration demonstration sites. For patients on atypical antipsychotic medication, screenings are done consistent with the 2004 Consensus Guidelines (The American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists, and the North American Association for the Study of Obesity, 2004). Screenings are conducted initially by the psychiatric RN with ongoing screening done by the RN care manager. Lab results are routinely entered into the web-based CMTS, making it easy for different providers to access this information.

Information exchange and medical records - All patients are registered with and have their medical record in NeighborCare's EHR, NextGen. The patient tracking sheet is used to communicate important patient information between the behavioral and physical health providers. The RN care manager at Navos makes sure this information

is kept updated and that everyone is "in the know." However, this is labor intensive, as everything is done manually, and then eventually entered into patients' medical record by the PCP or MA. Navos is looking to implement an EHR in the near future, and would like one that has interoperability capability with NextGen (Navos cannot use NextGen because it does not provide what they need for their behavioral health inpatient services).

Logistics of primary care clinic at Navos:

- PCP has fully equipped exam room at Navos
- PCP and MA hold clinic at Navos one ½ day per week
- PCP sees 10 – 15 patients per session
- PCP and MA use remote access to NeighborCare's EHR
- PCP appointments scheduled through NeighborCare's clinic; walk-in appointments also accepted (this is called "open access" or "advanced access")
- Often patients' behavioral healthcare manager attends PCP appointments, which helps coordinate care between providers

Community Support Services – Akron, OH (NCCBH, 2010)

Community Support Services (CSS) serves adults with serious mental illness, as well as people who are homeless, involved in the criminal justice system, or have a co-occurring behavioral illness and substance abuse problems. They established an integrated primary care clinic at their CMHC a little over a year ago and also participate in the National Council's Collaborative Project on Integrated Healthcare, which is a longitudinal study of the effect of coordinated medical and psychiatric care on life expectancy.

Clinic staff includes a nurse practitioner and primary care physician contracted through a local physician's group, as well as rotating nurse practitioner students from the University of Akron. There is also a pharmacy on site, with staffing provided by a local pharmacy partnership. CSS's information technology staff developed an electronic record for primary care. The goal is to have a totally integrated electronic record that is shared among the primary care clinic, the pharmacy, and behavioral health providers at CSS.

Lessons learned include: 1) The importance of cooperation and collaboration between the medical and psychiatric communities - regular meetings were vital, 2) The importance of a project manager with knowledge and skills in both medical and psychiatric care, and with dedicated project management time so that other duties do not undermine the effort, and 3) Time must be allocated to "credential" medical providers in a distinct location, e.g. an outpatient behavioral health center.

Missouri's Multi Modal Approach to Integrating Primary and Behavioral Healthcare (NASMHPD, 2009)

Missouri implemented a statewide disease management and primary care/behavioral healthcare integration initiative that adds primary care nurses on site in CMHCs and utilizes data analytics to reduce fragmentation and gaps in medical care. The initiative is as much about bringing two systems of care together, as it is about integrating primary and behavioral healthcare. Designed for patients with serious mental illness and co-occurring physical illness, the program informs both behavioral health and medical caregivers of patients' potential health risks and presents patterns of service so that providers can proactively focus interventions.

A detailed integrated health profile based on claims data is delivered bimonthly to medical and behavioral health providers, case managers, nurse liaisons, CMHCs, and other key contacts. The report provides a comprehensive picture of the patient's treatment history including diagnoses, important health and pharmacy alerts, current

medications and adherence information, and a list of recent hospitalizations, emergency room visits, and outpatient services. Key caregivers and contact information is also provided.

Prescribing patterns that do not reflect best practice standards are highlighted and educational information is provided to prescribers. Patient adherence information is sent to key contacts through twice-weekly email reports on failure to refill critical medications. This allows for rapid intervention to minimize adherence-related relapse. Finally, the project offers outreach and care coordination through a health liaison and designated nurse care managers to ensure care coordination across providers, case managers, and CMHCs.

Early results are impressive: the number of patients who lacked a psychiatric treatment home decreased over the first year from 36% to 9%; psychiatric inpatient days decreased by an average of 50%, for an estimated savings of more than $6 million; more than 70% of patients had a primary care visit within a 12-month period, according to claims; sampled chart reviews indicate a higher percentage (three agency sample over 90%). Missouri is currently planning to expand the program to a population of children in state custody who live in residential care facilities.

Lessons Learned include: 1) The importance of dedicated project management resources, 2) The hard work of team building between the organizations and at the clinical level should not be ignored, 3) Major system transformation takes time and requires leadership, 4) CMHCs and FQHCs generally do not understand each other's funding sources and financing mechanisms, often leading to myths and misunderstandings that must be addressed, 5) Local conditions dictate nearly every aspect of the actual form, progress and success of implementation, 6) Primary care and behavioral health typically have very different cultures that must be recognized and addressed, 7) Given the relatively small number of staff involved at each site, turnover in clinical staff often results in "starting over," and 8) Changes in leadership at the state and local levels can threaten successful implementation.

3. Behavioral Health in Primary Care Settings

IMPACT Model (NCCBH, 2009; University of Washington)

The IMPACT Model is the premier model of evidence-based depression treatment of depression in primary care. IMPACT Team Care doubles the effectiveness of depression treatment (University of Washington, Department of Psychiatry & Behavioral Sciences). The five fundamental elements of IMPACT include:

1. Collaborative care is the cornerstone - the patient's PCP works with the care manager/BHC to develop and implement a treatment plan (medications and/or brief, evidence-based psychotherapy) and the care manager/BHC and PCP consult with the psychiatrist to change treatment plans if patients do not improve.
2. A care manager/ BHC is embedded in the primary care team. The BHC may be a nurse, social worker, or psychologist and may be supported by a MA or other paraprofessional.
3. A designated psychiatrist provides consultation to the care manager/BHC and PCP on the care of patients who do not respond to treatments as expected.
4. Outcome measurement and registry tracking performed by care managers, used to measure depressive or other symptoms at the start of patients' treatment and regularly thereafter, using a validated measurement tool (e.g., the PHQ-9).
5. Stepped care in which treatment is adjusted based on clinical outcomes and according to an evidence-based algorithm.

The IMPACT model is now being used and studied for all age groups and many other behavioral health conditions found in primary care.

Washtenaw, MI (Grazier, Hegedus, Carli, Neal, & Reynolds, 2003; NCCBH, 2010)

In 2000 the Washtenaw Community Health Organization was created as a public-private partnership to integrate all health services for low-income and vulnerable people in Washtenaw County. From this vision, a model emerged of partnerships with primary care providers, housing shelter programs, public housing communities, and others who share the common belief that access to holistic healthcare is central to their mission. The model began when a local community behavioral health provider and a safety net primary care clinic joined forces by embedding a full-time behavioral health professional and 4 hours per week of psychiatric consultation and treatment service time within the clinic. This staffing arrangement provides the primary care clinic an opportunity to improve its treatment of patients who need behavioral health interventions without fragmenting their care. In each of the five comprehensive sites, they serve people of all ages who have behavioral health issues with various degrees of severity. In this model, potential behavioral and physical health issues are recognized and treated in their early stages.

Lessons learned include: 1) The importance of commitment to the shared vision, collaboration, and guidance from leadership, 2) Commitment to continuous program improvement, 3) Perseverance - bringing different healthcare cultures together is a complex task and should not be underestimated, and 4) Collaboration requires compromise and willingness to learn from each other to develop innovative ways of providing service.

Community Care of North Carolina (McCarthy & Mueller, 2009; Lancaster & Hewson, 2007)

Community Care of North Carolina (CCNC) is a public–private partnership that provides key components of a medical home and care management for almost one million low-income enrollees in publically-funded state programs. CCNC is a community-based system of fourteen regional networks, which are nonprofit organizations consisting of a partnership between local providers including hospitals, primary care physicians, county health and social services departments, and other stakeholders. More than 1,300 primary care practices with approximately 3,500 physicians currently participate in CCNC networks statewide, representing about half of the primary care practices in the state. The state provides resources, information, and technical support. Physician fee for service (FFS) reimbursement is supplemented by a per-member per-month (PMPM) fee for case management. The regional networks also receive a PMPM fee to cover the cost of care management and network administration. Each site provides standardized model components and uses a web-based registry and tracking system to document outcome and performance measures.

The standardized behavioral health services available at all primary care sites includes screening, assessment, brief supportive counseling, therapy, case management, medication monitoring, and coordinated team care. An analysis of one county that participates in this program found the following decreases in healthcare costs (controlled):

- Overall Health Care Costs: reduction of $66 per user/patient per month
- Mental Health Care Costs: reduction of $295 per user/patient per month
- Inpatient Health Care Costs: reduction of $1455 per user/patient per month
- Cost of program = $340,000 or $17 per patient per month

Lessons learned from this program include: 1) Importance of having all community players at the table from the beginning, 2) Each site is unique and needs much support in determining how to set up integrated care, 3) Strong

positive communication between therapist and practice clinicians is critical, 4) Therapist must be willing to work in non-traditional setting with a fast paced, short term, crisis management, teaching style; 3) Must have strong physician and office manager advocate for change, and 3) Psychiatric consultation is important for physicians to feel they have back up when they need it.

4. Wellness Programs Focused on Physical Health in Specialty Behavioral Health Settings

In SHAPE Lifestyles Program - New Hampshire (AHRQ, 2009; Jue, 2009)

In SHAPE is an innovative health program of Monadnock Family Services, a CMHC, intended to expand the lifespan of people with serious mental illness by improving their physical health and quality of life. Participants spend time each week with personal mentors/trainers exercising, taking walks, in classes, or working on nutrition plans. Mentors/trainers help participants track their progress, set goals, and stay motivated. Participants gather every three months to celebrate their achievements, win prizes, and get acquainted to potentially develop peer exercise partnerships. All participants have an assigned primary care physician and regularly receive medical care. More information can be found here: AHRQ Innovations Exchange | Exercise and Nutrition Program Helps Individuals With Serious Mental Illness Develop Healthier Lifestyles, Improve Fitness and Mental Well-Being
Evaluation Results:

- Participants lost weight for the first time in years; some dramatic weight loss, others lost a few pounds
- Improvements in fat to muscle ratio
- Changed hip to waist ratio (girth/waistline)
- Weight gain stopped for many despite continued use of certain psychotropic medications that can lead to weight gain
- Lowered blood pressures: discontinuation of related medications
- Lowered cholesterol: discontinuation/reduction of Lipitor
- Reduced levels of some psychotropic medications, in consultation with psychiatrists, for some participants
- Participants consistently report higher energy, improved moods, more restful sleep
- Participants joining smoking cessation classes
- Some previously unemployed participants returned to part or full-time work; others reinitiated high school or college education
- Activity levels of participants have remained at higher levels than before enrolling in the project
- 80% of participants continued activities beyond their initial 6 months of participation

5. Summary

The integration of behavioral healthcare into primary care settings as part of the PCMH model is rapidly expanding, but it is unclear if the scope of behavioral health services available in primary care settings is adequate to meet the needs of people with serious mental illness. Furthermore, there are many barriers to primary care for people with serious mental illness, and research indicates that CMHCs may be the most important point of entry to the healthcare system. Given the prevalence of co-morbid physical and behavioral health conditions, the high cost of caring for this group of people, and the emerging changes in the healthcare system, the integration of primary care services and coordinated care for people with serious mental illness is critical.

Few national models exist of the fully integrated Person-Centered Healthcare Home, but there are lessons learned from many integration efforts nationwide that we can build upon. Section II of this report will assess the current continuum of integrated primary care and behavioral health services available in Multnomah County. Section III will use the information about "where we are" as a community to plan for integrated healthcare capacity in all settings that serve people with serious mental illness to ensure there is no "wrong door" for receiving patient-centered, whole-person healthcare.

Section I Bibliography

AAFP. (2007, Feb 21). *Joint Principles of the Patient-Centered Medical Home.* Retrieved March 4, 2010, from American Academy of Family Physicians: http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.dat/022107medicalhome.pdf

AHRQ. (2009, June 8). *AHRQ Healthcare Innovations Exchange.* Retrieved March 19, 2010, from AHRQ: http://www.innovations.ahrq.gov/content.aspx?id=2444

AMH. (2006, September). *Peer Delivered Services.* Retrieved June 3, 2010, from Oregon Department of Human Services, Addictions and Mental Health Division: http://www.oregon.gov/DHS/mentalhealth/consumers-families/peer-delivered-services.pdf

Center for Healthcare Strategies, Inc. (December 2008). *Case Study: Washington State Medicaid: An Evolution in Care Delivery.* Center for Healthcare Strategies, Inc.

Center for Healthcare Strategies, Inc. (2010, March). *Options for Integrating Care for Dual Eligible Beneficiaries.* Retrieved March 16, 2010, from Center for HealthCare Strategies, Inc.: http://www.chcs.org/usr_doc/Options_for_Integrating_Care_for_Duals.pdf

Center for Healthcare Strategies, Inc. (2009). *The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions.* Center for Healthcare Strategies, Inc.

Druss, B., & Rosenheck, R. (December 1998). Mental Disorders and Access to Medical Care in the United States. *Am J Psychiatry*, 155:1775-1777.

Druss, B., Marcus, S., Campbell, J., Cuffel, B., Harnett, J., Ingoglia, C., et al. (2008). Medical services for clients in community mental health centers: results from a national survey. *Psychiatric Services* , 917-920.

Freeman, D. S. (2007, March 15). *Taking the Road Less Traveled: Evolution of the Cherokee Health Systems Integrated Behavioral Health & Primary Care System.* Retrieved March 25, 2010, from The American College of Mental Health Administration: http://www.acmha.org/content/summit/2007/Freeman_031507.pdf

Graber, M., Bergus, G., Dawson, J., Wood, G., Levy, B., & Levin, I. (2000). Effect of a patient's psychiatric history on physicians' estimation of probably of disease. *Journal of General Internal Medicine*, 15(3)204-206.

Grazier, K. L., Hegedus, A. M., Carli, T., Neal, D., & Reynolds, K. (2003). Integration of Behavioral and Physical Health Care for a Medicaid Population Through a Public-Public Partnership. *Psychiatric Services* , 54:1508–1512.

Hogg Foundation for Mental Health. (2008). *Connecting Body and Mind: A Resource Guide to Integrated Healthcare in Texas and the United States.* Austin, TX: Hogg Foundation for Mental Health.

IHI. (n.d.). *The Triple Aim*. Retrieved March 30, 2010, from Institute for Healthcare Improvement: http://www.ihi.org/IHI/Programs/StrategicInitiatives/TripleAim.html

Institute of Medicine (IOM). (2006). *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series.* Washington, DC: The National Academies Press.

Jansma, C. (2010, February 5). *Get ready: ACOs are coming*. Retrieved March 12, 2010, from mlife.com: http://www.aafp.org/online/en/home/publications/news/news-now/practice-management/20100208pwc-top-10.html

Jarvis, D. A. (2009). *Healthcare Payment Reform and the Behavioral Health Safety Net: What's on the Horizon for the Community Behavioral Healthcare System?* Seattle, WA: MCPP Healthcare Consulting, Inc.

Jue, K. (2009, Summer). *NASMHPD Meeting Presentations Summer 2009.* Retrieved March 19, 2010, from NASMHPD: http://www.nasmhpd.org/general_files/meeting_presentations/Summer%202009%20Commish/KenJue_IN-SHAPE.pdf

Lancaster, M., & Hewson, D. L. (2007, February 27). *Center for Health Care Strategies Purchasing Institute.* Retrieved March 19, 2010, from Center for Health Care Strategies, Inc.: http://www.chcs.org/usr_doc/North_Carolina_-_MLancaster.pdf

Lester, H., Tritter, J., & Sorohan, H. (2005). Patients' and health professionals' views on primary care for people with serious mental illness: focus group study. *BMJ*, 330:1122.

Levinson, M. C., Druss, B., Dombrowski, E., & Rosenheck, R. (2003). Barriers to primary medical care among patients at a community mental health center. *Psychiatric Services*, 1158-1160.

Mauer, B. J. (2009, Winter). *A New "Home" for People with Serious Mental Illness.* Retrieved March 17, 2010, from The National Council for Community Behavioral Healthcare: http://www.thenationalcouncil.org/galleries/resources-services%20files/Medical%20Homes%20Article.pdf

McCarthy, D., & Mueller, K. (2009, June). *Community Care of North Carolina: Building Community Systems of Care Through State and Local Partnerships.* Retrieved March 19, 2010, from The Commonwealth Fund: http://www.commonwealthfund.org/~/media/Files/Publications/Case%20Study/2009/Jun/1219_McCarthy_CCNC_case_study_624_update.pdf

Mendelson, S. D. (2008). *Metabolic Syndrome and Psychiatric Illness.* Elsevier.

NASMHPD. National Association of State Mental Health Program Directors Medical Council. (2006). *Morbidity and Mortality in People with Mental Illness.* NASMHPD.

NASMHPD. National Association of State Mental Health Program Directors Medical Directors Council. (2005). *Integrating Behavioral Health and Primary Care Services: Opportunities and Challenges for State Mental Health Authorities.* Alexandria, VA: NASMHPD.

NASMHPD. National Association of State Mental Health Program Directors. (2009, Summer). *NASMHPD Summer Meeting Presentations*. Retrieved March 17, 2010, from http://www.nasmhpd.org: http://www.nasmhpd.org/general_files/meeting_presentations/Summer%202009%20Commish/JoeParks_Missouri.pdf

National Committee for Quality Assurance. (n.d.). *PPC - Patient-Centered Medical Home* . Retrieved March 10, 2010, from National Committee for Quality Assurance: http://www.ncqa.org/tabid/631/Default.aspx

NCCBH. National Council for Community Behavioral Healthcare. (n.d.). *Case Studies*. Retrieved March 17, 2010, from National Council for Community Behavioral Healthcare: http://www.nationalcouncillearningcommunities.org/CaseStudies/tabid/62/Default.aspx.

NCCBH. National Council for Community Behavioral Healthcare. (2010). *Communities: Stories From the Field Examples of Primary Care and Behavioral Health Integration*. Retrieved March 25, 2010, from National Council for Community Behavioral Healthcare: http://www.thenationalcouncil.org/cs/resources_services/resource_center_for_healthcare_collaboration/communities/stories_from_the_field

NCCBH. National Council for Community Behavioral Healthcare. (2010, March 30). *Webinars: Recordings and Presentations.* Retrieved March 30, 2010, from National Council for Community Behavioral Healthcare: http://www.thenationalcouncil.org/galleries/policy-file/NC%20Live%203-30-10%20HCR%20What%20Happens%20Next%20Presentation%20FINAL.pdf

NCCBH. National Council for Community Behavioral Healthcare. (2010, Februrary 23). *Press Releases: President Obama Backs National Council Position on New Federal Definition for Community Mental Health Providers*. Retrieved March 12, 2010, from National Council for Community Behavioral Healthcare: http://www.thenationalcouncil.org/cs/press_releases/president_obama_backs_national_council_position_on_new_federal_definition_for_community_mental_health_providers

NCCBH. National Council for Community Behavioral Healthcare. (2009). *Behavioral Health/Primary Care Integration and the Person-Centered Healthcare Home.* Washington, DC: National Council for Community Behavioral Healthcare.

NCCBH. National Council for Community Behavioral Healthcare (2010). *Substance Use Disorders and the Healthcare Home.* Washington, DC: National Council for Community Behavioral Healthcare.

Oregon DHS. (2009, April 14). *HSI Integration Policy Statement*. Retrieved March 24, 2010, from State of Oregon Department of Human Services: http://www.oregon.gov/DHS/hsi/policy-statement.shtml

PCPCC. (n.d.). *Evidence of Quality*. Retrieved March 4, 2010, from Patient Centered Primary Care Collaborative: http://www.pcpcc.net/content/evidence-quality

Puhl, R. M. (2010, May 27). Treating Obese Patients: The Importance of Improving Provider-Patient Interaction. *Medscape Public Health & Prevention*.

Samet, J., Friedmann, P., & Saitz, R. (2001). Benefits of linking primary medical care and substance abuse services: Patient, provider, and society perspectives. *Archives of Internal Medicine*, (1)85-91.

The American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists, and the North American Association for the Study of Obesity. (2004). *Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes.* Alexandria, VA: American Diabetes Association.

The Commonwealth Fund. (2008, July 23). *Testimony--Achieving Person-Centered Primary Care: The Patient-Centered Medical Home.* Retrieved March 12, 2010, from The Commonwealth Fund: http://www.commonwealthfund.org/Content/Publications/Testimonies/2008/Jul/Testimony--Achieving-Person-Centered-Primary-Care--The-Patient-Centered-Medical-Home.aspx

The Pledge for Wellness. (2007, September). Retrieved February 17, 2010, from Center for Psychiatric Rehabilitation: http://www.bu.edu/cpr/resources/wellness-summit/index.html

University of Washington, Department of Psychiatry & Behavioral Sciences. (n.d.). *IMPACT*. Retrieved March 19, 2010, from IMPACT: http://impact-uw.org

Healthcare Integration Report
SECTION II:
Description of Current Integrated Service Continuum in Multnomah County

A. Multnomah County FQHC Clinics Providing Integrated Healthcare Services

1. Introduction

A number of Federally Qualified Health Center (FQHC) clinics in Multnomah County currently provide primary care and behavioral health[3] services. Five of the six clinics we examine in this report are pilot programs for CareOregon's Primary Care Renewal (PCR) project, which began in spring 2007 and includes grant money to help clinics transition to a team-based care delivery model described below:

> "Patients are seen by high-functioning clinical care teams. Teams may differ from clinic to clinic, but usually consist of a PCP, a medical assistant, a case manager, a behavioral health practitioner, and sometimes a team assistant. The team approach allows more patients to be seen, and also allows patients to receive the care they need from the care team member who can most effectively deliver it." (CareOregon)

The PCR project has an explicit focus on integrated behavioral healthcare. Project goals are to screen for behavioral health problems as a routine part of patient care, with a behavioral health practitioner incorporated into the care team to offer solution-focused counseling and resources to patients.

Another project underway is the Qualis Safety Net Medical Home Initiative which is sponsored by The Commonwealth Fund and the MacColl Institute for Healthcare Innovation at the Group Health Research Institute. CareOregon and the Oregon Primary Care Association (OPCA) are the recipients of the grant, which began in April 2009, receiving $125,000 per year for four years. They house one of five regional coordinating centers focused on transforming primary care by helping safety net primary care clinics become high-performing Patient Centered Medical Homes (PCMH) and achieve benchmark levels of quality, efficiency, and patient experience. This project involves 13 primary care clinics in Oregon, including the PCR clinics, and will provide technical assistance, training, and centralized evaluation. Qualis Health, a quality improvement organization in Seattle, Washington, developed the evaluation measures for all sites.

Multnomah County FQHC Clinics Providing Integrated Healthcare Services	Pilot Program for CareOregon's Primary Care Renewal Project and Qualis Medical Home Initiative?
Multnomah County Health Department	Yes
OHSU – Richmond Clinic	Yes
Central City Concern – Old Town Clinic	Yes
Outside In	Yes
NARA Indian Health Clinic	No
Virginia Garcia*	Yes

*Virginia Garcia clinics are not located in Multnomah County, however, they are included in this report because they are an experienced community leader in providing integrated services.

[3] The term behavioral health is used throughout this report as a term that includes mental health, behavioral and lifestyle aspects of physical health conditions, and substance use/abuse.

Multnomah County MHASD assessed the existing continuum of integrated services at these six clinics by conducting standardized site visits from October – December 2009. We used a condensed and modified version of questions called the Medical Home IQ (MHIQ) developed by the primary care practice transformation organization TransforMED designed to self-assess components of the Patient-Centered Medical Home (PCMH) in primary care clinics (TransforMED). These areas emphasize the "must pass" elements of the National Committee for Quality Assurance (NCQA) Physician Practice Connections-Patient Centered Medical Home certification process (National Committee for Quality Assurance)**.** Additional information about the behavioral health delivery model, team-based care processes, and billing practices was also ascertained. We collected information using an interview format of self-assessment by clinic managers and/or health directors. The topic areas are summarized below:

MHASD Topic Areas to Assess the Continuum of Integrated Healthcare Services in Multnomah County

Area 1: Practice-Based Team Care and Delivery of Behavioral Health Services
Area 2: Patient-Centered Care
Area 3: Practice-Based Services
Area 4: Quality and Safety
Area 5: Health Information Technology
Area 6: Care Coordination
Area 7: Care Management
Area 8: Billing Practices

2. Results of Site Visits to FQHC Clinics in Multnomah County Providing Integrated Services

Area 1: Practice-Based Team Care and Delivery of Behavioral Health Services

Multnomah County Health Department – Westside Clinic

All six Multnomah County Health Department clinics provide integrated services; we focus on the Westside Clinic for this report because they serve a high number of patients with serious mental illness and have higher utilization of behavioral health services than the other clinics. The Multnomah County Health Department - Westside Clinic has provided high levels of integrated behavioral health and primary care for ten years, but began actively implementing many aspects of the PCMH, including team-based care, as part of the CareOregon's PCR project. There are three teams at this clinic, serving approximately 4,000 total patients per year. Teams are led by Primary Care Providers (PCPs), which includes Family Medicine and Internal Medicine Medical Doctors (MDs), and Nurse Practitioners (NPs). Patient panel sizes are approximately 800 patients for every 1.0 FTE of PCP. Each team has a Licensed Practical Nurse (LPN) Panel Manager that proactively manages the patient population through a series of registries, for example, calling patients who need preventive care or follow-up appointments. Each team's 1.0 FTE Community Health Nurse (CHN) provides patient care and education. The 1.0 FTE Care Manager on each team works with patients on entitlements and accessing available resources. Behavioral health services are provided by Psychiatric Nurse Practitioners (PNPs), who perform screening, make diagnoses, and provide medication management. Licensed Clinical Social Workers (LCSWs) provide individual therapy and case management. Teams meet on a weekly basis to discuss patient care and work processes. In the future, team meetings may include a patient representative.

The practice also has a "Sustainability Team" to conduct practice observations, and even surprise tests, aimed at improving clinic and office operations. This clinic has tried to arrange their physical space so that teams are stationed together, however, there are structural limitations and the clinic hopes to obtain funding to remodel to better accommodate their cross-functional teams.

Oregon Health and Science University (OHSU) – Richmond Clinic

This clinic is currently a FQHC Look-Alike, but expects to attain full FQHC status soon. There are four color-coded teams ("Pods") at this clinic, serving approximately 12,000 total patients per year. The site is also a teaching clinic for OHSU Family Medicine residents, who conduct their continuity clinics at this site and therefore supplement each team with additional, but variable, PCP FTE time. A Nurse Case Manager acts as the 'glue' on each team, responsible for outreach and managing the patient panel through the use of patient registries. 3.0 FTE of Medical Assistants (MAs) or LPNs function in identical roles supporting PCPs. An Eligibility Specialist works with all patients at the practice to connect them to entitlements and resources. The behavioral health staff and services are also shared among all teams. A recently added 0.1 FTE Psychiatrist provides consultation, and two LCSWs (1.5 FTE) help identify what types of additional behavioral health services are needed, as well as provide consultation to PCPs. If patients' problems are amenable to shorter-term therapy (3 - 6 visits) they can get therapy on-site through a relationship with George Fox University. Four PsyD practicum students (0.4 FTE each) provide individual counseling focused on solving problems and increasing access to other available services. These students are supervised by a licensed PsyD instructor (0.3 FTE at the clinic). Clinic staff focuses on "warm handoffs," helping patients transition to new providers via referrals and/or when a patient is identified as needing behavioral health services. Although PCPs have become more comfortable prescribing psychiatric medications, patients with more serious, chronic mental health needs are referred to community mental health centers that have expertise serving individuals with this level of need.

Teams meet together monthly to discuss patient care and clinical processes, and also form a variety of quality improvement (QI) teams to improve practice operations and care delivery. Teams each have their own color-coded physical space where all team members sit together and in close proximity to their team's exam rooms.

Central City Concern – Old Town Clinic (CCC-OTC)

The Central City Concern Old Town Clinic has ample experience providing high levels of primary care and behavioral health services, primarily to homeless adults, but they transitioned to providing team-based care about two years ago as part of CareOregon's PCR project. Three teams serve approximately 2,600 patients per year, 45% of whom are uninsured. Patient panel sizes differ at this site, depending on each team's PCP FTE. One team has approximately 2.0 FTE PCP and the other teams have 1.7 FTE PCP, which includes 0.3 FTE of Internal Medicine Resident MD time spread across the teams. MDs, Naturopathic Doctors (NDs), Physician's Assistants (PAs) and NPs, and are all considered PCPs. Each team has a Panel Manager, who functions as the leader or the "hub" of the team and proactively manages the patient panel. One Panel Manager is a Registered Nurse (RN), one is a LPN, and one is a MA. Each team has 2-3 MAs, a 1.0 Referral Coordinator, a 0.9 FTE Acupuncturist, a scheduler, a person from management, and a Medical Records person (they do not have an electronic health record). All three teams share a 1.0 FTE Pharmacist. Behavioral health services are delivered on each team by 0.9 FTE of mental health providers; two of whom are PNPs that perform mental health assessments, medication management, and individual therapy, and one is a LCSW who performs shorter-term behavioral health interventions, primarily for underlying medical conditions. The mental health providers are technically assigned to a particular team but provide services across teams as needed. A Psychiatrist provides consultation to the PNPs three hours a week. Teams meet twice a month to discuss clinic operations and office processes. This clinic has arranged their physical space to allow cross-functional teams to sit together.

Outside In

The FQHC practice at Outside In serves approximately 7,000 patients per year; of those 90% are uninsured. Their two priority populations are people under 30 years old and homeless people of any age. However, the majority of their patients are between 25 – 35 years old. They have two primary care teams and will expand to three in 2010. Each Primary Care Team has 1.5 FTE PCP (Family Medicine MD and/or ND) and an additional

1.0 FTE PCP of rotating MD residents from OHSU who comprise the Acute Care Team to cover same-day appointments for the clinic's open/advanced access feature. Each team also has a recently-added 1.0 FTE Nurse Care Manager (the panel manager, who works primarily with chronic disease patients), 2.5 FTE MAs, 2.0 FTE Access Coordinator (whose duties include helping clients with services, benefit and entitlement enrollment), and 2.0 FTE Referral Team, who manages patient referrals. PCPs are each paired with a MA. This two person team interfaces with the practice's supplemental services to provide wraparound care. These supplemental services include a full range of acupuncture services and Chinese herbal medicine delivered by a full time team dedicated for this purpose.

Behavioral health services (primarily interventions related to physical health conditions) are delivered by 2.5 FTE Licensed Clinical Social Workers (LCSW) and unlicensed Qualified Mental Health Professionals (QMHP) split between the teams as needed. In addition, patients are assigned to the Specialty Mental Health Team when they have chronic or more serious mental health needs. This team also provides consultation for the primary care teams and is comprised of 0.2 FTE Psychiatrist, 0.8 FTE PNP, 1.5 FTE Master of Social Work (MSW) Counselors, 1.0 FTE LCSW, and 0.8 FTE Pharmacist. To calculate Behavioral Staff FTE per team in Table 1.1, the Specialty Mental Health Team's FTE and the Behavioral Health Services' staff FTE were added together and divided by the two teams equally. The current physical space does not allow teams to sit together, but they received a Federal Stimulus grant, allowing them to begin remodeling in January 2010 to create cross-functional team offices and add exam rooms.

Native American Rehabilitation Association– Indian Health Clinic (NARA - IHC)

The NARA FQHC clinic attempted to implement multiple practice teams but faced a number of problems such as patient and provider dissatisfaction and so discontinued teams after one year. However, they intend to try again in the near future to implement team-based care. They currently operate as one large practice team, and provide high levels of both primary care and behavioral health services. This practice serves 3,600 patients per year, 20 – 25% of whom are non-Native American and 51% uninsured. This program receives Indian Health Service funding and has about 50 current grants to support the wide range of services they provide. The practice employs 3.4 FTE PCP (one Internal Medicine MD, one Family Medicine MD, and three NPs). There are 2.5 FTE RNs to support the PCPs, and additional 1.0 RN for diabetic case management, 0.75 FTE Dietician, and four MAs. An Acupuncturist provides individual and group acupuncture four hours per week and a Podiatrist provides services once per month at the clinic's diabetes group. The clinic also has a grant-funded breast and cervical outreach team that provides education and resources to increase women's breast and cervical cancer screenings. Behavioral health services provided at this clinic are delivered by 1.6 FTE Psychiatrists who perform psychiatric evaluations, individual therapy, medication management, and consultations, and 1.6 FTE Licensed QMHPs who provide case management and therapy. They also employ a grant-funded 1.0 FTE MSW Mental Health Project Coordinator, who manages depression screening and "warm handoffs" for patients identified as needing behavioral health services. NARA has additional mental health locations where patients may receive their mental health services from other psychologists or QMHPs, who will coordinate care with patients' PCPs. (FTE for these mental health providers are not included in Table 1.1 because these services are delivered at separate locations.) The practice providers and staff meet monthly to discuss clinical and office operations. NARA's physical space is currently quite limited and does not allow teams to be physically located together. They recently applied for a $12 million Federal Stimulus grant to purchase a new building, expand their operations, and implement cross-functional team space, but were not selected for funding.

Virginia Garcia – Hillsboro Clinic

Although Virginia Garcia clinics operate in Washington County, they are an experienced community leader in providing primary care and behavioral health services and as such have been included in this report. As a participant in CareOregon's PCR project, they began rolling out implementation of team-based care first at their

Cornelius clinic but have now implemented it all their clinics; the Hillsboro clinic is the focus of this report. There are five teams, serving approximately 10,000 patients per year. There is approximately 1.8 FTE PCP per team and includes MDs, NPs, PAs, and one Nurse Midwife. Each team has one RN and, for every PCP on the team, a MA. They also have a Primary Care Coordinator who helps PCPs prepare to see patients by prepping charts. This role may also evolve into providing some case management in the future. There is also one Team Assist who helps patients access resources such as signing up for Oregon Health Plan, makes reminder calls, follows up on referrals, and provides case management tracking for obstetrical patients. Behavioral health services delivered at this site are focused on situations where patient behaviors are affecting their physical health. Short-term behavioral health services are provided to patients through a contractual partnership with LifeWorks NW. Each team has a 0.20 FTE Psychologist Behavioral Health Provider (BHP) and a 0.20 FTE Mental Health Assistant. The assistant is an unlicensed Qualified Mental Health Associate (QMHA) who serves three purposes: 1) cultural/language translation and promotion, 2) medical assistant-style help for the BHP, and 3) skills training/case management. They have some patients with a moderate to severe mental illness they see for primary care services, but this is not where they typically receive their ongoing behavioral healthcare.

The teams meet monthly to discuss clinical and office operations and include front desk or medical records staff. Quality Improvement (QI) Clinical Care Workgroups and "Lean Teams" form to identify and quickly address needed care delivery and operations improvements. It is unclear to what extent the BHPs are interactive members of the healthcare team –there has been some LifeWorks NW provider turnover, making team cohesion difficult. The office space has been adapted so that each team physically sits together, but some of the space is not optimally functional and they would like to make additional structural changes to accommodate their teams.

Area 2: Patient-Centered Care

Providing true patient-centered care requires a paradigm shift at the organizational leadership level, care providers, and staff, the results of which are not easily measured. However, the use of patient advisory groups, written value statements, staff training, and patient satisfaction surveys are good indicators of how committed a practice is to the concept of patient-centered care. While the practices we visited have implemented most of these elements, the areas with the most room for improvement include shared decision making/involving the patient in his or her care and measuring how well patients manage their self care.

Area 3: Practice-Based Services

In order to provide comprehensive primary care, practices must offer a wide scope of services to patients such as routine screening and preventive care, and important services at the point of care for patients with chronic conditions. While most practices we visited provide the vast majority of these services, it is noteworthy that three of the six indicated they were not using risk assessment guidelines for metabolic monitoring for patients on psychiatric medications. No clinics have registries for patients with behavioral health needs or being prescribed antipsychotic medications. Another potential improvement is to use an electronic prescription tool to support decision-making and promote safety and efficiency at the point of care. Currently, only three of the six practices use an electronic prescription tool.

Area 4: Safety and Quality

All six practices we visited have implemented a variety of basic safety and quality elements including use of age-appropriate screening measures and evidence-based guidelines, tracking recommended clinical care outcomes and using case management services for patients with chronic diseases, use of patient satisfaction surveys, and measuring clinical performance. Variations among the practices are evident in the area of measuring clinical performance, where practices without an Electronic Health Record (EHR) or have one that does not mine data

easily, are at a disadvantage. Although all the practices are measuring some areas of clinical performance, those with EPIC EHR and are members of OCHIN (OHSU-Richmond, Multnomah County Health Department-Westside, and Virginia Garcia-Hillsboro) have the ability to measure performance at different levels (practice, team, provider), more frequently (e.g. monthly), and measure more areas.

Area 5: Health Information Technology

Four of the six clinics we visited have EHRs. Three use EPIC and are members of OCHIN which means that patients at those clinics have a single, shared medical record and the clinics can use some common reporting tools that measure clinical improvement and/or organizational performance to benchmark against each other. In terms of basic technological functions, it is notable that only one practice uses email with patients and two use email with other providers and hospitals. This is mostly due to privacy concerns, but in order to efficiently coordinate care with outside providers and communicate with patients, they will need to utilize email technology more effectively in the future.

Only two or fewer clinics employ more advanced technological functions such as clinical practice guidelines and decision support software, web-based information sharing with patients, and electronic prescription writing linked to patient-specific demographic and clinical information, leaving ample room for improvement in these areas. The following provides some site-specific information on health information technology and capacity.

Multnomah County Health Department – Westside Clinic
As an OCHIN member and EPIC EHR user, the clinic produces monthly reports at the team and individual provider level, with performance in each area compared to the practice as a whole and to practice goals. The clinic measures access variables such as percent same-day appointments and patient-PCP continuity. The clinic has identified important conditions to track as a measure of their performance. This data is reported on a "dashboard" and comes from a variety of registries including diabetes, HgA1Cs, hypertension, depression screening, and medication reconciliation.

OHSU -Richmond Clinic
This clinic uses EPIC EHR and is also an OCHIN member. They produce monthly reports at the practice, team, and provider level and have developed sophisticated indices for operations, productivity, and clinical performance. Performance is measured using a "dashboard" of clinically important conditions tracked using registries including HgA1Cs, hypertension, diabetes, and, in the near future, mammography. The practice also measures the performance of clinic operations such as the completion of medication and allergy reviews, patient-PCP continuity, and average cycle time.

CCC – Old Town Clinic
Although they do not have an EHR at this time, CCC uses data management systems to measure their clinic's annual performance in areas such as clinical processes/outcomes and service provision. They recently received a grant for program expansion and plan to implement an EHR, GE Centricity, within the next year.

Outside In
Outside In uses GE Centricity EHR but has encountered difficulties running reports and using the registry functions. They currently run practice reports annually and plan to increase their capacity within the coming year to ultimately produce monthly "dashboard" reports at the practice, team, and provider level.

NARA Indian Health Clinic

Although NARA does not have an EHR, they use a variety of data management systems including chronic disease management software, which allows them to run registries and measure practice performance annually in a few areas. They also use practice management, patient information, and billing software. The clinic is eager to implement an EHR, and it is likely that Indian Health Services (IHS) will decide to move forward with implementing their Resource and Patient Management System (RPMS) nationwide in the next couple of years.

Virginia Garcia – Hillsboro Clinic

Virginia Garcia is an OCHIN member and has EPIC EHR with similar registry capabilities as OHSU – Richmond and Multnomah County Health Department – Westside Clinic. They currently produce quarterly reports at the practice level, and are working to generate reports at the team and provider level. They have developed a sophisticated set of key measures in the areas of patient access, clinical quality and performance, and patient and employee experience. However, they do not currently collect this information for their BHPs and are working on developing those measures to incorporate into their EHR.

Area 6: Care Coordination

Care coordination is a critical element for the integration of healthcare services, particularly when patients receive their physical and behavioral health services at different locations. While all the clinics we visited provide some level of behavioral health services on-site, it is interesting to note that three of the six clinics did not feel they have collaborative relationships with BHPs outside of their practice and none of the clinics have a written protocol describing the schedule for communicating with case managers external to the practice. Only three of the six clinics have established a procedure for receiving communications regarding the recommendations and outcomes of care administered by collaborating providers outside of the practice. Only two clinics have a written protocol that identifies the timeframe for following up with patients after a hospital admission or emergency room visit, which could have been due to mental health problems. There are many barriers to effective patient care coordination and we hope the information included in this report will act as a starting point for addressing those barriers in our community.

Area 7: Care Management

The six clinics we visited have implemented a majority of the care management elements we describe in this report, such as using charting and population management tools. Areas for improvement are: 1) managing patients with chronic diseases and risk factors by routinely creating individualized plans of care and treatment goals with the patients, and then assessing progress towards goals, 2) following up with patients after an important appointment is missed, and 3) establishing registries for patients on psychiatric medications, including tracking mechanisms for Metabolic Syndrome screening and treatment.

Area 8: Current Billing Practices

In order to obtain a snapshot of how services are being paid for at integrated clinics, we collected limited billing information from the six clinics. OHSU - Richmond and Virginia Garcia do not have certificates to provide mental health services and are not billing a Mental Health Organization (MHO), although Virginia Garcia is currently in the process of obtaining the certificate. Virginia Garcia clinics bill CareOregon or Department of Medical Assistance Programs (DMAP) for the behavioral health services provided by LifeWorks NW BHPs. OHSU – Richmond is not being reimbursed for any of the behavioral health services they provide, although some CareOregon PCR grant money is supporting the cost. However, the grant ends in June 2010 and it is unclear how the clinic will sustain behavioral health services.

All of the information collected from site visits to the six FQHC clinics providing integrated healthcare services is located at the end of Section I of this report. See the chart below for details.

MHASD Topic Areas to Assess the Continuum of Integrated Healthcare Services in Multnomah County	Table and Page Number
Area 1: Practice-Based Team Care and Delivery of Behavioral Health Services at FQHC Clinics Providing Integrated Services in Multnomah County	Table 1, 1.1, and 1.2 Pages 44 - 46
Area 2: Patient-Centered Care at FQHC Clinics Providing Integrated Services in Multnomah County	Table 2, Page 47
Area 3: Practice-Based Services at FQHC Clinics Providing Integrated Services in Multnomah County	Table 3, Pages 48 - 49
Area 4: Quality and Safety at FQHC Clinics Providing Integrated Services in Multnomah County	Table 4, Page 50
Area 5: Health Information Technology at FQHC Clinics Providing Integrated Services in Multnomah County	Table 5, Pages 51 - 52
Area 6: Care Coordination at FQHC Clinics Providing Integrated Services in Multnomah County	Table 6, Pages 53 - 54
Area 7: Care Management at FQHC Clinics Providing Integrated Services in Multnomah County	Table 7, Pages 55 - 56
Area 8: Current Billing Practices at FQHC Clinics Providing Integrated Services in Multnomah County	Table 8, Page 57

B. Integrated Physical Health Services at Multnomah County Community Mental Health Centers

1. Site Visits to CMHCs Providing Integrated Primary Care Services

From November 2009 – February, 2010 MHASD staff visited three CMHCs providing some level of integrated primary care services on site to assess their delivery model and the range of services available.

Asian Health and Service Center (AHSC)

This program provides a range of services and events to the Asian community, serving approximately 3,000 people annually. Their mental health program provides services to approximately 150 – 160 Chinese and Korean-speaking people annually. Those speaking other Asian languages are referred to the OHSU Intercultural Psychiatric Program (IPP), located next door, with whom AHSC has a long-standing relationship and shared leadership (Medical Director). Forty-three percent of their mental health clients are uninsured, and 95% are non-English speaking.

There is a low mental health (MH) provider-to-client ratio (about 40 clients for every 1.0 FTE MH provider), which allows providers to offer very high levels of case management services. They have nine MH providers/case managers (QMHP, QMHA, and LCSWs) and two Psychiatrists for eight hours per week. The MH providers meet regularly to discuss care client care and operations. The services AHSC offers relevant to physical health include:

1) Ensuring their clients have a PCP: If they do not, the MH providers make appointments for their clients (mostly at OHSU - Richmond and Rosewood Family Medicine Clinic), arrange transportation and interpreting services, and often accompany them to their appointments. They work with clients before the PCP appointment to prepare their agenda and questions.
2) Facilitating access to physical health resources: Work with clients to access healthcare resources such as applying for OHP or helping clients understand their own private insurance issues.

3) Chinese Medicine Clinic: Every Monday afternoon, four interns and their professor (a Naturopathic Doctor) from National College of Naturopathic Medicine (NCNM) hold a half-day clinic at Asian Health Services. They see 12 -15 patients each week and use acupuncture and Chinese herbal medicine to treat a range of mental and physical health symptoms and illnesses.
4) A range of physical health-related projects and services, mostly grant-supported:
    - "Asian Wellness Connection" is a new project funded by United Way, in partnership with OHSU - Richmond and Rosewood Family Medicine clinics. The project focuses on people with chronic conditions and provides a higher level of communication/coordination between clients' MH clinicians and PCPs. MH clinicians will attend doctors' appointments with their clients and make sure that their clients are following through with PCP instructions. This often involves explaining instructions in understandable ways through health education, and addressing client concerns about treatments in a culturally sensitive format. This program will also have a pre and post-test survey to help evaluate the project's effectiveness.
    - Women's Health Program jointly-funded by Susan G. Komen Foundation, American Cancer Society, and Avon. This project provides outreach and education about breast and cervical health, as well as an array of case management services including connecting women with resources to pay for care (e.g. State Breast and Cervical Health Program), scheduling and attending appointments with women.
    - Colorectal research project with OHSU, funded by the National Cancer Institute. This project focuses on education about colorectal health and increasing men's screening rates.
    - A variety of health education and support groups including diabetes, nutrition, chronic pain, hypertension, cholesterol, and cancer.

It is interesting to note that MH clients utilize AHSC for a very wide variety of reasons because they are non-English speaking and rely heavily on the interpretive services they provide. This helps the MH providers/case managers stay informed of clients' lives, their physical health issues, and also increases involvement of family members, who typically communicate regularly with MH providers regarding clients' functioning and status**.**

OHSU Intercultural Psychiatric Program (OHSU IPP)

This innovative program provides culturally sensitive MH services for immigrant, refugee, and ethnic communities with an emphasis on individuals and families whose first language is not English. They serve approximately 1,300 clients from a wide variety of countries and deliver services in 16 different languages. The majority of clients are insured by OHP, some are privately insured and others are uninsured. This program has received grant money, mostly for the Torture Treatment Center, which allows them to serve uninsured patients.

Prior to 2008, OHSU IPP was located on the Marquam Hill OHSU campus very near the old OHSU Emma Jones Hall Family Medicine clinic. Then, as now, MH counselors at OHSU IPP routinely asked their clients if they have a primary care provider and connected with that provider if one existed. If not, counselors would schedule appointments at the OHSU Family Medicine clinic in nearby Emma Jones Hall. Counselors would then accompany their clients to all appointments and translate for them. Additionally, having the patient's MH counselor at the appointment served the function of providing coordinated care for mental and physical health. Gradually, Dr. Meg Hayes (Family Medicine Physician at OHSU) noticed that the Family Medicine doctors, herself included, had a very difficult time seeing OHSU IPP patients due to language and cultural barriers, particularly within a 15 minute office visit. In addition, the MH counselors that would accompany their clients to the appointments would often have to sit and wait for extended periods of time. Dr. Hayes felt motivated to help this population by developing better ways to meet their physical health needs. She developed a relationship between OHSU IPP and OHSU Family Medicine and began seeing IPP clients in an exam room at OHSU IPP. Dr. Hayes was at OHSU IPP two afternoons each month and saw approximately eight patients each of those afternoons.

Approximately two years ago OHSU Family Medicine moved the Emma Jones Hall clinic to the new South Waterfront building, and, due to financial considerations, OHSU IPP was forced to relocate off of OHSU's main campus. OHSU IPP's current location has made it more difficult to provide integrated care. Dr. Hayes must travel to the site for clinic twice a month and patients no longer have direct access to services such as blood draws that were readily available on the hospital campus. However, the investment OHSU IPP made in putting in the exam room and Dr. Hayes' sheer resourcefulness have continued to make integrated care possible.

Dr. Hayes sees patients at OHSU IPP mostly for chronic disease management such as hypertension and diabetes. Appointments are scheduled for 30 minutes, instead of the usual 15 minutes, to allow extra time for translation and negotiation of cultural issues that arise. She has also conducted a few educational groups on site for chronic diseases. Dr. Hayes practices acupuncture and also provides those services on-site if needed. The exam room contains an exam table, small refrigerator, sink, and supply cabinet. Primary care services provided by Dr. Hayes are billed through OHSU Family Medicine, while mental health services are billed to Verity if the patient is enrolled in the county's MHO.

Dr. Hayes collects on-site urine samples and performs pap smears and sends labs off for processing - she will sometimes even hand-deliver them to labs. Patients who need blood drawn and lab work for their physical health are sent to an OHSU facility, which is now more difficult for patients since it requires travel to a different location. The psychiatrists order and review labs related to psychiatric medications the majority of the time, although it appears this is an area that could benefit from some role clarification. Lab and test results are communicated electronically back to Dr. Hayes through the OHSU EPIC EHR system. However, OHSU IPP is not on EPIC yet, so patients' mental health records are kept separately. Psychiatrists and MH counselors at OHSU IPP communicate directly with Dr. Hayes via OHSU's secure email system, and she enters any relevant MH information into patients' health records in EPIC.

This program practices several elements of team-based care. Clients have two MH providers: a Psychiatrist and a counselor, and spend a substantial amount of time with each. In addition, because their counselor attends physical health appointments with them, care is regularly coordinated. OHSU IPP also holds monthly provider meetings to discuss clients, and although Dr. Hayes' schedule doesn't allow her to attend, she maintains regular communication with patients' Psychiatrists and MH counselors, facilitated by the fact that they are all within the OHSU system and able to communicate easily via secure email.

Primary Care at 12th (PCAT) Project at Central City Concern 12th Avenue Recovery Center

Central City Concern's 12th Avenue Recovery Center is a CMHC located in downtown Portland serving a high proportion of clients with serious mental illness. Over the years, MH case workers have attempted to connect their clients with primary care, even at the nearby CCC-Old Town Clinic (OTC), but found most of their efforts ineffective. Watching the physical health of their clients decline, they began plans to establish primary care capacity on-site. They installed two fully equipped exam rooms complete with computers and began to stock a supply room largely relying on resources at their FQHC OTC. A Physician Assistant (PA) PCP and a MA from OTC were selected for the PCAT clinic. Rather than a RN or LPN Panel Manager, they decided to transition a MSW case worker at the 12th Avenue site into this role. They felt this was beneficial because she had worked in medical clinics and hospitals previously and had already established relationships with many clients at 12th Avenue. PCAT opened on November 30, 2009 with three half-day clinics per week. Since then, the PA has seen approximately 60 unique patients for 165 visits. On a typical half-day session the PA sees four patients, with appointments lasting up to 40 minutes each. Their goal is to see five patients per half-day session, but they have many no-shows, and attempt to supplement time slots with walk-in appointments. They anticipate a rolling enrollment over time at the PCAT clinic as more people hear about the services available and begin to establish trust with the PCP.

The MH case workers and psychiatric RNs help identify patients in need of primary care services and the Panel Manager keeps a list with an additional 50 people they hope will establish a medical home with the PCP on-site. Many patients have multiple co-morbid conditions, including chronic diseases, as well as skin rashes and foot problems. The PCP and Panel Manager effectively coordinate care through frequent communication with the Psychiatrists, RNs, and case workers and by participating in team meetings. They would like to transition all healthcare to the PCP including blood draws for metabolic monitoring and psychiatric medications. The clinic has a phlebotomy room complete with fridge and the MA performs blood draws. CCC does not have an EHR yet so patient information is paper-based, which is cumbersome, and information is not always comprehensive and easily accessible to various staff.
CCC received an $8.9 million American Recovery and Reinvestment Act (ARRA) grant at the end of November 2009, which will allow them to expand their medical home clinical operations significantly and adopt an EHR (GE Centricity). They purchased land adjacent to the OTC where they will construct a new building. The 12th Avenue Recovery Center will relocate to that building in the next few years. AARA and CareOregon PCR funds have supplemented the start-up costs of the PCAT project, but CCC plans to sustain the project through FQHC billing.

2. Performance Improvement Collaborative Projects for Integrated Services at CMHCs

Mental Health Collaborative Project: Kaiser Permanente and Verity Integrated Behavioral Healthcare

The State of Oregon Department of Medical Assistance Programs (DMAP) charged all MHOs, Fully Capitated Health Plans (FCHPs), and Physician Care Organizations (PCOs) that provide services to Medicaid enrollees to develop a collaborative performance improvement project (PIP) that would improve the coordination and continuity of care between behavioral health and primary care for Medicaid enrollees.

Kaiser and Verity partnered to develop a PIP to improve the continuity and coordination of care for their mutual enrollees. Many members did not have any documented communication in their record between providers, therefore, current medication lists, diagnoses, and labs were not available or confirmed for accuracy across settings. To address this issue, Kaiser developed a communication form designed for behavioral health providers to complete and fax to Kaiser's Exceptional Needs Care Nurse (ENCN) to initiate communication. The form lists current medications prescribed by MH providers and any labs and diagnostic information. The ENCN reconciles the information with the patient's physical health medical record. Any discrepancies are noted and communicated to the PCP for review and inclusion in the medical record. The ENCN then adds any additional medications, diagnoses, or labs in the medical record pertinent for behavioral health providers to the communication form, and faxes back to that provider. The goal is that both providers have comprehensive and accurate information about their patients in addition to behavioral and physical health providers' contact information. In addition, through routine exchange of information, patients will be better monitored for medication compliance and timely receipt of appropriate labs related to use of psychiatric medications.

The project has two measures: 1) The percent of Verity/Kaiser members that had a primary care encounter within 12 months pre-intervention, and 12 months post-intervention, and 2) Percent of Verity/Kaiser members with urgent care and/or emergency department visits within 12 months pre-intervention, and 12 months post intervention. This measure is also stratified by those who had at least one primary care encounter and those that had none.

Mental Health Collaborative Project: CareOregon, LifeWorks NW, and Verity Integrated Behavioral Healthcare

This PIP examines whether interventions to clients with serious mental illness provided by a nurse embedded in a CMHC increase client visits to PCPs, compliance with Verity lab protocols, and decrease emergency department visits. Project participants include CareOregon, Verity MHO, and LifeWorks NW – Gresham site. An RN with experience in

both medical and behavioral health is stationed at the CMHC to perform health screening, assist clients in establishing care with a PCP, and monitor lab requirements. The nurse also coordinates care between PCPs and behavioral health providers until patients are fully established with a PCP and major health concerns are addressed.

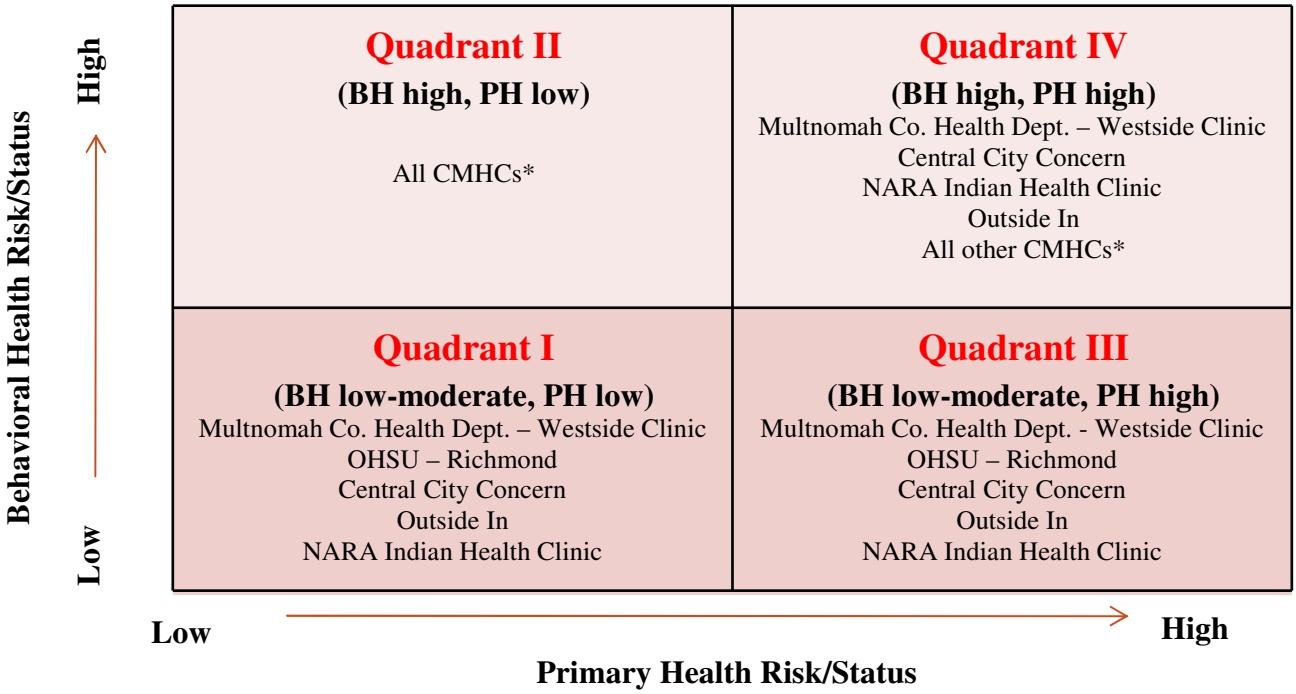
The project measures: 1) Number of PCP visits and subsequent emergency department use, and 2) Whether patients taking anti-psychotic medications have appropriate lab work completed that adheres to the Verity Atypical Anti-Psychotic Medication Lab Protocol.

C. The Four Quadrant Clinical Integration Model in Multnomah County

The National Council for Community Behavioral Health (NCCBH) developed the Four Quadrant Clinical Integration Model (4QM) as a planning tool for communities to use to address the needs of population subsets (NCCBH, 2009). Each quadrant considers the behavioral and physical health complexity of different populations. This section of the report attempts to describe the continuum of integrated primary care and behavioral health services currently available in Multnomah County. Based on our understanding of the services available and populations served at each site, local organizations have been placed in the quadrant(s) relevant to the populations they serve (Refer to Figure 1 below)**.** Understanding "where we are now" is critical for mapping out "where we want to go."

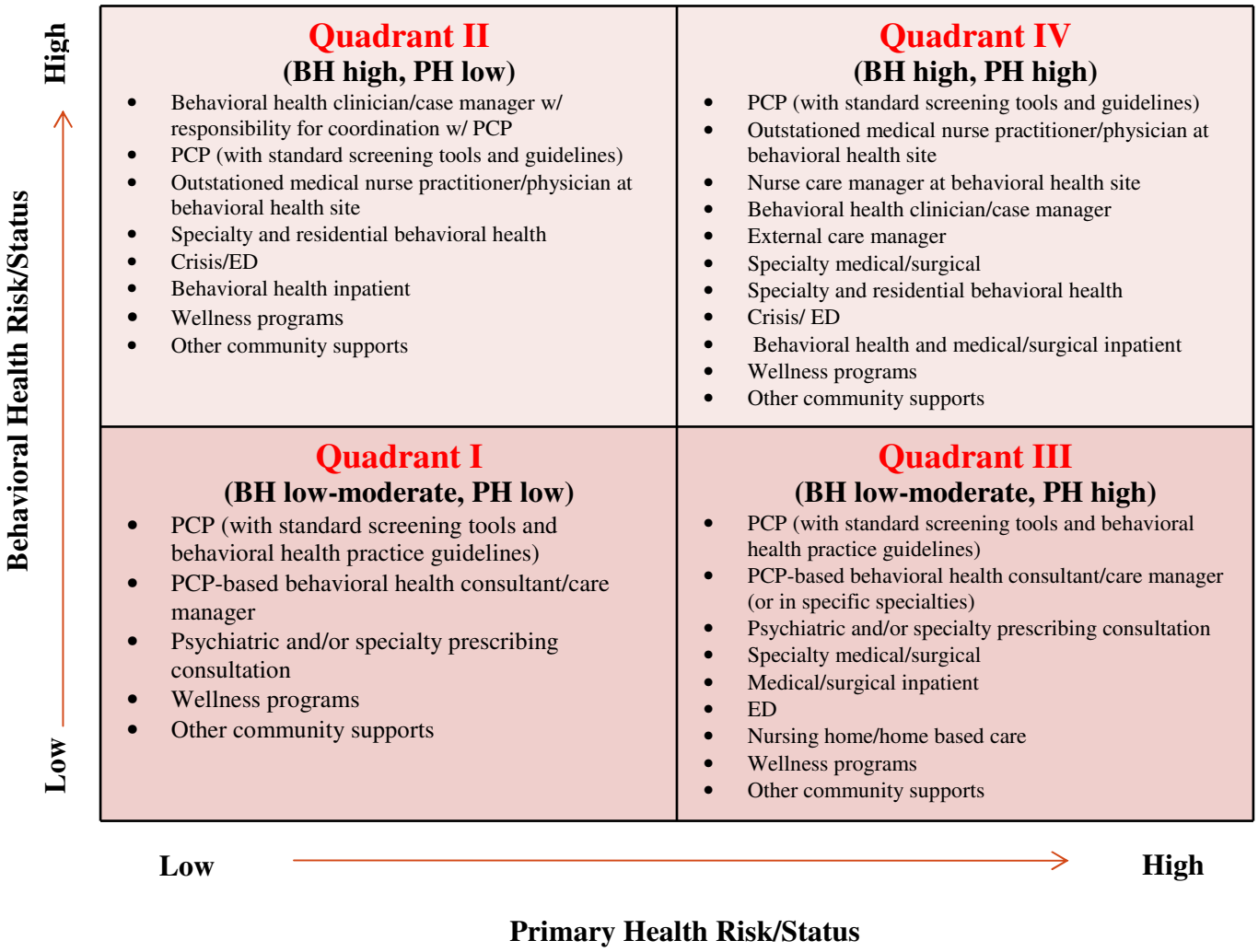
The National Council also uses the 4QM to describe the major elements – services, providers, and provider roles - that should be present at organizations serving populations within each quadrant (Refer to Figure 2**,** Page 41). Note that people with serious mental illness could be served in all settings; the recommendation is to plan to deliver services based upon the needs of the individual, personal choice and the specifics of the community and collaboration (NCCBH, 2009). The CMHCs and four of the six FQHC primary care clinics we visited in Multnomah County serve populations in Quadrants II and IV.

Figure 1: The Four Quadrant Model in Multnomah County: Where Are Population Subsets Receiving Care?



*Asian Health & Service Center, Cascadia Behavioral Health, Central City Concern, CODA, DePaul, VOA/Inact, LifeWorks NW, Luke-Dorf, Lutheran Community Service, NARA outpatient MH clinics, OHSU Intercultural Psychiatric Center, Outside In, Project Quest, Western Psychological

Figure 2: The Four Quadrant Integrated Service Model:
The National Council Recommended Elements



1. Integrated Options for CMHCs (NCCBH, 2009; Jarvis, 2009):

As discussed in Section I of this report, the NCCBH recommends that CMHCs implement one of three options in order to meet the needs of people with serious mental illness – establish a fully integrated PCHH, establish a focused partnership PCHH, or establish linkages to multiple PCMHs. Based on information gathered for this report, the following compares the fidelity of service delivery models in our community that serve Quadrants II and IV to the integrated healthcare model set forth by the NCCBH and expert consultants Barbara Mauer and Dale Jarvis.

3) Establish a fully integrated Person-Centered Healthcare Home

A single organization provides full-scope primary care and specialty behavioral health services, and 24/7 accountability for a broad community population, as well as people with serious mental illness. The Cherokee System serves as a national model. The fully integrated PCHH would include:

- Preventive screening/health services
- Acute primary care
- Women and children's health
- Behavioral health
- Management of chronic health conditions
- End of life care

These services are supported by enabling services, EHRs, registries, access to lab, x-ray, medical/surgical specialties, and hospital care.

In Multnomah County, the organizations that most closely resemble this model are: Multnomah County Health Department – Westside Clinic, Central City Concern – Old Town Clinic, Outside In, and NARA Indian Health Clinic. However, departures from the recommended elements include: None of the sites provide end of life care, Outside In and CCC-OTC do not serve children or provide obstetrical care. Multnomah County Health Department – Westside Clinic, NARA IHC, and CCC-OTC do not provide inpatient hospital care. Only Multnomah County Health Department – Westside provides access to imaging services. (Refer to Table 3, Pages 48 - 49)

4) Establish a focused partnership Person-Centered Healthcare Home

A CMHC partners with a primary care clinic to create PCHHs for people with serious mental illness. Explicit role clarification and processes are in place to achieve clinical integration across organizations. The National Council recommends six research-based components that should be included in a focused partnership model:

1) Medical nurse practitioners or primary care physicians located in CMHCs*
2) If a medical nurse practitioner is located at a CMHC, there should be a primary care supervising physician*
3) Embedded nurse care manager in CMHCs
4) Regular screening and registry tracking/outcome measurement at the time of psychiatric visits
5) Evidence-based practices to improve health status of all people with chronic health conditions
6) Wellness programs

*The National Council does not recommend that CMHCs hire a nurse practitioner directly, without the backup of a skilled primary care physician and a full scope primary care practice.

In Multnomah County, the organizations that most closely resemble this model are: OHSU – IPP and PCAT at CCC – 12th Avenue Recovery Center. Departures from the model include: OHSU – IPP does not have a nurse care manager, does not provide wellness programs, and does not provide regular screening and registry tracking/outcome measurement for all clients at the time of psychiatric visits. PCAT at CCC utilizes a Physician's Assistant (instead of NP or MD) for their PCP, and a MSW case worker (instead of nurse) as their panel manager. Regular screening and registry tracking/outcome measurement is not performed for all clients at the time of psychiatric visits.

3) Establish linkages to multiple primary care Patient-Centered Medical Homes

Behavioral health organizations that do not envision providing primary care services or a focused partnership PCHH are still responsible for providing a minimum set of services on site at CMHCs:

- Identify the current PCP for each client, and when none exists, assist the individual in establishing a relationship with a PCP and accessing care
- Regular screening and tracking at the time of psychiatric visits for all clients receiving psychotropic medications—check glucose and lipid levels, as well as blood pressure, and weight/Body Mass Index (BMI). Record and track changes and response to treatment and use the information to adjust treatment accordingly. Monitoring should be the standard of practice, as recommended by the 2004 Consensus Guidelines (The American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists, and the North American Association for the Study of Obesity, 2004)
- Establish specific methods for communication and treatment coordination with PCPs and ensure that timely information is shared in both directions
- Provide education and link individuals to self-management assistance and support groups

In Multnomah County, no CMHCs are providing the minimum set of recommended services and have established relationships with full-scope primary care PCMHs.

D. Summary and Implications for Integrated Healthcare in Multnomah County

From our site visits it is clear that our community is rapidly expanding the integration of behavioral healthcare into primary care safety-net settings. However, we found that the type of behavioral health services offered and how they are delivered varies widely among the clinics. Furthermore, it is unclear if the scope of behavioral health services available in these primary care settings is adequate to meet the needs of people with serious mental illness. Based on the information we collected from the six FQHC clinics that provide integrated services, the following are areas for improvement relevant to providing collaborative care and/or behavioral health in FQHC primary care settings:

- Only one clinic uses email with patients and two use email with other providers and hospitals
- Three of the six clinics do not feel they have collaborative relationships with behavioral health providers outside of their practice
- No clinics have a written protocol for communicating with case managers external to the practice
- Only three of the six clinics have established a procedure for receiving communications regarding the recommendations and outcomes of care administered by collaborating providers outside of the practice
- Only two of the six clinics have a written protocol that identifies the timeframe for following up with patients after a hospital admission or ER visit, which could have been because of mental health issues
- Only three of the six clinics have risk assessment clinical guidelines for metabolic monitoring of patients on psychiatric medications
- No clinics have a registry for patients with behavioral health needs or being prescribed psychiatric medications that increase risk of Metabolic Syndrome
- Behavioral health service delivery model and team composition are very different within and across clinics

Based on the site visits and information we collected about CMHCs in Multnomah County, we found that none are providing the NCCBH-recommended minimum physical health services.

The following strategic plan (Section III) will build on the 4QM for system planning, primarily focused on populations with high behavioral health needs, Quadrants II and IV, to ensure they have access to evidence-based, recommended system components and, ultimately, to Person-Centered Healthcare Homes at locations that best serve their needs and preferences.

Table 1: Practice-Based Team Care at FQHC Clinics Providing Integrated Services in Multnomah County

PRACTICE-BASED TEAM CARE QUESTIONS	Clinic					
	Mult. Co. Health Dept. – Westside	OHSU - Richmond	CCC – OTC	Outside In	NARA IHC	Virginia Garcia - Hillsboro
Q2. Every practice team is led by a physician	No	Yes	No	Yes	No	No
Q3. Providers follow consistent, evidence-based diagnosis and treatment guidelines for the practice's identified clinically important	Yes	Yes	Yes	Yes	Yes	Yes
Q4. Practice promotes the concept of cross training for staff positions where appropriate	Yes	Yes	Yes	Yes	Yes	Yes
Q5. Medical team meets at least monthly to discuss clinical practice functions	Yes	Yes	Yes	Yes	Yes	Yes
Q6. Office staff meet at least monthly to discuss office operations and functions	Yes	Yes	Yes	Yes	Yes	Yes
Q7. Clinical and office staff meet together at least monthly to discuss office operations and clinical processes.	Yes	Yes	Yes	No	Yes	Yes
Q8. Practice uses "team huddles" to plan the work of the business day	Yes	Yes	Yes	Yes	Yes	Yes
Q9. Practice staff members conduct periodic observations of practice work flow for the purpose of improving operations and care delivery	Yes	Yes	Yes	Yes	Yes	Yes
Q10. Appropriate scope of practice protocols have been created and agreed upon by the physician and NP or PA	Yes	Yes	Yes	No	Yes	Yes

Table 1.1: Team Composition and FTE at FQHC Clinics Providing Integrated Services in Multnomah County

TEAM COMPOSITION	Clinic					
	Mult. Co. Health Dept. - Westside	OHSU - Richmond	CCC - OTC	Outside In	NARA IHC	Virginia Garcia - Hillsboro
Total number of teams at clinic	3	4	3	2	1[4]	5
Approximate patient panel size per team	1,300	3,000	750[5]	3,500	4,400	1,800
Primary Care Staff FTE Per 1,000 Patients						
Primary Care Provider Total	1.15	1.0	2.66[6]	0.71[7]	0.84	1.0
Primary Care Provider – Medical Doctor	1.15	0.73[8]	0.8	0.57	0.27	0.61
Primary Care Provider – Naturopathic Doctor	0	0	0.13	0.14[9]	0	0
Primary Care Provider – Nurse Practitioner or Nurse Midwife	0	0.27 (NP or PA)	0.53	0	0.59	0.39
Primary Care Provider – Physician Assistant	0		1.2	0	0	0
Registered Nurse (CHN/Nurse Care Manager/Panel Manager)	0.77	0.33	1.33	0.29	0.91	0.56
Certified Medical Assistant (Referral or Access Coordinator/Panel Manger)	1.15	1.0 (MA or LPN)	2.67	0.71	0.71	0.56
LPN (Referral or Access Coordinator/Panel Manger)	0.77		0	0	0	0.56
Pharmacist (clinic total, not per team)	0	0.33	1.33	0.23	0.23	0.56
Behavioral Health Staff FTE Per 1,000 Patients						
Psychiatrist	0	0.01	1.33	0.03	3.64	0
Psychiatric Nurse Practitioner	0.54	0	0	0.11	0	0
PhD/PsyD Licensed Psychologist	0	0.025	0	0	0	0.11
PhD/PsyD Unlicensed Psychologist	0	0	0	0	0	0
LCSW/LMFT/LPC (Licensed QMHP)	0.62	0.01	1.2	0.14	0.36	0
Unlicensed QMHP	0	0	0	0.02	0	0
Unlicensed QMHA	0	0	0	0	0	0.11
Other behavioral health staff	0	0.13[10]	0	0	0.23	0

[4] NARA currently operates as one large practice team, but anticipates implementing additional teams in the future.
[5] CCC – Old Town Clinic has one large team and two smaller ones. Described here is the largest practice team.
[6] CCC – Old Town Clinic has 0.3 FTE additional PCP MD time composed of OHSU Internal Medicine Residents, which has been divided equally by the three teams.
[7] The Acute Care Team at Outside In, comprised of rotating OHSU Family Medicine MD residents, adds an additional 2.0 FTE of MD PCP to the practice. This FTE has been divided equally by the two teams.
[8] OHSU Richmond teams each have 2 Faculty MDs and 3 MD residents (1 PGY-1, 1 PGY-2, and 1 PGY-3) that conduct their continuity clinics at this site. This adds additional, but highly variable, PCP FTE to each team. Therefore, the 2.2 FTE of MD PCP includes resident time, but is an estimate.
[9] One team at Outside In has 2.0 FTE of PCP MDs and 0.5 FTE of ND and the other team has 2.5 PCP MDs.
[10] PsyD practicum students from George Fox University, supervised by a licensed PsyD instructor, provide all individual counseling at OHSU Richmond.

Table 1.2: Integrated Behavioral Health Services Relevant to People with Serious Mental Illness at FQHC Clinics in Multnomah County

INTEGRATED BEHAVIORAL HEALTH SERVICES RELEVANT TO PEOPLE WITH SERIOUS MENTAL ILLNESS	Clinic					
	Mult. Co. Health Dept. – Westside	OHSU - Richmond	CCC – OTC	Outside In	NARA IHC	Virginia Garcia - Hillsboro
Identification and Treatment of Mental Health Conditions in Primary Care	Yes	Yes	Yes	Yes	Yes	Yes
Treatment of Co-morbid Medical and Psychological Presentations in Primary Care	Yes	Limited	Yes	Yes	Yes	Limited
Medical Presentations Which Need Behavioral Treatment in Primary Care	Yes	Yes	Yes	Yes	Yes	Yes
Management in Primary Care for patients with serious mental illness	Limited	No	Limited	Yes	Yes	No
Consulting Psychiatrist	No	Limited	Yes	Yes	Yes	Limited
Prescribing/Med Management (Psychiatrist/Psychiatric NP)	Yes	Limited	Yes	Yes	Yes	Limited
Pharmacy On Site	Yes	Yes	Yes	Yes	Yes	Yes
Blood Draws On Site	Yes	Yes	Yes	Yes	Yes	Yes
Patient Education	Yes	Limited	Yes	Yes	Yes	Yes
Care Management/Coordination	Yes	Yes	Yes	Yes	Yes	Yes
Case Management for patients with Serious mental illness	Limited	No	Limited	Limited	Limited	No
Access & Referral Coordinator/Entitlements Eligibility Specialist	Yes	Yes	Yes	Yes	Yes	Yes
Individual Therapy	Limited	Limited	Yes	Yes	Yes	Limited
Group Therapy	No	No	No	No	No	Limited
Wellness Groups	No	No	No	Yes	Yes	No
Peer Supports	No	No	No	Yes	?	No
Alternative Treatment Options (e.g. Acupuncture)	No	No	Yes	Yes	Yes	Yes
Behavioral Health Staff Embedded in Team and Participate in Team Meetings	Yes	Yes	Yes	Yes	Yes	Yes

Yes = This service is available in a capacity suitable for the needs of patients with serious mental illness
No = This service is not available at clinic site
Limited = This service is available, but capacity is limited relevant to the needs of patients with serious mental illness

Table 2: Patient-Centered Care at FQHC Clinics Providing Integrated Services in Multnomah County

PATIENT-CENTERED CARE	Clinic					
	Mult. Co. Health Dept. – Westside	OHSU - Richmond	CCC – OTC	Outside In	NARA IHC	Virginia Garcia - Hillsboro
Q1. Practice has written value statements reflecting the practice's commitment to providing patient-centered care in their practice.	Yes	Yes	Yes	No	Yes	Yes
Q2. Practice has a statement informing patients of their rights and responsibilities in the healthcare partnership.	Yes	Yes	Yes	Yes	No	Yes
Q3. Staff training, which emphasizes sensitivity to patient diversity, is provided to staff members, at least annually.	Yes	Yes	Yes	Yes	Yes	Yes
Q4. Practice offers patient education materials in a clear and understandable format, written in the appropriate language, at the 5th or 6th grade level.	Yes	Yes	Yes	Yes	Yes	Yes
Q5. Providers in the practice routinely assess a patient's comprehension of the treatment goals by having the patient "teach back" the information given.	No	Yes	No	Yes	No	No
Q6. Practice has created a process for notification and follow-up on all patients discharged from the hospital.	Yes	Yes	Yes	No	No	Yes
Q7. Practice has a patient advisory group.	Yes	Yes	Yes	No	No	Yes
Q8. Practice measures how well patients are able to manage their self care (ex. taking medications or changing dressing on a wound.)	Yes	No	Yes	No	No	No
Q9. Providers in your practice involve patients in shared decision-making regarding treatment options by informing patients of the benefits and harms of the different choices and discussing patient preferences.	Yes	Yes	Yes	Yes	Yes	No
Q10. Practice providers encourage patients to engage in "agenda setting" by creating questions prior to their visit with the provider.	Yes	Yes	Yes	No	No	No
Q11. Practice providers refer patients to formal support programs to assist in self-management for medical conditions and age specific risk factors.	Yes	Yes	Yes	Yes	Yes	Yes
Q12. Practice has a formal patient feedback process in place to receive information regarding the patient's experience/satisfaction?	Yes	Yes	Yes	Yes	Yes	Yes
If yes, which one?	Care Oregon & in-house survey	Care Oregon & OHSU survey	Care Oregon & in-house survey	Care Oregon & in-house survey	Indian Health Services survey	Care Oregon & in-house survey

Table 3: Practice-Based Services at FQHC Clinics Providing Integrated Services in Multnomah County

PRACTICE-BASED SERVICES	Clinic					
	Mult. Co. Health Dept. - Westside	OHSU - Richmond	CCC – OTC	Outside In	NARA IHC	Virginia Garcia - Hillsboro
Q1.Which of the following services does the practice provide:						
Acute care services	Yes	Yes	Yes	Yes	Yes	Yes
Chronic care services	Yes	Yes	Yes	Yes	Yes	Yes
Prevention services	Yes	Yes	Yes	Yes	Yes	Yes
Invasive procedures (minor surgical procedures)	Yes	Yes	Yes	Yes	Yes	Yes
Non-invasive procedures (cast application)	Yes	Yes	Yes	Yes	No	Yes
Imaging services	Yes	Yes	No	No	No	No
Laboratory services	Yes	Yes	Yes	Yes	No	No
Counseling services for behavioral and mental health conditions	Yes	Yes	Yes	Yes	Yes	Yes
Obstetrical care	Yes	Yes	No	No	Yes	Yes
Inpatient care	No	Yes	No	Yes	No	No
Basic patient education	Yes	Yes	Yes	Yes	Yes	Yes
End of life care	No	Yes	No	No	No	Yes
Immunizations	Yes	Yes	Yes	Yes	Yes	Yes
Q2. The practice currently uses a reminder system (either paper or electronic) based on preventive clinical guidelines for age appropriate services for which of the following:						
Screening tests	Yes	Yes	Yes	Yes	Yes	Yes
Immunizations	Yes	Yes	No	Yes	Yes	Yes
Risk assessments	Yes	Yes	Yes	Yes	Yes	Yes
Health counseling	Yes	Yes	Yes	No	Yes	Yes

Table 3, Continued

PRACTICE-BASED SERVICES, Continued	Clinic					
	Mult. Co. Health Dept. - Westside	OHSU - Richmond	CCC – OTC	Outside In	NARA IHC	Virginia Garcia - Hillsboro
Q3. Most or all providers currently use age appropriate, risk assessment clinical guidelines for which services:						
Mammography	Yes	Yes	Yes	Yes	Yes	Yes
Colorectal cancer screening	Yes	Yes	Yes	No	Yes	Yes
Prostate cancer screening	No	Yes	Yes	No	Yes	No
Depression	Yes	Yes	Yes	Yes	Yes	Yes
Cardiovascular health	No	Yes	Yes	Yes	Yes	Yes
Obesity	No	Yes	Yes	No	Yes	Yes
Diabetes	Yes	Yes	Yes	Yes	Yes	Yes
Dementia	No	No	No	No	No	No
Falls in the elderly	No	No	No	No	No	No
Metabolic monitoring for patients on psychiatric medications	No	Yes	No	Yes	Yes	No
Q4. The practice performs health screening and preventive services with all patients seen on a regular basis.	Yes	Yes	Yes	Yes	Yes	Yes
Q5. The practice uses an electronic prescription tool to support decision-making and promote safety and efficiency at the point of care.	Yes	Yes	No	Yes	No	No
Q6. Written policies and protocols are established for clinical procedures performed in the practice.	Yes	Yes	Yes	Yes	Yes	Yes
Q7. Point of care services for individuals with chronic or recurrent conditions include which of the following:						
Reviewing patient self-monitoring activities and documenting the outcomes in the patient's medical record	Yes	Yes	Yes	Yes	Yes	Yes
Determining barriers when prescription medications have not been purchased or taken as prescribed	No	Yes	Yes	Yes	Yes	Yes
Medication reconciliation with patient at every visit	Yes	Yes	Yes	Yes	No	Yes
Reviewing the patient's historical clinical measurements to determine progress and outcomes	No	Yes	Yes	Yes	Yes	Yes
Creating a plan for following up with the patient after the visit	No	Yes	Yes	Yes	No	Yes

Table 4: Quality and Safety at FQHC Clinics Providing Integrated Services in Multnomah County

QUALITY AND SAFETY	Clinic					
	Mult. Co. Health Dept. - Westside	OHSU - Richmond	CCC – OTC	Outside In	NARA IHC	Virginia Garcia - Hillsboro
Q1. Which of the following age sensitive screening and assessment measures does the practice routinely conduct?						
Cognitive assessments for patients over the age of 75	No	No	No	Yes	No	No
Tobacco use for patients aged 12 and over	Yes	Yes	Yes	Yes	Yes	Yes
Alcohol use in patients aged 15 and over	Yes	Yes	Yes	Yes	Yes	Yes
Risk for falls in the elderly	No	No	No	Yes	No	Yes
Use of seat belts	Yes	Yes	No	No	Yes	Yes
Use of car seats for children	Yes	Yes	No	No	Yes	Yes
Use of bike helmets	Yes	Yes	No	No	No	Yes
Obesity	Yes	No	Yes	Yes	Yes	Yes
Violence and abuse	Yes	No	Yes	Yes	Yes	Yes
High risk sexual activity	Yes	Yes	Yes	Yes	Yes	Yes
Q2. The practice has adopted and uses three or more written evidence-based guidelines (EBG's) in the diagnosis and treatment of patients with the most prominent chronic, recurrent and/or at risk conditions within the practice population.	Yes	Yes	Yes	Yes	Yes	Yes
Q3. The practice has a method for tracking recommended clinical care measures and outcomes for patients with chronic diseases.	Yes	Yes	No	Yes	Yes	Yes
Q4. The practice uses care/case management processes in the management of patients with chronic diseases.	Yes	Yes	Yes	Yes	Yes	Yes
Q5. The practice conducts formal patient evaluation processes relating to their experience (satisfaction) with your practice in which of the following areas:						
Access to care - ability to schedule an appointment at the time they request	Yes	Yes	Yes	Yes	Yes	Yes
Quality of communication between the physician and the patient	Yes	Yes	Yes	Yes	Yes	Yes
Quality of communication between the practice staff and the patient	Yes	Yes	Yes	Yes	Yes	Yes
Confidence in materials and instruction for patient self care management	No	No	Yes	Yes	No	Yes
Overall satisfaction with the practice	Yes	Yes	Yes	Yes	Yes	Yes
Q6. The practice measures performance in which of the following areas:						
Clinical processes (ex: such as percent of women age>50 who have had mammograms)	Yes	Yes	Yes	Yes	Yes	Yes
Clinical outcomes (ex:HbA1c levels for diabetics)	Yes	Yes	Yes	Yes	Yes	Yes
Service provision (ex: wait and cycle time data)	Yes	Yes	Yes	Yes	No	Yes
Patient safety (ex: medication errors)	Yes	No	No	Yes	Yes	Yes

Table 5: Health Information Technology at FQHC Clinics Providing Integrated Services in Multnomah County

HEALTH INFORMATION TECHNOLOGY	Clinic					
	Mult. Co. Health Dept. – Westside	OHSU - Richmond	CCC – OTC	Outside In	NARA IHC	Virginia Garcia - Hillsboro
Q1. Which of the following basic functions does technology serve in your practice? (Implied in this question is the practice's ability to send and receive information as appropriate to each element.)						
Schedule appointments	Yes	Yes	Yes	Yes	Yes	Yes
Communication with care providers outside the practice (hospitals, emergency rooms, specialists, case managers, home health aides, etc.)	Yes	No	No	Yes	Yes	No
Financial data management	Yes	Yes	No	Yes	Yes	Yes
Electronic billing	Yes	Yes	Yes	Yes	Yes	Yes
Electronic lab/X-ray ordering and receipt of results	Yes	Yes	No	Yes	Yes	Yes
Clinical information (Electronic health record)	Yes	Yes	No	Yes	No	Yes
General clinical information retrieval from web sources (i.e., evidence-based guidelines)	Yes	Yes	No	Yes	Yes	Yes
E-mail with patients	No	Yes	No	No	No	No
E-mail with providers	No	Yes	No	No	Yes	No
E-mail with hospitals	No	Yes	No	No	Yes	No
Practice management	Yes	Yes	Yes	Yes	Yes	Yes
Track referrals	Yes	Yes	Yes	Yes	Yes	Yes
Q2. Which of the following advanced technological functions are currently in use in your practice?						
Clinical practice guidelines and decision support software	No	Yes	No	Yes	Yes	No
Population management and chronic disease management software	No	Yes	No	Yes	Yes	Yes
Web-based information sharing with patients (patient portal)	No	No	No	No	No	No
E-prescribing (electronic prescribing)	Yes	Yes	No	Yes	No	Yes
E-visits (electronic visits)	No	No	No	No	No	No
Electronic access to lab reports	Yes	Yes	Yes	Yes	Yes	Yes
Electronic access to imaging reports	Yes	No	No	Yes	No	Yes
Q3. The practice uses an electronic health record.	Yes	Yes	No	Yes	No	Yes
If yes, which one?	Epic-OCHIN	Epic-OCHIN	N/A	GE Centricity -Logician	N/A	Epic-OCHIN

Table 5, Continued

HEALTH INFORMATION TECHNOLOGY, continued	Clinic					
	Mult. Co. Health Dept. – Westside	OHSU - Richmond	CCC – OTC	Outside In	NARA IHC	Virginia Garcia - Hillsboro
Q4. If your practice uses an electronic health record technology, which of the following does it provide/track?						
Population management information (e.g. Patients needing clinical review or action, medication review, preventive care, specific tests, follow-up visits, case management support)	Yes	Yes	N/A	Yes	N/A	Yes
General patient information such as name, DOB, gender, marital status, language preference, voluntary self-identified race/ethnicity, address, telephone number (primary contact number), email address, ID (internal and external), emergency contact information, legal guardian, health insurance information, preferred method of communication	Yes	Yes	N/A	Yes	N/A	Yes
Clinical patient information such as current and past clinical diagnoses, dates of previous clinical visits, billing codes for services	Yes	Yes	N/A	Yes	N/A	Yes
A problem list for patients	Yes	Yes	N/A	Yes	N/A	Yes
Medication list	Yes	Yes	N/A	Yes	N/A	Yes
Q5. The practice uses an electronic prescription writer that is linked to patient specific demographic and clinical information.	Yes	No	No	Yes	No	No
Q6. The electronic prescription writer is capable of creating a secured prescription for controlled substances?	Yes	No	No	Yes	No	Yes
Q7. Practice providers can electronically access which of the following types of patient information during a patient encounter:						
Problem list/Diagnoses	Yes	Yes	No	Yes	No	Yes
B/P, height, weight, head circumference, BMI	Yes	Yes	Yes	Yes	No	Yes
Allergies and adverse reactions	Yes	Yes	No	Yes	No	Yes
Lab test results	Yes	Yes	Yes	Yes	No	Yes
Imaging results	Yes	Yes	No	Yes	No	Yes
Pathology reports	Yes	Yes	No	Yes	No	Yes
Advanced directives	Yes	Yes	No	Yes	No	No
Age appropriate prevention services	Yes	Yes	No	No	No	Yes
Patient medications	Yes	Yes	No	Yes	No	Yes
Consult reports	Yes	Yes	No	Yes	No	Yes
Q8. A provider can click on a patient's electronic health record and bring up all the data (clinical and administrative) for the patient.	Yes	Yes	N/A	Yes	N/A	Yes
Q9. If your practice has an EHR and you are providing mental health services using mental health billing codes, are all these services documented in your EHR?	Yes	N/A	N/A	Yes	N/A	No
If NO, please list which mental health services are documented in paper records:	N/A	N/A	N/A	N/A	N/A	N/A
Q10. Everyone uses the information systems in the practice according to their position requirements.	Yes	Yes	No	Yes	Yes	Yes

Table 6: Care Coordination at FQHC Clinics Providing Integrated Services in Multnomah County

CARE COORDINATION	Clinic					
	Mult. Co. Health Dept. – Westside	OHSU - Richmond	CCC – OTC	Outside In	NARA IHC	Virginia Garcia - Hillsboro
Q1. The practice plan for coverage after hours is:						
A phone message sends the patient to the ER	No	No	No	No	Yes	No
An answering service directs calls	No	No	Yes	No	Yes	Yes
A triage answering service directs calls to a clinician	Yes	No	No	Yes	No	No
A practice provider carries a pager (or cell phone) in an on call rotation	No	Yes	No	Yes	Yes	Yes
The practice provides urgent/extended hours	No	No	Yes	No	No	Yes
Q2. A collaborative relationship -- including 1) provision of services not currently provided by the practice, 2) timely information exchange and appropriate processes for patient hospital admission, discharge, and follow-up care and 3) support for patient transition to a new care provider -- has been developed with other providers in the community.						
Hospital and emergency room	No	Yes	Yes	No	No	Yes
Maternity care	Yes	Yes	No	No	Yes	Yes
Specialist care	Yes	Yes	Yes	No	Yes	No
Behavioral healthcare	No	No	Yes	No	Yes	Yes
Pharmacy	No	Yes	No	No	Yes	Yes
For other services not provided by the practice (radiology, laboratory, physical therapy, case management, etc.)	Yes	Yes	Yes	Yes	Yes	Yes
Q3. The practice has established a procedure for receiving communications regarding the recommendations and outcomes of care administered by collaborating providers outside of the practice.	Yes	Yes	No	No	Yes	Partially
Q4. The practice has a tracking procedure in place for lab and imaging tests supporting which of the following:						
Ordering lab tests and having results reviewed by clinicians	Yes	Yes	Yes	Yes	Yes	Yes
Ordering imaging tests and review of results by clinicians	Yes	No	Yes	No	Yes	Yes
Flagging abnormal and overdue results	Yes	Yes	Yes	Yes	Yes	Yes
Notifying patients with abnormal test results	Yes	Yes	Yes	Yes	Yes	Yes
Notifying patients regarding normal test results	No	Yes	Yes	Yes	Yes	No
Notifying collaborating providers outside of the practice of abnormal test results	Yes	No	Yes	No	Yes	Yes
Notifying collaborating providers outside of practice of normal test results	No	No	Yes	No	Yes	Partially

Table 6, Continued

CARE COORDINATION, continued	Clinic					
	Mult. Co. Health Dept. – Westside	OHSU - Richmond	CCC – OTC	Outside In	NARA IHC	Virginia Garcia - Hillsboro
Q5. The practice has a procedure in place for tracking all referrals designated as "critical" including which of the following elements:						
No formal tracking procedures are in place for tracking critical referral information	N/A	N/A	N/A	N/A	N/A	Yes
Origination of the referral	Yes	Yes	Yes	Yes	Yes	N/A
Clinical details sent	Yes	Yes	Yes	Yes	Yes	N/A
Report returned to the practice	Yes	No	Yes	No	Yes	N/A
Provider review and initialing of the report before filing	Yes	Yes	Yes	Yes	Yes	N/A
Administrative details-requirement for health plan approval	Yes	Yes	No	No	Yes	N/A
Q6. The provider routinely receives and reviews a copy of the patient's record for after-hours care (urgent care, emergency room) provided outside of the practice.	Yes	Yes	Yes	Yes	Yes	Yes
Q7. The practice has a process in place for coordinating information and recommendations received from providers external to the practice, into the patient's care management process.	Yes	No	Yes	Yes	Yes	Yes
Q8. The practice is able to import outside consult reports into the practice electronic health record.	Yes	Yes	N/A	Yes	N/A	Partially
Q9. The practice has a written protocol describing the schedule for communicating with case managers external to the practice.	No	No	No	No	No	No
Q10. The practice has a written protocol that identifies the timeframe for following up with patients after a hospital admission or emergency room visit.	Yes	No	Yes	No	No	No

Table 7: Care Management at FQHC Clinics Providing Integrated Services in Multnomah County

CARE MANAGEMENT	Clinic					
	Mult. Co. Health Dept. – Westside	OHSU - Richmond	CCC – OTC	Outside In	NARA IHC	Virginia Garcia - Hillsboro
Q1. Appropriate language (interpretation) services are made available for patients with limited English proficiency or for patients who have other interpretation needs.	Yes	Yes	Yes	Yes	Yes	Yes
Q2. The practice systematically organizes and documents care in the medical record (either electronically or paper format) using at least three of the following charting tools: Problem lists Lists of OTC medications, supplements or alternative therapies Lists of prescribed medications for chronic and short-term conditions Template for age-appropriate risk factors Template for narrative progress notes Screening tool for developmental testing Growth charts and BMI if less than 18 years old	Yes	Yes	Yes	Yes	Yes	Yes
Q2a. The charting tools above are documented in what percentage of the records of patients seen in the last three months?	75-100%	75-100%	50-74%	75-100%	75-100%	75-100%
Q3. The practice collects data to identify and support population management processes within the practice related to which of the following factors:						
Most frequently seen diagnoses	No	Yes	Yes	No	No	Yes
Community risk factors or risk factors in the practice's patient population	Yes	No	No	No	Yes	Yes
Three or more clinically important conditions on which to concentrate care management	Yes	Yes	No	No	No	Yes
Q4. The providers in the practice proactively engage in managing the care of patients with chronic diseases by monitoring laboratory testing and calling patients in for follow-up testing and examinations on a periodic basis.	No	Yes	Yes	Yes	Yes	Yes
Q5. The providers in the practice manage patients with chronic or recurrent conditions and identified risk factors by routinely creating individualized plans of care and treatment goals with the patients.	No	Yes	Yes	Yes	Yes	No
Q6. Patient progress toward goals is routinely assessed in the management of chronic or recurrent conditions and identified risk factors.	No	Yes	Yes	Yes	Yes	No
Q7. When patients do not meet or pursue agreed upon treatment goals the providers in your practice routinely assess the barriers that have kept the patient from meeting their treatment goals.	Yes	Yes	Yes	Yes	Yes	No
Q8. The practice routinely follows up with a patient when an important appointment is missed.	No	Yes	Yes	Yes	No	Yes
Q9. The providers in the practice routinely work with patients (and their families as appropriate) to create a patient/provider agreement (pact) which outlines the responsibilities of the provider, the behavioral expectations of the patient and encourages the patient to become involved in the treatment decision-making process and self-management of their health.	Yes	Yes	Yes	Yes	Yes	No

Table 7, Continued

CARE MANAGEMENT, continued	Clinic					
	Mult. Co. Health Dept. – Westside	OHSU - Richmond	CCC – OTC	Outside In	NARA IHC	Virginia Garcia - Hillsboro
Q10. In the past three months, the practice has routinely conducted and documented at least three of the following activities intended to support each patient's ability to self manage their chronic disease process: Evaluating readiness for change, patient/family preferences and abilities Making understandable educational resources available Working with the patient to use self-monitoring tools for recording and reporting self-monitoring results Making referrals to self-management support programs Offering educational programs or classes Utilizing other self-management resources as indicated Making available a written plan of care	Yes	Yes	Yes	Yes	Yes	Yes
Q10a. The three self-management activities above are documented in what percentage of patients seen	25-49%	25-49%	75-100%	75-100%	75-100%	50-74%
Q11. Which of the following processes are in place in your practice to improve patient flow and care management:						
Patients are reminded of appointments by a member of the practice team or through an automated system	Yes	Yes	Yes	No	Yes	Yes
Chart information is collected and readily available prior to the visit	Yes	Yes	Yes	Yes	Yes	Yes
Lab and imaging reports are available and reviewed prior to the patient visit	Yes	Yes	Yes	No	Yes	Yes
The number of physical steps taken in the delivery of care are minimized	Yes	Yes	Yes	Yes	Yes	No
Point of care reminders are provided	Yes	Yes	Yes	Yes	Yes	No
Standing orders for medication refills, lab tests and routine preventive services are managed by non-physician staff members	Yes	Yes	Yes	Yes	Yes	Yes
Patient and family education is provided by team members other than the provider	Yes	Yes	Yes	Yes	Yes	No
Patient education materials are available in each exam room	Yes	Yes	Yes	No	Yes	Yes
Non-physician staff coordinate care for chronic diseases with case management	Yes	Yes	Yes	No	Yes	Yes
Q12. The practice uses a population management tool (either paper or electronic) to conduct which of the following:						
Pre-visit planning	Yes	Yes	Yes	Yes	No	No
Medication management and review	Yes	Yes	Yes	Yes	No	No
Clinical review	Yes	Yes	Yes	Yes	No	No
Reminders for preventive care (screening tests, immunizations, risk assessments, counseling, etc.)	Yes	Yes	Yes	Yes	Yes	Yes
Reminders for specific tests	No	Yes	Yes	Yes	Yes	Yes
Follow-up visits	No	Yes	Yes	Yes	Yes	No
Coordinate care/provide case management support	Yes	No	Yes	Yes	Yes	No

Table 8: Current Billing Practices at FQHC Clinics Providing Integrated Services in Multnomah County

BILLING PRACTICES	Clinic					
	Mult. Co. Health Dept. – Westside	OHSU - Richmond	CCC – OTC	Outside In	NARA IHC	Virginia Garcia - Hillsboro
Q1. Codes billed to CareOregon/Family Care for physical health diagnoses served in your primary care site:						
99201 - 99205 PCP New patient	Yes	Yes	Yes	Yes	Yes	Yes
99211 - 99215 PCP Established patient	Yes	Yes	Yes	Yes	Yes	Yes
99078 Educational group, e.g. prenatal, obesity, diabetes	No	No	No	No	No	No
99401 – 99404 Prevention individual	No	Yes	No	No	Yes	No
99411- 99412 Prevention group	No	No	No	No	No	No
96150 – 96154 Consultation behavioral intervention	No	No	Yes	No	No	Yes
Q2. Codes billed to Verity/Family Care for mental health diagnoses served in your primary care site:						
90801 – 90802 Psychiatric assessment	Yes	N/A [11]	Yes	No	Yes	N/A [12]
90804, 90806, 90808, 90810, 90812, 90814 Individual psychotherapy	Yes	N/A	Yes	No	Yes	N/A
90805, 90807, 90809, 90811, 90813, 90815 Individual psychotherapy with medical evaluation and management	No	N/A	Yes	No	Yes	N/A
90846 – 90849 Family psychotherapy	No	N/A	Yes	No	Yes	N/A
90853 – 90857 Group psychotherapy	No	N/A	Yes	No	Yes	N/A
90862 Pharmacologic management	Yes	N/A	Yes	Yes	Yes	N/A
90882 Environmental intervention for medical management	Yes	N/A	Yes	No	No	N/A
90887 Interpretation/explanation of results, psychiatric or medical	Yes	N/A	Yes	No	No	N/A

[11] OHSU – Richmond does not have a certificate of approval to bill Verity/Family Care for mental health services

[12] Virginia Garcia does not yet have a certificate of approval to bill for mental health services, although they are in the process of obtaining one

Section II Bibliography

CareOregon. (n.d.). Retrieved February 10, 2010, from CareOregon: http://www.careoregon.org/pcr/documents/PCR_101.pdf

Jarvis, Dale. (2009). Behavioral Health and its Role in the Changing Healthcare Landscape. *Association of Oregon Community Mental Health Programs.*

National Committee for Quality Assurance. (n.d.). *PPC - Patient-Centered Medical Home* . Retrieved March 10, 2010, from National Committee for Quality Assurance: http://www.ncqa.org/tabid/631/Default.aspx

NCCBH. (2009). *Behavioral Health/Primary Care Integration and the Person-Centered Healthcare Home.* Washington, DC: National Council for Community Behavioral Healthcare.

NCCBH. (2010). *Substance Use Disorders and the Healthcare Home.* Washington, DC: National Council for Community Behavioral Healthcare.

OCHIN. (n.d.). Retrieved March 8, 2010, from OCHIN: http://www.ochin.org/index.html
Qualis Health. (n.d.). Retrieved March 1, 2010, from http://www.qhmedicalhome.org/safety-net/index.cfm

TransforMed. (n.d.). *TMED MHIQ*. Retrieved March 8, 2010, from TransforMed: http://www.transformed.com/MHIQ/welcome.cfm

Healthcare Integration Report
Section III:

Long-term System of Care
Strategic Plan Recommendations

A. MHASD Strategic Goals and the Healthcare Integration Project

The Mental Health and Addiction Services Division (MHASD) operates within Multnomah County's Department of County Human Services (DCHS).

MHASD MISSION:

To enhance and maintain high-quality, accessible, and culturally appropriate systems of care for children, youth and adults with behavioral, emotional, and addictive problems.

MHASD manages the public system of care for children, youth and adults with behavioral, emotional, and addictive problems. MHASD strives to develop and maintain a person-centered system of care, incorporates evidence-based practices, and endorses a recovery philosophy. In partnership with the community, MHASD makes ongoing improvements to the availability, accessibility, and quality of prevention and treatment services. MHASD serves more than 4,300 of the County's most vulnerable residents every month, either directly or through one of its provider agencies. This results in service to 24,000 adults and children each year in all programs, including prevention – about 3.5% of the County population. Though many get the help they need, others do not seek help because they are unaware that a behavioral health and addiction problems can be effectively treated, or because they do not have insurance coverage or the money to pay for services out of their own income.

In fall 2009 MHASD produced a strategic plan for 2010 – 2013. The integration of physical and behavioral healthcare is one of four top division goals.

2010 – 2013 MHASD Strategic Goals:

I. Involve consumers and families in planning and delivery of services.

II. Enhance the system of care to better meet the needs of consumers.

III. Integrate physical healthcare with behavioral health and addiction services.

IV. Strengthen financial and system accountability.

In order to achieve this strategic goal, the Healthcare Integration Project launched in August 2009 with key objectives to:

- Understand the current national, state, and local context for integrated healthcare (Section I)
- Study national models and recommended evidence-based practices for providing integrated healthcare services (Section I)
- Describe the current continuum of integrated healthcare services available in Multnomah County (Section II)
- Achieve a person-centered approach to healthcare integration planning by understanding and incorporating behavioral health[13] consumer and consumer advocates' recommendations (Section III)
- In collaboration with local stakeholders, develop plans and recommendations for the bidirectional integration of behavioral health and primary care services, primarily focused on the needs of adults with serious mental illness (Section III)

This section of the MHASD Healthcare Integration report presents behavioral health consumer, consumer advocate, and provider stakeholder input, continuing to build on information from Sections I and II, to set forth

[13] The term behavioral health is used throughout this report as a term that includes mental health, behavioral and lifestyle aspects of physical health conditions, and substance use/abuse.

recommendations and action steps for the integration of behavioral health and primary care services in Multnomah County. Our overarching vision is that people living with serious mental illness in our community have access to Person-Centered Healthcare Homes (PCHH) at locations that best serve their needs and preferences.

B. Behavioral Health Consumer and Consumer Advocate Recommendations

Multnomah County MHASD conducted one active behavioral health consumer and three consumer advocate input sessions from October – December 2009 as part of the Healthcare Integration Project. The input and recommendations contained in this report from consumer advocates and active consumers ensures a person-centered approach is included in our planning efforts for integrated healthcare services. A full description of the input sessions and results is located in Appendix B. The following are six key recommendations from consumers and consumer advocates regarding the integration of behavioral health and primary care services:

Behavioral Health Consumer and Consumer Advocate Key Recommendations for Integrated Healthcare:

1. **Ensure there is no "wrong door" for receiving care** – Consumers should have access to behavioral and physical healthcare services at locations of their choice, either in primary care clinics or CMHCs
2. **Establish team-based, coordinated care** - Consumers value and desire long-term relationships with a team of providers; they believe that communication between providers will increase the effectiveness of their care
3. **Honor consumer choices** – Consumers should have a choice of where they receive care, including staying with established providers, and whether or not to share their mental health information with PCPs
4. **Incorporate services to help facilitate receipt of physical healthcare** – Consumers would like longer appointment times with PCPs, "warm hand-offs" when introduced to new providers, availability of on-site blood draws at CMHCs, and peers/advocates/mentors/case managers to help them prepare for and/or attend PCP appointments
5. **Educate providers and consumers** – PCPs need more education about mental health issues, including medication management, interactions between mental and physical health conditions, and be dually-trained for substance use/abuse. Consumers need education about the importance of primary care, how to negotiate the healthcare system, and how to talk to PCPs about medication and health concerns
6. **Create environment of respect and acceptance** – Consumers value being positively acknowledged by all staff and providers, greater tolerance of diversity, and not being judged or dismissed by PCPs

C. Verity Provider Review Subcommittee on Standardization of Integrated Healthcare Services

1. Introduction

MHASD Healthcare Integration Project staff conducted six collaborative meetings with a Verity Provider Review Committee (PRC) subcommittee from October 2009 through March 2010. Representatives from five agencies that contract with Verity MHO participated in the meetings. The guiding vision of the subcommittee is to overcome barriers to integrated services patients need so that appropriate care is received at the right time and place. The goals of the meetings were to 1) identify barriers and potential solutions to integrated healthcare and

2) prioritize and plan for areas of standardization at sites providing integrated healthcare services. PRC subcommittee participants included:

- Multnomah County Health Department – Westside Clinic
- Central City Concern
- Luke-Dorf
- LifeWorks NW
- Cascadia Behavioral Healthcare

A prioritizing activity at the first meeting allowed subcommittee members to vote for topic areas to help define the group's subsequent efforts. Below are the results (Also see Appendix C for examples of questions discussed for each area):

1) Documentation of services/housing of records and information exchange
2) Billing codes and claims submission
3) Metabolic Syndrome screening/treatment and lab protocols for people on psychiatric medications
4) Performance/outcome measures
5) Provider team composition and service delivery/payment model
6) Screening instruments

The subcommittee identified additional areas requiring work in order to facilitate integrated healthcare, but are outside the scope of authority for this subcommittee: Fully Capitated Health Plan (FCHP) credentialing issues, DMAP Audit/Edit problems with rejecting claims, and internal coding/billing problems at FQHCs.

2. Verity PRC Subcommittee Recommendations and Work Output

Documentation of services/housing of records and information exchange

The subcommittee identified and discussed barriers to providing integrated healthcare. One barrier the group identified is the different documentation requirements for behavioral health services in a CMHC versus a primary care clinic. Also, the behavioral health requirements for "closing" clients and creating discharge summarizes does not fit well in primary care settings where patients remain part of the patient panel over time even though they may not be seen regularly. To overcome these barriers the subcommittee prepared and submitted an ISSR a request for variance to Oregon Administrative Integrated Services and Supports Rules (ISSR) for Community Mental Health Services in order to facilitate integrated healthcare services.

The group also identified barriers related to exchanging patient information between primary care and behavioral health providers. To overcome this barrier the subcommittee developed a standard set of requested patient information to include on all Release and Exchange of Information forms. The central idea is to make it easier for behavioral health and primary care providers to get the appropriate information needed to better coordinate care for their patients. In addition, a workgroup of community primary care and psychiatric providers was established to identify and tackle barriers related to information exchange in order to coordinate patient care (See also "Metabolic Syndrome screening/treatment and lab protocols for people on psychiatric medications").

Subcommittee Output: - *ISSR variance request prepared and submitted* (See Appendix D)
- *Standardized elements and wording for Authorization to Release and Exchange Health Information forms* (See Appendix E)

Billing codes and claims submission

In Oregon, physical and mental health services for Medicaid managed care are billed and paid for separately by different organizations. In Multnomah County, the FCHPs (Care Oregon, Family Care, Providence, and Kaiser) pay for physical healthcare and Managed Mental Health Organizations (MHO) (Verity and Family Care) pay for behavioral health services. A considerable barrier to integrated healthcare is the prohibition of same-day billing for FCHPs using evaluation and management CPT codes (99211 through 99215) for physical and mental health services provided by different licensed medical practitioners. For example, if a patient with a physical and mental health condition, e.g. diabetes and schizophrenia, is at an appointment with their PCP to treat their diabetes, they cannot also see and bill for a psychiatrist or psychiatric nurse practitioner on the same day to treat their schizophrenia. However, the Health and Behavior Assessment and Intervention CPT codes (96150 through 96154 billed to FCHPs) allow certain behavioral health specialists to work with a patient upon referral from a medical professional who has made the primary physical health diagnosis. This means that a brief 15 minute intervention could be provided, which would be paid for by a FCHP, but it would have to be related to the physical health diagnosis of diabetes. The separation of mental health from physical health and the subsequent inability to bill for same-day services by FCHPs creates barriers for patients to receive the care they need at the point of contact.

Given the complexity of billing for integrated care services, MHASD worked with the Verity PRC subcommittee to develop an integrated billing/service matrix to help delineate the billing codes and services performed at integrated care sites and the appropriate billing entity.

Subcommittee Output: - MHASD Integrated Healthcare Billing/Service Matrix (See Appendix F)

Metabolic Syndrome screening/treatment and lab protocols for people taking psychiatric medications

The subcommittee agreed it would be more appropriate and effective to have primary care and psychiatric Medical Directors and providers address the issue of Metabolic Syndrome monitoring and treatment. They asked the MHASD Medical Director to convene a group of community physicians to begin work on this issue. A meeting was arranged in January 2010 with primary care and psychiatric physicians/providers representing 15 local organizations including hospitals, community mental health organizations, family medicine practices, the county health department, psychiatric providers, and the CareOregon FCHP. A number of barriers and potential solutions were identified to increase Metabolic Syndrome monitoring/treatment and coordination of patient care. A smaller workgroup of physicians will begin meeting in April 2010 to tackle the barriers identified by the larger group.

Subcommittee Output: - Psychiatric and primary care providers' meeting to identify and discuss barriers related to Metabolic Syndrome monitoring/treatment (See Appendix G)

- *Provider workgroup assembled to continue work to address barriers to Metabolic Syndrome monitoring/treatment in Multnomah County*
- *2004 Consensus Guidelines for Metabolic Syndrome* (See Appendix H)
- *Verity Recommended Lab Protocol* (See Appendix I)

Performance/outcome measures

The subcommittee decided that performance/outcome measures will be delegated to the MHASD Quality Management (QM) Committee, with input and approval from Medical Directors at sites. The recommended

measures for QM approval will be: 1. The Cascades Community Engagement Evaluation Strategy measurements for people with serious mental illness and 2. Selection of appropriate "Breakthrough Outcome" measures from the State of Oregon final integration report.

Subcommittee Output: MHASD will recommend that the Verity QM Committee incorporate outcome/performance measures from: 1. The Cascades Community Engagement Evaluation Strategy measurements for people with serious mental illness (See Appendix J) and 2. Selection of appropriate "Breakthrough Outcome" measures from the State of Oregon final integration report (See http://www.oregon.gov/DHS/hsi/docs/integration-final-report.pdf)

Provider team composition and service delivery/payment model

The subcommittee discussed what elements should be included in MHASD's Healthcare Integration Project strategic plans, with the intention to release an Request For Program Qualifications (RFPQ) in late 2010 that includes requests for proposals for integrated primary care services delivered in CMHCs as well as integrated behavioral health services in primary care; to be funded by a combination of fee for service, plus case rate, plus pay for performance (FFS+ case rate + P4P) structure. The group discussed what services should be included in the RFPQ, who should deliver those services, and what requirements should be included in order to receive the combination payment.

The group agreed that the standard behavioral health services that should be offered in integrated primary care setting include:

- Mental health assessments
- Short-term, evidence-based individual and group treatment, approximately 4 -8 visits
- Medication management
- Health and behavioral interventions related to physical health conditions
- Depression screening
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) for substance use and abuse
- Enrollment and updating patient information into the CMTS web-based registry (more information to follow)

The staff complement to perform the above mentioned functions should include:

- Qualified Mental Health Professional – Licensed Psychologist, Licensed Clinical Social Worker
- Onsite prescriber (psychiatrist or psychiatric nurse practitioner)
- Psychiatrist consultant
- Medical Assistant
- Medical Nurse Care Manager or other appropriately educated paraprofessional - The group requested that MHASD gather Panel/Care Manager job descriptions to look at the list of job duties and make decisions using that information about what type of staff would be acceptable for this role.

Integrated activities to be paid for by a case rate structure include:

- Care Manager functions including but not limited to time to input data/perform upkeep for the web-based registry such as the University of Washington Advancing Integrated Mental Health Solutions (AIMS) called the "Care Management Tracking System" (CMTS).
- "Warm Handoffs"
- Consultations from any behavioral health staff to the PCP (both brief and more in-depth)

Subcommittee Output: Consensus regarding new MHASD RFPQ requirements for integrated healthcare - the types of services and providers for behavioral healthcare delivered in primary care settings.

Screening instruments

The subcommittee did not discuss this topic area in depth; however, there was group consensus that Screening, Brief Intervention and Referral to Treatment (SBIRT) substance use screening tools should be used as well as other evidence-based screening tools in alignment with state and community-wide recommendations including the Cascades Community Engagement Behavioral Health Integration Measurement/Evaluation Strategy.

Subcommittee Output: Alignment with state and community-wide recommendations, specifically, the Cascades Community Engagement Behavioral Health Integration Measurement/Evaluation Strategy, which includes SBIRT and other evidence-based screening tools (See Appendix J).

D. Multnomah County MHASD Long-Term System of Care Strategic Plan Recommendations

The following recommendations build upon all information presented in this report – national models and evidence-based integrated care practices; the national, state, and local context for integrated healthcare services; the continuum of integrated services currently available in Multnomah County; behavioral health consumer and consumer advocate recommendations; and local provider stakeholder input - to set forth suggested action steps for the bidirectional integration of behavioral health and primary care services in Multnomah County. The recommendations are separated into two areas – behavioral health services delivered in FQHC safety-net primary care settings and primary care services delivered in CMHC settings. We focus on the safety-net primary care system in our community, acknowledging that some people with behavioral health problems receive physical healthcare at other clinics. Our overarching vision is to ensure people with serious mental illness have access to Person-Centered Healthcare Homes that care for the overall health and well-being of people at locations that best serve their needs and preferences.

1. Recommendations for Behavioral Health Services in FQHC Primary Care Clinics in Multnomah County

Recommendation #1: Establish standardized elements of the behavioral health delivery model and minimum set of services available in FQHC safety-net primary care clinics.
Rationale: Consumers should have access to a minimum set of recommended behavioral health evidence-based services in primary care settings, if that is where they choose to receive their care.
Alignment with Consumer Recommendations: 1) Make sure there is no "wrong door" for receiving care and 2) Honor consumer choice
Alignment with Verity Provider Stakeholder Recommendations: PRC subcommittee recommendations for provider team composition and service delivery model.
MHASD Action Steps: ➢ Develop RFPQ in late 2010 for integrated health services in primary care clinics (and CMHCs). Incorporate requirements for recommended evidence-based services. ➢ Disseminate recommendations for behavioral health service delivery model in primary care settings: Step 1: Standardized screening for behavioral health problems conducted during an office visit to the primary care provider (PCP). Any staff member at the PCP's office can conduct the standardized screening. Step 2: Results of the screening tool interpreted by the PCP who then counsels/refers patients to appropriate

services, and provides "warm handoffs" if patient screens positive for behavioral health problems. This is the initial step in creating a treatment plan.

Step 3: A behavioral health diagnostic assessment is completed by a person who meets the criteria of a Qualified Mental Health Professional (QMHP).

Step 4: Behavioral health services are performed by a QMHP and include all the following as appropriate:

- Mental health assessments
- Short-term, evidence-based individual and group treatment, approximately 4 - 8 visits
- Medication management
- Health and behavioral interventions related to physical health conditions

Step 5: Ongoing care coordination and registry tracking/outcome measurement performed by Clinical Care Manager for people with behavioral health needs

Recommendation #2: Standardize and streamline documentation requirements and patient health information exchange procedures.

Rationale: Differential documentation requirements and complexities with exchanging patient information should not be barriers to integrated healthcare. Standardizing and streamlining these requirements should facilitate integrated and coordinated healthcare for behavioral health consumers choosing to receive care in primary care settings.

Alignment with Consumer Recommendations: 1) Establish team-based, coordinated care 2) Honor consumer choice and 3) Ensure there is no "wrong door" for receiving care

Alignment with Verity Provider Stakeholder Recommendations: Minimize documentation requirements and information exchange barriers to facilitate integrated, coordinated healthcare

MHASD Action Steps:

- Submit a variance request to State of Oregon Addictions and Mental Health Services for exemption of certain documentation requirements in primary care settings (Submitted, See Appendix D)
- Disseminate and encourage use of standardized Authorization To Release and Exchange Health Information form for use at integrated care sites (See Appendix E)
- Continue to provide resources to facilitate the primary care/behavioral health provider workgroup for information exchange issues related to Metabolic Syndrome monitoring and treatment (See also Metabolic Syndrome screening/treatment and lab protocols for people taking psychiatric medications, page 63)

Recommendation #3: Standardize and simplify billing and coding practices for integrated behavioral health services.

Rationale: Minimize barriers related to billing for integrated services in order to provide and be appropriately reimbursed for the care people need at the right time/place and delivered by the appropriate provider.

Alignment with Consumer Recommendations: 1) Ensure there is no "wrong door" for receiving care 2) Establish team-based, coordinated care

Alignment with Verity Provider Stakeholder Recommendations: Clarify and simplify billing and coding procedures to make providing integrated healthcare financially feasible.

MHASD Action Steps:

- Set up meetings with appropriate staff and providers at FQHC clinics providing integrated healthcare for technical assistance and dissemination of materials prepared by Verity PRC subcommittee: the Integrated Billing and Coding Matrix (See Appendix F) and information about billing "incident to" a physician's services
- Continue to monitor State of Oregon health services integration efforts and formation of Oregon Health Authority (OHA). Advocate for billing and coding changes to facilitate integrated healthcare.

Recommendation #4: Establish web-based registry tracking and outcome measurement for: 1) all individuals receiving behavioral healthcare at FQHC safety-net primary care clinics and 2) all individuals receiving their behavioral healthcare at CMHCs and physical healthcare at FQHC safety-net primary care clinics.

Rationale: A web-based registry will permit behavioral health and primary care providers at different locations to access/share critical patient information and better coordinate patient care. Tracking behavioral health outcomes and proactively managing patients with behavioral health needs will increase effectiveness of care.

Alignment with Consumer Recommendations: 1) Establish team-based, coordinated care 2) Honor Consumer Choice, and 3) Incorporate services to help facilitate receipt of physical healthcare

Alignment with Verity Provider Stakeholder Recommendations: Enroll behavioral health patients in web-based registry and track outcomes to be able to provide evidence-based, coordinated healthcare

MHASD Action Steps:

- Implement a web-based registry such as the University of Washington Advancing Integrated Mental Health Solutions (AIMS) Care Management Tracking System (CMTS) at all FQHCs providing integrated healthcare services
  - Evaluate standard MHASD contracting options for a minimum two year pilot project versus intergovernmental agreement with University of Washington.
  - Obtain Verity QM Committee agreement to incorporate the Cascades Community Engagement Behavioral Health Integration Measurement/Evaluation Strategy outcome measures into the registry (See Appendix J)
  - Obtain behavioral health and primary care provider stakeholder agreement to incorporate into the registry the 2004 Consensus Metabolic Monitoring Guidelines (See Appendix H) and/or Verity Recommended Lab Protocol (See Appendix I) for people taking psychiatric medications

Recommendation #5: Help establish evidence-based wellness programs and Peer Wellness Coaches in FQHCs to help people with behavioral health needs engage in wellness programs/activities.

Rationale: Wellness programs that focus on lifestyle health are effective at increasing health status and quality of life for people with behavioral health needs. Specific outcomes include: reducing/stopping weight gain, lowering cholesterol and blood pressure, improvements in mood and sleep, and higher energy levels (AHRQ, 2009; Jue, 2009).

Alignment with Consumer Recommendations: 1) Incorporate services to help facilitate receipt of physical healthcare - Specific requests from consumers for peer-based services and wellness programs related to physical health 2) Honor consumer choice

Alignment with Verity Provider Stakeholder Recommendations: Overcome barriers to integrated services so that individuals receive the appropriate care at the right place and time.

MHASD Action Steps:

- Sponsor AMH-approved peer delivered service training program for Certified Peer Specialists. Once certified as Peer Specialists, their services can be encountered to Medicaid (Billing code H0038)
- Sponsor training program for Certified Peer Specialists to become "Peer Wellness Coaches" as a part of integrated care teams in FQHCs
  - Consider Peer Wellness Coach curriculum developed by Benton County (See Appendix L)
- Engage with Multnomah County Health Department and the Cascades Community Engagement group to consider hiring Peer Wellness Coaches and adopting, if not already in place, evidence-based wellness programs at all FQHCs. Programs would include, but not be limited to: smoking cessation, weight management, nutrition, exercise, and chronic disease self-management (e.g. diabetes)

2. Recommendations for integrated primary care services delivered in Community Mental Health Centers that contract with MHASD to provide services to people with serious mental illness in Multnomah County:

Recommendation #1: Establish primary care providers onsite in CMHCs that provide services to large numbers of people with serious mental illness.

Rationale: CMHCs may be the most important point of entry to the healthcare system for people with serious mental illness (Druss, et al., 2008). They may feel more comfortable and be more likely to receive primary care services at CMHCs where they already receive behavioral health treatment and have established trusting relationships.

Alignment with Consumer Recommendations: 1) Honor consumer choice – Consumers want to have the choice to receive physical health care at CMHCs 2) Establish team-based, coordinated care and 3) Incorporate services to help facilitate receipt of physical healthcare

Alignment with Verity Provider Stakeholder Recommendations: Overcome barriers to integrated services so that individuals receive the appropriate care at the right place and time.

MHASD Action Steps:

- Provide venues for collaborative dialogue between FCHPs, MHASD, and CMHC and FQHC executives to discuss options for focused partnerships to place primary care physicians or medical nurse practitioners in CMHCs. Issues to be addressed include contracting, start-up costs, structural space and equipment/supply needs, and credentialing providers. If nurse practitioners are utilized, national recommendations are to ensure there is backup from a skilled supervising physician and a full scope primary care practice.
- Establish resources necessary to hire a consultant/grant writer to position Multnomah County to compete for next round of SAMHSA grants for primary care services in specialty mental health settings. Obtaining additional funding for start-up costs and structural changes necessary to provide primary care onsite at CMHCs is critical.
- Collaborate with CareOregon to analyze matched client data to determine if and where people with serious mental illness are receiving primary care. This will help identify the highest need group to target to begin establishing primary care.

Recommendation #2: Establish embedded Clinical Care Managers within all CMHCs serving people with serious mental illness.

Rationale: Care Managers are a critical evidence-based component of collaborative care models and for people with serious mental illness in CMHC settings. Care Management in CMHCs has been shown to improve rates of receiving primary care services, quality of primary care services received, and mental health-related quality of life for people with serious mental illness (Druss, von Esenwein, Compton, Rask, Zhao, & Parker, 2010).

Alignment with Consumer Recommendations: 1) Establish team-based, coordinated care 2) Honor Consumer Choice and 3) Incorporate services to help facilitate receipt of physical healthcare

Alignment with Verity Provider Stakeholder Recommendations: Overcome barriers to integrated services so that individuals receive the appropriate care at the right place and time.

MHASD Action Steps:

- Evaluate patient caseload size and Clinical Care Manager FTE needed at each CMHC
- Evaluate options for utilization of medical RN versus LPN
- Evaluate credentialing / training requirements for the Clinical Care Manager position under FFS
- Work with agencies to identify space and equipment available and/or needed for Clinical Care Manager
- Develop Verity start-up and ongoing costs for each patient enrolled and tracked in CMTS web-based registry to fund the Clinical Care Manager position.
- Develop job duties/descriptions for Clinical Care Managers including but not limited to:
    - Enroll patients and perform ongoing monitoring and documentation in the CMTS web-based registry

- Support individuals with chronic health conditions and/or with abnormal laboratory values or other health risks noted in routine metabolic screening
- Perform phlebotomy for lab tests
- Longitudinal monitoring of health status/outcomes and communicating the need for treatment adjustments to the patients' primary care team and psychiatric providers
- Coordinate patient care across multiple medical providers on behalf of the team
- Establish relationships with outside healthcare providers and may accompany individuals to outside medical appointments
- Work with individuals to connect them to the full-scope primary care PCHHs, link them to enabling services, benefits counseling, and peer mentors
- Plan and co-lead ongoing wellness groups that support smoking cessation, weight and chronic disease management, nutrition, and physical exercise. Work with Peer Wellness Coaches to conduct these wellness programs (See also Recommendation #7)

Recommendation #3: Establish web-based registry tracking and outcome measurement for all individuals receiving care at CMHCs serving people with serious mental illness.

Rationale: A secure, web-based registry will enable monitoring and outcome measurement of critical physical health factors including Metabolic Syndrome and other lab tests. Also, behavioral health providers and PCPs at different locations will be able to access/share critical patient information and coordinate patient care. Tracking outcomes and proactively managing people with physical and behavioral health needs will increase the effectiveness of care.

Alignment with Consumer Recommendations: 1) Establish team-based, coordinated care 2) Honor Consumer Choice and 3) Incorporate services to help facilitate receipt of physical healthcare

Alignment with Verity Provider Stakeholder Recommendations: Overcome barriers to integrated services so that individuals receive the appropriate care at the right place and time.

MHASD Action Steps:

- Implement a web-based registry such as the University of Washington Advancing Integrated Mental Health Solutions (AIMS) Care Management Tracking System (CMTS) at all CMHCs serving people with serious mental illness.
  - Evaluate standard MHASD contracting options for a minimum two year pilot project versus intergovernmental agreement with University of Washington.
  - Obtain Verity QM Committee agreement to incorporate the Cascades Community Engagement Behavioral Health Integration Measurement/Evaluation Strategy outcome measures for people with serious mental illness into the CMTS registry (See Appendix J)
  - Obtain stakeholder buy-in to incorporate into the web-based registry the 2004 Consensus Metabolic Monitoring Guidelines and Verity Recommended Lab Protocol (See Appendices G and H) for people taking psychiatric medications

Recommendation #4: Provide point-of-service access to blood draws onsite at CMHCs serving people with serious mental illness to eliminate barriers to regular metabolic monitoring and recommended lab work.

Rationale: Recent evidence indicates very low rates of recommended metabolic testing for Oregon Medicaid recipients taking second-generation antipsychotic drugs, despite repeated FDA warnings of increased diabetes risk (Morrato, 2010). Significant barriers to regular testing exist; even if prescribing providers at CMHCs order the appropriate tests, clients must travel to a different location to get their blood drawn, a considerable obstacle for people with serious mental illness. We can eliminate this systemic barrier by providing blood draws onsite at CMHCs.

Alignment with Consumer Recommendations: 1) Establish team-based, coordinated care 2) Incorporate services to help facilitate receipt of physical healthcare - Specific consumer requests for blood draws on site at CMHCs

Alignment with Verity Provider Stakeholder Recommendations: Overcome barriers to integrated services so that individuals receive the appropriate care at the right place and time.

MHASD Action Steps:

- Work with and encourage CMHCs to establish blood draws onsite using one of two options:
  1) Establish or expand existing relationships with pharmacies to increase their services to include blood draws onsite and lab processing, or even establish an onsite pharmacy
  2) Use the RN Clinical Care Manager to perform phlebotomy and arrange for transportation of blood samples to lab for processing. If this option is chosen, evaluate cost effectiveness of two options for transporting blood samples to a lab: 1) Use Multnomah County courier service and laboratory testing through Multnomah County Health Department lab or 2) use other local or regional laboratory that offers courier service
- Work with CareOregon to determine whether start-up funding and/or other funding is available
- Evaluate time and resources available for having RN Clinical Care Manager perform blood draws or hire/retrain other staff to perform phlebotomy
- Obtain stakeholder approval to incorporate into the web-based registry the 2004 Consensus Metabolic Monitoring Guidelines (See Appendix H) and/or Verity Recommended Lab Protocol (See Appendix I) for people taking psychiatric medications

Recommendation #5: Establish accountability practices for prescribing providers at CMHCs to ensure 1) appropriate lab work is ordered, 2) lab results are reviewed in a timely manner, and 3) appropriate treatment adjustments are made and/or care is coordinated with patients' PCPs.

Rationale: Recent evidence indicates very low rates of recommended metabolic testing for Oregon Medicaid recipients taking second-generation antipsychotic drugs, despite repeated FDA warnings of increased diabetes risk (Morrato, 2010).

Alignment with Consumer Recommendations: 1) Establish team-based, coordinated care 2) Incorporate services to help facilitate receipt of physical healthcare

Alignment with Provider Stakeholder Recommendations: Overcome barriers to integrated services so that individuals receive the appropriate care at the right place and time. The group agreed that prescribing providers should be responsible and held accountable for ensuring recommended lab monitoring and treatment.

MHASD Action Steps:

- Ensure the web-based registry will allow tracking of prescribing providers' compliance with lab protocols
- Evaluate using pay-for-performance and/or case rate mechanism to encourage and ensure prescribing providers comply with lab protocols – order appropriate tests, review results in a timely manner, and make treatment adjustments and/or coordinate care with patients' PCPs accordingly
- Obtain stakeholder approval to incorporate into the web-based registry the 2004 Consensus Metabolic Monitoring Guidelines (See Appendix H) and/or Verity Recommended Lab Protocol (See Appendix I)
- Evaluate other practices to ensure greater accountability and performance-based measures for prescribing providers at CMHCs

Recommendation #6: Begin to develop Person Centered Healthcare Homes (PCHH) for people with serious mental illness in Multnomah County by first focusing on: 1) transitioning to team-based and collaborative care structures/operating practices in CMHCs and 2) Providing education/training on "Integration 101" topics for behavioral health providers/staff

Rationale: National and State of Oregon efforts are now focused on ensuring all people (and especially people with chronic conditions and those receiving publically-funded healthcare) receive care in a Patient-Centered Medical Home (a.k.a. PCHH for people with serious mental illness). A fundamental element of PCHHs and healthcare reform efforts is the team-based care model, which is very different from the current delivery model in CMHCs. The transition to team-based care will be demanding and require substantial changes in provider culture/norms and the physical structure at CMHCs. It is imperative that behavioral health organizations and providers begin this transformation soon and with guidance, consultation, and training from experts in facilitating organizational change and transitioning to true team-based collaborative care.

Alignment with Consumer Recommendations: 1) Establish team-based, coordinated care 2) Honor consumer choice

Alignment with Provider Stakeholder Recommendations: PRC subcommittee recommendations for provider team composition and service delivery model

MHASD Action Steps:

- Explore options to hire consultants and trainers - compare options presented in this report (See Appendix K)Provide MHASD-sponsored training to community behavioral health providers (including clinicians and case managers) regarding appropriate "Integration 101" topics such as team-based care and the physical health needs/common conditions (e.g. Metabolic Syndrome) for people with serious mental illness
- Work with state of Oregon AMH training staff (Shawn Clark) and OHSU/PSU people working to develop integration curriculum (Dr. Vikki Vandiver at PSU)
- Establish an advisory committee of representatives from CMHCs to develop a shared vision and guiding principles for creating PCHHs for people with serious mental illness in Multnomah County. This group will also need to consider possible differences for PCHHs for special groups such as older adults and transition-aged youth.
- Work with CMHCs to establish focused partnerships with FQHCs in close geographic proximity or FQHCs serving a significant percent of shared patients
- Evaluate potential differences in physical space requirements for integrated team-based care in a CMHC setting versus a primary care setting

Recommendation #7: Establish evidence-based wellness programs and Peer Wellness Coaches in all CMHCs serving people with serious mental illness to help consumers engage in integrated health services and wellness programs/activities.

Rationale: Evidence-based wellness programs in CMHCs that focus on lifestyle health are effective at increasing health status and quality of life for people with serious mental illness. Specific outcomes include reducing/stopping weight gain, lowering cholesterol and blood pressure, improvements in mood, sleep, and higher energy levels (AHRQ, 2009; Jue, 2009). Futhermore, the Oregon Addictions and Mental Health Services Division recognizes the indisputable value of peer delivered services and has pledged to increase the use and availability of peer delivered services (AMH, 2006).

Alignment with Consumer Recommendations: 1) Incorporate services to help facilitate receipt of physical healthcare - Specific requests from consumers for peer-based services and wellness programs related to physical health.

Alignment with Verity Provider Stakeholder Recommendations: Overcome barriers to integrated services so that individuals receive the appropriate care at the right place and time.

MHASD Action Steps:

- Sign the 10x10 *Pledge for Wellness,* thereby expressing organizational commitment to promoting wellness and reducing preventable early mortality for people with mental health problems by 10 years in the next 10 years.

- The pledge can be signed online at *http://www.10x10.samhsa.gov*.

➢ Sponsor AMH-approved peer delivered service training program for Certified Peer Specialists. Once certified as Peer Specialists, their services can be encountered to Medicaid (Billing code H0038)

➢ Sponsor training program for Certified Peer Specialists to become "Peer Wellness Coaches" as a part of integrated care teams in CMHCs

- Consider using Peer Wellness Coach curriculum developed by Benton County (See Appendix L)
- Develop job duties/description for Peer Wellness Coach including but not limited to:
  - Under supervision of Nurse Care Manager, work one-on-one with clients identified as having physical health needs to help them achieve wellness goals, participate in wellness programs, and engage in physical healthcare services
  - In partnership with Nurse Care Manager, co-facilitate wellness programs and support groups
  - Assess clients' strengths and needs in relation to physical ,emotional, and holistic wellness
  - Provide encouragement and outreach to clients and help address barriers to achieving wellness goals
  - Complete documentation of services and participate in outcome measurement

➢ Determine payment rates/models for sustaining Peer Wellness Coaches at CMHCs

➢ Consider adopting MHASD-sponsored evidence-based wellness program such as the In SHAPE Lifestyles (See Section I, page 23: Wellness Programs Focused on Physical Health in Specialty Behavioral Health Settings)

Recommendation #8: Establish resources necessary to hire a project manager/grant writer/consultant to position Multnomah County to compete for next round of SAMHSA grants for primary care services in specialty mental health settings and implement the recommendations presented in this report.

Rationale: The new national healthcare reform law (Section 5604 of the PPACA) authorizes $50 million for the SAMHSA grant program for providing integrated primary care services in CMHCs. This program was previously funded at $14 million, and funded 13 projects in 2009. These grants will be an important mechanism for facilitating robust primary care capacity in CMHCs in Multnomah County to address the physical health needs of people with serious mental illness. Competition for these grants will be steep and require professional grant writing capacity with dedicated time and resources to position Multnomah County MHASD as a legitimate contender. Additionally, in order to implement the recommendations in this report, dedicated project management skills and time are necessary.

Alignment with Consumer Recommendations: 1) Establish team-based, coordinated care 2) Honor Consumer Choice and 3) Ensure there is no "wrong door" for receiving care

Alignment with Verity Provider Stakeholder Recommendations: Overcome barriers to integrated services so individuals receive the appropriate care at the right place and time.

MHASD Action Steps:

➢ Explore options/resources available for dedicated "Integrated Healthcare Project Manager/Grant Writer/Consultant" with expertise in grant writing and integrated healthcare.

Recommendation #9: Fully develop financial model for payment by MHASD of integrated health services to include fee-for-service, case rate, and pay for performance mechanisms.

Rationale: In order to establish and facilitate integrated healthcare services in CMHCs, appropriate payment strategies will need to be developed to reflect national trends for payment of services such as care management/coordination that do not fit well in a fee-for-service model.

Alignment with Consumer Recommendations: 1) Establish team-based, coordinated care 2) Honor Consumer Choice and 3) Ensure there is no "wrong door" for receiving care

Alignment with Verity Provider Stakeholder Recommendations: Establish payment mechanisms to appropriately reimburse providers for integrated healthcare services onsite at CMHCs and support the elements of care management/coordination that do not fit well in a fee-for-service payment model.
MHASD Action Steps: ➢ Work with MCCP Consulting to develop payment methods and cost projections (See Appendix K)

3. Conclusion

The national and local movement to integrate behavioral health and primary care services necessitates Multnomah County MHASD to deliberately plan and invest the time and resources necessary to address the health disparity for people living with serious mental illness. Furthermore, the sweeping healthcare system changes over the next 5 to 10 years will present extraordinary opportunities, as well as threats, for the community behavioral health system. Now is the time for forethought and action. We must simultaneously commit to address the *Pledge for Wellness* (to reduce the 25 year mortality gap) and the Triple Aim™ (to increase population health, enhance patient experience/quality, and control costs) for people living with serious mental illness in our community. The integration of primary care and behavioral health services is indisputably vital for achieving these goals.

Appendix A

American Academy of Family Physicians (AAFP)
American Academy of Pediatrics (AAP)
American College of Physicians (ACP)
American Osteopathic Association (AOA)

Joint Principles of the Patient-Centered Medical Home
February 2007

Introduction

The Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care for children, youth and adults. The PC-MH is a healthcare setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.
The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PC-MH.

Principles

Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation – the personal physician is responsible for providing for all the patient's healthcare needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex healthcare system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
- Evidence-based medicine and clinical decision-support tools guide decision making.
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient-centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement.
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation.
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

Background of the Medical Home Concept

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care. The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving patient care called the "medical home" (AAFP, 2004) or "advanced medical home" (ACP, 2006).

For More Information:
American Academy of Family Physicians
http://www.futurefamilymed.org
American Academy of Pediatrics:
http://aappolicy.aappublications.org/policy_statement/index.dtl#M
American College of Physicians
http://www.acponline.org/advocacy/?hp
American Osteopathic Association
http://www.osteopathic.org

Appendix B: Active Consumer and Consumer Advocate Input Session Results

1. Introduction

Multnomah County MHASD conducted one active behavioral health consumer and three consumer advocate input sessions from October – December 2009 as part of the Healthcare Integration Project. The input and recommendations contained in this report from key consumer advocates and active consumers ensures a person-centered approach is included in our planning efforts for integrated healthcare services.

2. Consumer Advocate Input Sessions

The first two consumer advocate input sessions were conducted with five key consumer advocates who regularly provide input on MHASD and State-level projects. The third meeting was conducted with the Adult Mental Health and Substance Abuse Advisory Committee (AMHSAAC) during a special joint Mental Health and Addictions Subcommittee meeting. This group, comprised of current behavioral health consumers and providers, meets monthly and advises MHASD on a variety of issues. Fifteen subcommittee members attended this input session. Light snacks and beverages were available, and a $25 stipend was offered to compensate behavioral health consumer participants for their time at the two-hour session.

Questions for the three consumer advocate meetings were divided into four topic areas (See page 76). For the larger AMHSAAC meeting, members sat at small group tables, with 4-5 people at each table to allow for optimal participation. One facilitator/scribe (MHASD staff) wrote key comments and areas of agreement on large paper in front of each group. Each topic area was allotted approximately 30 minutes for dialogue. After discussions were completed, the MHASD staff person from each table group shared with everyone at the session the themes from their table.

Themes from the consumer advocate input sessions are displayed on pages 77-78 using an Affinity Diagrams organized into two areas:

1) General considerations and recommendations from mental health consumers about integrated care
2) Considerations for integrated care by types of mental health consumer groups

Topic Areas and Questions for MHASD Consumer Advocate Input Sessions

Topic 1. Matching Services to Needs – Clients Getting Medication Management Only

Fifteen percent of the people being served in Community Mental Health Centers in Multnomah County are only going for medication management, either because that is the only mental health service they need or because it is the only mental health service they are willing to accept.

Q1. What works well now for people receiving medication management only from Community Mental Health Centers and how can we transfer what works well in mental health setting to a person-centered healthcare home located in a primary care office?
1a. Should a long term plan and/or options for potential pilot demonstration projects shift the care for this group of people to a person-centered healthcare home located in a primary care office? Why? Why not?

Topic 2. Matching Services to Needs - Clients Getting High Levels of All Services

Twenty-five percent of the people being served in Community Mental Health Centers in Multnomah County are experiencing ongoing acute symptoms and need services like Assertive Community Treatment or high levels of all services only available in a community mental health center.

Q2. If we add physical health providers to the team of mental health providers and create a person-centered healthcare home in a community mental health center; what mental health services currently available are most important to keep? What mental health services need to be added?
Q2a. If we add physical health providers to the team of mental health providers to create a person-centered healthcare home in a community mental health clinic; what medical services available in most primary care offices are most important to add so that people will choose to see the medical doctor/nurse practitioner?

Topic 3. Matching Services to Needs - Clients Getting Outpatient Mental Health Therapy

Sixty percent of the people being served in Multnomah County are experiencing symptoms of illness that require outpatient talk therapy and psychiatric medications in clinics not serving more severely ill persons.

Q3. Should a long term plan and/or options for potential pilot demonstration projects for this group of people include adding physical health providers to the team of mental health providers to create a person-centered healthcare home in these clinics? Why? Why not?
Q3a. If not, what route do we take to address the need for better overall health outcomes for this large group of people getting mental health services?

Topic 4. Matching Services to Needs - Clients Getting Alcohol and Drug Treatment

In Multnomah County people receive alcohol and drug treatment in agencies that provide both mental health and alcohol and drug treatment and agencies that provide only alcohol and drug treatment.

Q4. Should a long term plan and/or options for potential pilot demonstration projects for this group of people include adding alcohol and drug treatment providers to a team of mental health providers and physical health providers when create a PCMH in clinics? Why? Why not?
Q4a. If not, what route do we take to address the need for better overall health outcomes for this large group of people getting mental health services?

Diagram 1: Behavioral Health Consumer Advocate Input Results, by Theme

Considerations for ↓ Integrated Healthcare ↓

Recommended elements from CMHCs to ↓ incorporate into PCMHs ↓

Consumer Choice

- There should be "no wrong door" for receiving care
- Some people may prefer not to have their mental health diagnosis disclosed to their PCP
- Consumers should have choice to remain with providers they've already established relationships with
- Don't make CMHCs only for severely mentally ill - Having mix of people at different stages of recovery creates atmosphere of hope

Relationships with Providers

- Consumers value long-term, trusting relationships at CMHC
- Established relationships at CMHC might increase acceptance of primary care services
- At CMHC, all levels of clinic staff positively acknowledge clients

Behavioral/Physical Health Cultural Differences

- CMHC has atmosphere of respect and greater tolerance of differences
- Staff at CMHC trained to manage difficult social responses from clients
- CMHC has culture of empowerment and self-management
- Primary care clinic might label people as having "mental health needs" and treat them differently

Recommendations to help consumers obtain primary care

- Option for case manager or advocate to attend appointments
- "Warm hand-offs" between PCP and CMHC providers
- Different gender PCPs available
- Offer incentives for participation in wellness groups
- Reminder calls for appointments
- Augment CMHC - don't move people comfortable receiving care in CMHC
- Incorporate flexibility into scheduling
- Ability for family members to see same PCP

Provider Education Needed

- Need PCPs that listen and don't judge
- PCPs knowledgeable about mental/physical health interactions
- Dually-trained NP/PNP
- Dually-trained addictions/substance use

Consumer Education Needed

- How to talk to doctor about medication and health concerns
- Education about primary care system

Medication Management

- CMHC better equipped/skilled with complicated psychiatric medications
- CMHC orders medications, prepares bubble packs, has special hours to pick up medications

Essential Services

- Peer-based and other community supports
- Wellness groups
- Pain management
- Wellness Recovery Action Plans (WRAP)
- Special medication services such as bubble packs - for mental and physical health
- Dental and eye services
- Preventive care
- Blood draws on-site
- Holistic and alternative medicine options
- Help with employment, housing, benefits eligibility, and life skills

Alcohol and Drugs

- Alcohol and Drug specialists need to be part of every healthcare team
- Make sure alcohol and drug issues don't get lost
- Keep in mind needs of methadone and inpatient treatment patients

Diagram 2: Behavioral Health Consumer Advocate Input Results, by Types of Consumer Groups

Topic #1: Clients Getting Only Medication Management at CMHCs

Shift this group to primary care office?

- Care could possibly shift to a PCP office for this group because they use a lot of resources in a CMHC that might better be used with higher need groups
- If shift occurs, what matters is how people are approached, that they get to chose, and how transition is handled
- Need to ensure this group is getting all the mental health services they need
- Shifting to PCP office may increase preventive care & metabolic monitoring, which would be beneficial
- If people shift to PCP office, need linkage and warm-hand off back to CMHC should problems begin to arise
- Don't move people more comfortable in CMHC into PCP setting
- If stable and "less mentally ill" people move to PCP office, the CMHC won't have a mix of people at all stages of illness and recovery, which may create an atmosphere of hopelessness and lead to lowered expectations for consumers and staff at CMHC

Topic #2: Clients Getting High Levels of All Behavioral Health Services

Creating PCHHs in CMHCs – What Physical Health Services are Critical?

- Blood draws for lab work should be available on-site the same day
- Specific education routinely for all consumers for medication side effects
- Pharmacy and ability to manage large volumes of medication samples
- Same type of bubble pack, medication pick up & management for physical health meds
- Incentives for wellness program participation
- Chronic disease management programs, especially pain management
- Focus on high volume medical problems (hepatitis, hypertension, traumatic brain injuries, metabolic problems due to psych meds, diabetes)
- Immunizations, preventive care & education, annual exams. OB/GYN, x-rays, procedure rooms, dental & eye care, and holistic care options
- Availability of different gender PCPs
- Ability for family members share same PCP even if they don't need mental health services

Topic #3: Clients Getting Outpatient Behavioral Health Therapy

- This is a higher functioning group, so maybe shouldn't be a priority to have PCHH in outpatient CMHCs
- Maybe have case manager connecting people with primary care, making sure physical needs are met
- There are serious issues with patients not wanting physical and mental health providers sharing information
- Evaluate demographics and need of this group - possibly ask their preference using a survey
- Make sure there is no wrong door as well as quick referral methods for people at outpatient mental health clinic where other services are not offered
- Make sure to include TAY group and EASA program

Topic #4: Clients Getting Alcohol and Drug Treatment

- Alcohol and drug specialist is needed on every PCHH team in either PCP office or CMHC, but this cannot replace treatment
- Add plan for PCHH in methadone clinic
- No apparent need for PCHH in specialty alcohol and drug programs
- PCPs in this setting should have alcohol and drug expertise
- Therapists should be dually credentialed
- If no primary care in alcohol and drug program, use health status questionnaires and increase capacity of alcohol and drug providers to assess clients' physical health needs
- If no primary care in alcohol and drug program, increase provider communication and collaboration

3. Active Consumer Input Session

Current active behavioral health consumers were identified using a list of Verity members currently receiving behavioral health services in Multnomah County and a list of behavioral health clients at Empowerment Initiatives, a local non-profit peer mentor organization. Potential participants were called by MHASD staff and invited to an input session about having behavioral and physical health services located at the same place. The goal was to have 20 participants at the session. Thirty people were confirmed, leaving room for no-shows. Participants were provided Tri-Met tickets to and from the session, which was held at the Multnomah County East Building. Food and beverages were available, and a $25 stipend was provided to compensate participants for their time at the two-hour session.

Fifteen consumers participated in the input session. Participants sat at different tables in the room, with 3-4 people at each table to allow for the best possible small group participation. There were also two facilitators at each table, trained peer mentors from Empowerment Initiatives and MHASD staff. One person facilitated the discussion while the other wrote key comments and areas of agreement on large paper. After discussions were over, one person from each table shared the main comments from their table with the entire group.

MHASD staff worked with the consumer advocates at the prior input sessions mentioned above to develop the active consumer questions. Questions were divided into 3 topic areas, with 3 questions under each topic (see below). The groups had approximately 25 minutes to discuss each area.

Results from the input session are on pages 80-81, organized into 2 areas:

1) Benefits, concerns, and goals related to integrated healthcare/PCHHs
2) Recommendations for implementation of integrated healthcare/PCHHs

Topic Areas and Questions for MHASD Active Consumer Input Session

Topic #1: Reactions to and ideas about a healthcare team taking care of the whole person in a PCMH located in a CMHC

a) Would you go to see a regular doctor if there was one at your community mental health center?
b) What are your goals when you visit a regular doctor?
c) Do you think your mental health and physical health doctors talk to each other enough about your health?

Topic #2: Change and transitions

a) What can mental health and physical health providers do to make it more comfortable for you to get mental health & physical healthcare at the same place?
b) How can mental health and physical health providers make sharing your health information among your healthcare team more comfortable for you?
c) What do you value about your current mental health provider that you want to keep if physical health services are available at your community mental health center?

Topic #3: Types of services available

a) Would it be useful to have someone help you get your questions ready before your doctor appointment?
b) How much time do you think you'd need when you visit a regular doctor?
c) When your doctor orders blood work, do you want your blood drawn at your community mental health center? Would you like the blood draw done before you see the doctor so that results could be discussed at the appointment?

Diagram 3: Active Consumer Input Session Results: Benefits, Concerns, and Goals Related to Integrated Healthcare

Perceived benefits of integrated healthcare

- Communication between providers will increase effectiveness of care
- When doctors are not in the same location they do not talk to each other, and they may not even know you're seeing other providers
- Providers can communicate about medication interactions
- Doctors might be less prejudiced against people with mental health needs if everyone is working together
- A team that knows you makes you feel safe - trust is already established, which decreases anxiety
- Convenience: "One stop shopping is good"
- Want long-term relationships with providers

Concerns about integrated healthcare

- Privacy: Some participants voiced concerns about not being given a choice to share information between behavioral and physical health providers
- Some participants had reservations about their behavioral health information being shared with primary care doctors because some people felt that in the past they had been treated differently by doctors once their behavioral health diagnosis was disclosed
- Insurance coverage for people without Oregon Health Plan is a barrier to getting needed care

Consumer goals when seeing a primary care doctor

- Be respected, listened to, and not judged
- Help with pain management
- Get preventive care like mammograms, yearly check ups, and immunizations
- Options available such as alternative & naturopathic remedies
- More time with doctors
- Getting to root of problems, not just dismissed as mental health issues

Diagram 4: Consumer Input Session Results: Recommendations for Implementation of Integrated Healthcare and PCHHs

Recommendations for making it more comfortable to receive integrated care

- Have appointments with all providers together, or back-to-back
- Have case manager come to appointment
- Have better ways to communicate with doctors
- Create an environment where you can advocate for yourself or bring a support person/advocate
- More education for providers is needed so that patients are being heard and not written off as "drug seeking" and/or having physical problems dismissed as being mental problems

Recommendations for making information sharing more comfortable

- Providers talk directly to patients about how they feel about information sharing
- Provide a choice about what information is shared or not
- Might be helpful to have advocates at all doctor appointments and hospital visits
- More compassionate attitudes from providers

Recommendations for implementation

- Communication between psychiatric provider and primary care provider for all medication changes
- Keep option to stay with established providers
- Need caring doctors
- Doctors need more education about mental health issues
- Want family to be able to see same doctor
- Have understandable instructions & information written down to take home from doctor
- Want more time with doctor -15 minutes isn't enough to understand instructions and get answers to questions
- Alternative medicine options like acupuncture for both mental and physical health
- Visits with nutritionist to help with diet changes for medications

What services would help behavioral health consumers receive primary care?

- Someone to help prepare questions for doctor in advance of appointment
- Increased appointment time, depending on issues that need to be addressed
- Reduced wait time for seeing doctor
- Leaving appointment with all needs met, especially the doctor asking about medication issues

Blood Draws

- Blood draws at CMHC would save time, with results communicated to primary care doctor
- Blood draws could happen before doctor appointment, so results can be discussed with doctor
- Important to have skilled people drawing blood, to help people feel comfortable
- A few participants indicated they would not like their blood drawn at CMHC

Valued services at CMHCs that should be kept in PCHHs

- Full range of support & life skills groups
- Keep established relationship with current therapist
- Peer advocates and/or mentors with relevant life experience
- Group leaders that provide hope
- Medication management
- Help with referrals, instead of just providing a list with phone numbers

Appendix C: Verity PRC Subcommittee Prioritized Areas for Standardization

Rank	Prioritized Areas for Standardization
#1	**Documentation of services/housing of records and Information Exchange** ▪ What should the chart contain for a patient served in a primary care site providing integrated behavioral health services? ▪ What should the chart contain for a patient served in a CMHC integrated service site? ▪ What are the legal requirements? ▪ What are the policy and rules for housing of records? ▪ What information is needed to provide the best possible care? ▪ Protocols for how information about patients is exchanged between behavioral/physical health providers ▪ How do we work around different EHRs?
#2	**Medical/Mental CPT/HCPC codes & Payment Methodologies – How do you pay for a PCHH in a CMHC?** ▪ What services are you offering that you're not able to bill for? ▪ Should the county create billing guidelines? ▪ Codes currently being used by Multnomah County Health Department & CCC? ▪ FQHC wrap around payments for behavioral and physical health services can be incorporated into the plan ▪ Physical space and structural issues also need addressed
#3	**Metabolic screening and lab protocols for people on psychiatric medications** ▪ Verity lab protocol ▪ Group decided Dr. Cutler should meet with Medical Directors to discuss adopting standard practices. Issues will need to be addressed about who orders the labs, how results are communicated back to behavioral/physical health providers, etc. ▪ Meeting held 1/15/10 with 23 people from 15 organizations ▪ Pull together small work group of MDs to tackle barriers ▪ Researching information on running labs at CMHCs
#4	**Performance/outcome measures** ****This will be delegated to the QM Committee, with approval/input from medical directors at sites**
#5	**Provider team composition and Delivery Model** ▪ Who should lead a PCHH team in behavioral health setting? ▪ What other team members should be standard? ▪ Which team members should provide what services? ▪ What set of behavioral health services should be provided in a primary care practice?
#6	**Screening Instruments** ▪ What screening tools are CMHC sites using for behavioral and/or physical health? ▪ What screening tools are used in primary care sites?

Appendix D: ISSR Variance Request for Integrated Healthcare Services

April 16, 2010

Madeline M. Olson
Deputy Assistant Director
Department of Human Services
Addictions and Mental Health Division
500 Summer St. NE E 86
Salem, OR 97301-1118

Re: Variance Request Oregon Administrative Rules 309-032-1535 (2)(g) and (i), and 309-032-1525 (3)(g).

Dear Ms. Olson,

In order to more effectively provide integrated mental health and addictions services in a primary care setting Multnomah County, Mental Health and Addiction Services Division is requesting a variance to the Oregon Administrative Rule under variance request 309-032-1565 Variances, (1) Criteria for a Variance: Variances may be granted to a Local Mental Health Authority (LMHA), Community Mental Health Program (CMHP) or provider holding a certificate directly with the Division, by the Division: (b) If implementation of the proposed alternative services, methods, concepts or procedures would result in improved outcomes for the individual.

Specific Variance Requests:

309-032-1535 Individual Service Record
(2) General Requirements for Individual Service Record: All providers will develop and maintain an Individual Service Record for each individual upon entry. The record will, at minimum, include: (g) An ISSP or provisional ISSP, including any applicable behavior support or crisis intervention planning; and (i) A Service Conclusion Summary, when required.

309-032-1550 Service Conclusion
(2) Service Conclusion Process and Continuity of Care: Prior to service conclusion, providers must: (f) The provider must report all instances of service conclusion on the mandated state data system.

Variance Requested for Individual Service And Support Plan:
For integrated healthcare services provided in a primary care setting, the ISSP function will be described in an Assessment Note outlining the recommended treatment protocol including anticipated frequency and duration of services and measurable rehabilitative outcomes. These will be updated through the "Plan" section of subsequent Individual Service Notes.

Variance Requested for Service Conclusion Summary and State Data System Termination:
Integrated care involves the provision of brief & focused services to a large number of consumers and is not intended as an intensive service for addressing severe and/or persistent mental illness. As is the practice in the primary care setting, a consumer's "case" is "always open." A “Service Conclusion Summary” in this setting is not applicable thus a variance for the requirement of such is requested. Additionally, although consumers will be enrolled in the state data system (CPMS) a variance regarding termination requirements is requested. Many of the circumstances that require service conclusion will not be known to the provider in this setting and standard practice in this setting allows for the “case” to remain open even when an individual has not accessed services for an extended period of time. At the time of re-engagement following an extended period of absence, a new assessment would be completed and the ISSP updated at the start of services.

309-032-1525 Entry and Assessment
(3)(g) In addition to periodic assessment updates, any individual continuing to receive mental health services for one or more continuous years, will receive an annual assessment by a QMHP, that has documented approval by an LMP.

Variance Requested For LMP Approval:
In primary care settings not staffed with a medical professional meeting the definition of LMP as defined in 309-032-1505 (71) (a through e); we request a variance allowing documented review by the primary care physician of the annual assessment update conducted by a licensed health care professional as defined in 309-032-1505 (70).

Rationale for Variance Requests:

MHASD believes that these variances, if approved, will result in improved clinical outcomes and an increase in patient centered care. For many individuals, the ability to access mental health services in their primary care setting will result in less barriers to the receipt of those services (i.e. decreased no-shows in response to referrals) and in facilitation of the care team's ability to coordinate patient care. In the primary care setting the Individual Service and Support Plan becomes more relevant and useable when it is integrated into Individual Service Notes and is updated in real-time. Service continuity is maintained in this setting when a "case" is not opened/closed repeatedly and when repetition of the intake process is avoided. These modifications to community mental health center requirements are consistent with the culture of practice in primary care and will increase the ability of these settings to provide more integrated overall health care to mental health clients.

Conditions for Variance Request:

Mental health services will be delivered by licensed mental health professionals as defined by 309-032-1505 (70). MHASD will audit all participating sites within 1st year and will require providers wishing to deliver mental health services in primary care settings to provide policies and evidence of staff training consistent with this variance request.

Sincerely,

Karl R. Brimner, M.Ed.
Multnomah County Mental Health and Addiction Services Division Director
421 SW Oak, Suite 520
Portland, OR 97204

Appendix E: AUTHORIZATION TO EXCHANGE AND DISCLOSE HEALTH INFORMATION

Client Name: _____ AKA _____

Last First Middle Last First Middle

Date of Birth: _____ _____ / _____ _____ / _____ _____ _____ _____

I authorize the individual/agency indicated below to provide and exchange the following information with the Mental Health & Addiction Services Division.

Initial all appropriate box(es) and give complete name and address:

___ To release health records to: Name: _____

___ To receive health records from: Street Address: _____

___ To verbally exchange information with: City _____State_____Zip_____

___ To provide ongoing communication and share information with:

Purpose: I authorize MHASD to use or disclose the health information noted above for the following reasons:

_____

Specific information to be exchanged or disclosed includes all of the following:

- Diagnosis — medical and psychiatric
- Current medication list
- Current lab work
- Most recent H&P and most recent PCP visit note
- Most recent psychiatric assessment and psychiatric treatment note
- Name/Contact information for prescribing provider
- Crisis/Safety Plan **AND**
- Other: _____

_____

By **initialing** the spaces below, I specifically authorize the release of the following health information, if such information exists:

_____ Drug/Alcohol diagnosis, treatment or referral information ____Genetic testing information

_____ HIV/AIDS related records

I may revoke this authorization in writing at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand Multnomah County cannot guarantee information will not be disclosed if the information is released to an organization not subject to Federal and State privacy regulations

I understand that refusal to sign the authorization may affect MHASD's ability to coordinate and obtain services.

This authorization will expire upon end of treatment unless otherwise specified (insert date or event) _____

_____

I understand what this agreement means and I am signing voluntarily.

_____ _____ _____

Signature of Client/Parent(s)/Personal Representative (circle one) Date Relationship to Client

CODE	MENTAL HEALTH SERVICES IN PRIMARY CARE BILLED TO MHO (Primary Care Clinics that are not also a Certified Community Mental Health Program must credential individual providers through Verity)				
	SERVICE	**PROVIDERS**	**CPMS ENROLLMENT**	**FQHC WRAP APPLICABLE**	**DOCUMENT**
90801 – 90802	Psychiatric assessment	Psych MD & NP, LCSW, Licensed Psychologist, LPC	YES	Yes	MH Assessment, Tx Plan (ISSP), Progress Notes, Notice of Privacy Practices, Authorization to Treat, Info Exchange Acknowledgement, Rights & Responsibilities
90804, 90806, 90808, 90810, 90812, 90814	Individual psychotherapy	QMHP		Yes	
90805, 90807, 90809, 90811, 90813, 90815	Individual psychotherapy with medical evaluation and management	Psych MD & NP		Yes	
90846	Family psychotherapy (without the patient)	QMHP		No	
90847 & 90849	Family psychotherapy	QMHP		Yes	
90853 – 90857	Group psychotherapy	QMHP		Yes	
90862	Pharmacologic management	Psych MD & NP		Yes	
90882	Environmental intervention for medical management	Psych MD & NP, QMHP		No	
90887	Interpretation/explanation of results, psychiatric or medical (to family or other responsible person)	Psych MD & NP, QMHP		No	
H0002	Behavioral Health Screening to determine eligibility to treatment	QMHP		No	
H0004	Behavioral health counseling/therapy	QMHP		Yes	
H0031	Mental Health Assessment by Non-Physician (non-licensed provider)	QMHP		Yes	
H0032	Mental health service plan development by non-physician (non-licensed provider)	QMHP		Yes	
H0034	Medication training and support	QMHP		Yes	
H2010	Comprehensive Medication Services	Psych MD, NP, RN		Yes	
99406 - 99407	Smoking & tobacco cessation counseling	LCSW, QMHP, RN, CADC		Yes	
99408 & 99409	Screening, Brief Intervention and Referral to Treatment (SBIRT)	?		Yes	

CODE	SERVICE CODES RELATED TO PHYSICAL HEALTH DIAGNOSIS AND BILLED TO CAREOREGON OR DMAP				
	SERVICE	PROVIDERS	CPMS ENROLLMENT	FQHC WRAP ELIGIBLE	DOCUMENT
PHYSICAL HEALTH EVALUATION AND MANAGEMENT CODES					
99201 – 99205	PCP New patient	MD, ND, NP, PA	NO	Yes	H&P, Progress Notes, Notice of Privacy Practices, Authorization to Treat, Problem List, Rights & Responsibilities, Info Exchange Acknowledgement, ROI
99211 – 99215	PCP Established patient	MD, ND, NP, PA		Yes	
99078	Educational group, e.g. prenatal, obesity, diabetes	RN, Licensed psychologists, LCSW, LMFT, LPC		No	
99401 – 99404	Prevention individual	RN, Licensed psychologists, LCSW, LMFT, LPC		Yes	
99411 - 99412	Prevention group	RN, Licensed psychologists, LCSW, LMFT, LPC		Yes	
Lab Tests	Laboratory tests, including blood levels for monitoring of psychotropic medications/ Electrocardiograms done to monitor the effect of psychotropic medications	MD, ND, NP, PA		No	
Rx Drugs	Medications used in the treatment of side effects of psychiatric medications and psychiatric medications	MD, ND, NP, PA		No	
HEALTH AND BEHAVIOR ASSESSMENT AND INTERVENTION CODES					
96150 – 96154	Consultation behavioral intervention	Licensed psychologists, LCSW, LMFT, LPC	NO	Yes	
96101	Neuropsychological evaluations	Psychologists		Yes	
99406 & 99407	Smoking & tobacco cessation counseling	?		Yes*	
99408 &99409	Screening, Brief Intervention and Referral to Treatment (SBIRT)	?		Yes	

The mental health codes that are not reimbursed and not eligible for supplemental/wraparound payment are telephone and online assessments (98966, 98967, 98968 and 98969), and supportive rehabilitation services (90882, H2014, H2023, and H2032) and services that are not face to face with client (90846 and 90887).

* If smoking cessation is the sole reason for the visit

Appendix G: Identified Barriers and Possible Approaches to Achieve Routine Comprehensive Metabolic Monitoring and Treatment for Patients Taking Antipsychotic/Psychiatric Medications

Identified Barrier	Barrier Description	Possible Approaches to Overcome Barrier	Proposed Action Steps
Responsibility	Who is responsible for monitoring, ordering labs, responding appropriately to lab results, & treatment?	- Proposed community agreement that whoever prescribes the medication should take responsibility	
Standard Monitoring Protocol	Need to agree on standardized protocols to implement. Proposed use of Verity protocol and 2004 Consensus Guidelines	- Agreement to use standardized protocol/algorithm (Adults & Children) - Standardized Monitoring Form	
Process Mechanisms	No standard process for monitoring, ordering labs, and responding to lab results at both CMHCs and PC sites	- Standardized Monitoring Form	
	15 minute office visit makes it difficult to address all the patients' needs		
Provider Education	Providers only trained to prescribe 2nd gen. antipsychotics & don't feel comfortable prescribing alternatives like 1st gen. drugs	- Sponsored CME by OMA, OPA, OCCAP, AFP - Consultation lists for providers	
	Lack of clarity regarding clinical practice in response to metabolic symptoms		
Communication & Care Coordination	Provider's limited time and ability to access prescribing provider	-Consultation lists for providers - Position paper on need to support monetary costs of monitoring	
	PCPs don't feel comfortable changing or taking patients off medications without first collaborating with prescribing Psychiatrist	- Standardized Transfer Letter from Psychiatrist to PCP - Consultation lists of providers	
	State regulations (SB 163) make integrating patient info at health plan level difficult	- HB 3669 proposed to repeal SB 163	
	PCPs may not even know patients are taking antipsychotic meds	- Standardized Transfer Letter from Psychiatrist to PCP - Standardized use of ROI form	
Monetary Costs	Traditional FFS payments for MH services do not support cost of metabolic monitoring	Position paper on need to support monetary costs of monitoring	

Appendix H: 2004 Consensus Guidelines for Metabolic Syndrome

Table 3—*Monitoring protocol for patients on SGAs**

	Baseline	4 weeks	8 weeks	12 weeks	Quarterly	Annually	Every 5 years
Personal/family history	X					X	
Weight (BMI)	X	X	X	X	X		
Waist circumference	X					X	
Blood pressure	X			X		X	
Fasting plasma glucose	X			X		X	
Fasting lipid profile	X			X			X

*More frequent assessments may be warranted based on clinical status

complications for which these patients are at increased risk.

Baseline monitoring

The panel recommends that baseline screening measures be obtained before, or as soon as clinically feasible after, the initiation of any antipsychotic medication (Table 3). These include

- Personal and family history of obesity diabetes, dyslipidemia, hypertension, or cardiovascular disease
- Weight and height (so that BMI can be calculated)
- Waist circumference (at the level of the umbilicus)
- Blood pressure
- Fasting plasma glucose
- Fasting lipid profile

These assessments can determine if the patient is overweight (BMI 25.0–29.9) or obese (BMI ≥30), has pre-diabetes (fasting plasma glucose 100–125 mg/dl) or diabetes (fasting plasma glucose ≥126 mg/dl), hypertension (blood pressure >140/90 mmHg), or dyslipidemia. If any of these conditions are identified, appropriate treatment should be initiated. Psychiatrists should not hesitate to refer the patient to the appropriate health care professional or specialist knowledgeable about these disorders.

The panel recommends that nutrition and physical activity counseling be provided for all patients who are overweight or obese, particularly if they are starting treatment with an SGA that is associated with significant weight gain. Referral to a health care professional or program with expertise in weight management may also be appropriate.

Health professionals, patients, family members, and caregivers should be aware of the signs and symptoms of diabetes and especially those associated with the acute decompensation of diabetes such as DKA (Table 4). The latter is a life-threatening condition and always requires immediate treatment. Patients, family members, and caregivers also need to know that treatment with some SGAs may be associated with significant weight gain and a heightened risk of developing diabetes and dyslipidemia. For patients with, or at higher risk for, diabetes and in those treated with other medications that may increase these risks (e.g., valproate, lithium, Depo-Provera), it may be preferable to initiate treatment with an SGA that appears to have a lower propensity for weight gain and glucose intolerance (Table 2). Potential for weight gain should also be considered in the choice of other psychiatric and nonpsychiatric medications.

Table 4—*DKA clinical presentation*

Rapid onset of:
- Polyuria, polydipsia
- Weight loss
- Nausea, vomiting
- Dehydration
- Rapid respiration
- Clouding of sensorium, even coma

Follow-up monitoring

The patient's weight should be reassessed at 4, 8, and 12 weeks after initiating or changing SGA therapy and quarterly thereafter at the time of routine visits (Table 3). If a patient gains ≥5% of his or her initial weight at any time during therapy, one should consider switching the SGA. In such a situation, the panel recommends cross-titration to be the safest approach; abrupt discontinuation of an antipsychotic drug should generally be avoided. When switching from one antipsychotic drug to another, it is preferable to discontinue the current medication in a gradual fashion. The profile of the subsequent drug will determine the initial dose and escalation strategy. Particular consideration should be given before discontinuing clozapine because of the potential for serious psychiatric sequelae.

Fasting plasma glucose, lipid levels, and blood pressure should also be assessed 3 months after initiation of antipsychotic medications. Thereafter, blood pressure and plasma glucose values should be obtained annually or more frequently in those who have a higher baseline risk for the development of diabetes or hypertension. In those with a normal lipid profile, repeat testing should be performed at 5-year intervals or more frequently if clinically indicated.

Although limited data are available in children and adolescents regarding the risks of diabetes when SGAs are given, these patients should have their height, in addition to weight, measured at regular intervals and their BMI calculated. BMI percentile adjusted for age and sex should be used to determine if excessive weight gain has occurred, and if present, a change in therapy should be considered.

For people who develop worsening glycemia or dyslipidemia while on antipsychotic therapy, the panel recommends considering switching to an SGA that has not been associated with significant weight gain or diabetes (Table 2). All patients with diabetes should be referred to an American Diabetes Association–recognized diabetes self-management education program, if available. Referral to a clinician with experience treating people with diabetes is recommended. These patients should carry diabetes identification.

Immediate care or consultation is required for patients with symptomatic or severe hyperglycemia (glucose values ≥300 mg/dl), symptomatic hypoglycemia, or glucose levels ≤60 mg/dl, even in the absence of symptoms. The presence of

Appendix I: Verity Lab Protocol

	Recommended Verity Protocol		Draft 9/8/09	
Medication	**Labs**	**Lab Time periods**	**Other Screens**	**Time periods**
*Abilify (aripiprazole)	FBS, Lipid, Triglyceride	Baseline 3 months every 12 months thereafter	Blood Pressure Check, weight check	Baseline 1 months every 3 months
*Zyprexa (olanzapine)	FBS, Lipid, Triglyceride	Baseline 3 months every 12 months thereafter	Blood Pressure Check, weight check	Baseline 1 months every 3 months
*Invega (paliperidone)	FBS, Lipid, Triglyceride	Baseline 3 months every 12 months thereafter	Blood Pressure Check, weight check, EKG	Baseline (all) 1 month (BP, Weight, BMI) every 3 months (BP, Weight, BMI) 18 months (EKG)
*Seroquel (quetiapine)	FBS, Lipid, Triglyceride	Baseline 3 months every 12 months thereafter	Blood Pressure Check, weight check, EKG	Baseline (all) 1 months (BP, Weight, BMI) every 3 months (BP, Weight, BMI) 18 months (EKG)
*Risperdal (risperidone)	FBS, Lipid, Triglyceride	Baseline 3 months every 12 months thereafter	Blood Pressure Check, weight check, EKG	Baseline (all) 1 months (BP, Weight, BMI) every 3 months (BP, Weight, BMI) 18 months (EKG)
*Geodon (ziprasidone)	FBS, Lipid, Triglyceride	Baseline 3 months every 12 months thereafter	Blood Pressure Check, weight check, EKG	Baseline (all) 1 months (BP, Weight, BMI) every 3 months (BP, Weight, BMI) 18 months (EKG)
Clozapine (Clozaril)	WBC, ANC, Lipid, Triglyceride	Labs required every week for the 1st 6 months then every other week for the next 6 months then every 4 weeks after that,	Blood Pressure Check, weight check, EKG	Baseline 1 months every 3 months
Carbamazepine (Tegretol)	Na+, ALT/AST, CBC w/diff, Lipid, Triglyceride, HLA for Asian clients	Baseline 3 months every 12 months thereafter	Blood Pressure Check, weight check,	BP, Weight every clinician visit
Lithium (Eskalith, Lithobid)	SCr, TSH/TSR, Lipid, Triglyceride, UA	Baseline 3 months every 12 months thereafter	Blood Pressure Check, weight check,	BP, Weight every clinician visit
Valproate (Depacon)	ALT/AST, CBC w/diff, Lipid, Triglyceride	Baseline 3 months every 12 months thereafter	Blood Pressure Check, weight check,	BP, Weight every clinician visit
*Patients with risk factors for leukopenia/neutropenia, such as preexisting low white blood cell count (WBC) or a history of drug-induced leukopenia/neutropenia, should have frequent monitoring of complete blood count (CBC) during the first few months of treatment. Antipsychotic therapy should be discontinued at the first sign of a clinically significant decline in WBC that cannot be attributed to other causes.				

Appendix J: Cascades Community Evaluation Strategy, Tables 4 and 5

Table 4: Serious/Severe Mental Health Management in Primary Care

The focus is on patients in primary care who have serious/severe MH conditions. The emphasis is on the provision of primary care (which may include psychopharmacology, crisis, and case management services) and coordination with community based providers of MH services (if they are accessing those services—some may not be eligible and/or willing to be seen in specialty MH settings). Will need to develop standard definitions of serious/severe MH for following in registry (e.g., diagnosis of schizophrenia, bipolar, on atypical antipsychotic medications). Protocols based on the ADA/APA Guidelines will need to be developed regarding frequency/time measurement time periods for metabolic monitoring, which may vary based on prescribed medications. A standard definition for documented PCP and dental provider (e.g., have seen in last 12 months) will need to be developed.

Measure	Draft Specifications	Older Adult	Adult	Adolescent
Structure				
Use of registry for care management of individuals with serious/severe MH conditions	See Appendix B: Registry (Note: the approach to registry measurement here is based on NCQA's PCC-PCMH approach to measurement for electronic prescribing and lab test tracking) Type of Registry: 1. Registry linked to patient-specific demographic and clinical information 2. Stand-alone registry (Excel, Access, other) 3. No registry Choose one of the following: 1. 75-100% of primary care patients with serious/severe MH followed using Registry 1 2. 75-100% of primary care patients with serious/severe MH followed using Registry 2 3. Site has capability for either Registry 1 or 2 but does not use 4. Site does not have capability or less than 75% of patients with serious/severe MH were followed	X	X	X
% of patients w/ documented PCP and dental providers	N= All patients with serious/severe MH with documented PCP and dental providers D= Unduplicated number of patients with serious/severe MH being followed in the registry during the measurement time period	X	X	X
Process				
% of patients w/ serious/severe MH with BMI monitoring	N= All patients with serious/severe MH and monitoring of BMI D= Unduplicated number of primary care patients with serious/severe MH being followed in the registry during the measurement time period	X	X	X
% of patients w/ serious/severe MH with blood glucose monitoring	N= All patients with serious/severe MH and monitoring of blood glucose D= Unduplicated number of primary care patients with serious/severe MH being followed in the registry during the measurement time period	X	X	X
% of patients w/ serious/severe MH with lipid monitoring	N= All patients with serious/severe MH and monitoring of lipids D= Unduplicated number of primary care patients with serious/severe MH being followed in the registry during the measurement time period	X	X	X

% of patients w/ serious/severe MH with blood pressure monitoring	N= All patients with serious/severe MH and monitoring of blood pressure D= Unduplicated number of primary care patients with serious/severe MH being followed in the registry during the measurement time period	X	X	X
Outcome				
% of patients with change in MH status	Need to determine tool to measure change in MH status (e.g., ORS) N= all patients with serious/severe MH with baseline being the score on the tool taken at admission or on entry into registry and change being the most recent measure taken 6 months or later D= Unduplicated number of primary care patients with serious/severe MH on registry during the measurement time period	X	X	X
% of patients with change in disease condition	N= All patients with serious/severe MH with baseline being the most recent applicable PCR measures (e.g., blood pressure) taken at admission or on entry into registry and change being the most recent measures taken 6 months or later D= Unduplicated number of primary care patients with serious/severe MH on registry during the measurement time period	X	X	X
% of PCPs with high scores for BH Access/Confidence/Skills	N= Unduplicated number of PCPs reporting average scores of 2 or less on the LifeWorks NW Behavioral Health Systems Evaluation, by subscale: • Service access • Confidence level • Confidence in specific assessment and treatment skills D= Unduplicated number of PCPs in the organization/clinic site, by subscale	X	X	X
% of patients with high levels of satisfaction and activation	N= Unduplicated number of patients with serious/severe MH reporting a high level of satisfaction and activation using core questions to be developed* D= Unduplicated number of primary care patients on serious/severe MH registry during the measurement time period *Core questions include satisfaction questions common to PCR measurement, adding patient activation questions from the PACIC or PAM. Desired analysis would report at team level and stratify team scores from patients receiving primary care MH services compared to team scores from patients not receiving primary care MH services	X	X	X

Table 5: Identification and Treatment of Health Conditions for People with Serious/Severe MH Conditions Being Served in Mental Health Settings

The focus is on patients in specialty MH settings who have serious/severe MH conditions. The emphasis is on coordination with primary care services provided in community and/or primary care provided within the MH setting. Will need to develop a standard definition of serious/severe MH for following in registry (e.g., diagnosis of schizophrenia, bipolar, on atypical antipsychotic medications). Protocols based on the ADA/APA Guidelines will need to be developed regarding frequency/ time measurement time periods for metabolic monitoring, which may vary based on prescribed medications. A standard definition of MH provider will need to be developed, as well as a definition for documented PCP and dental provider (e.g., have seen in last 12 months). Smoking Cessation will also require standard definition.

Measure	Draft Specifications	Older Adult	Adult	Adolescent
Structure				
Use of registry for care management of metabolic syndrome	See Appendix B: Registry (Note: the approach to registry measurement here is based on NCQA's PCC-PCMH approach to measurement for electronic prescribing and lab test tracking) Type of Registry: 1. Registry linked to patient-specific demographic and clinical information 2. Stand-alone registry (Excel, Access, other) 3. No registry Choose one of the following: 1. 75-100% of patients with serious/severe MH followed using Registry 1 2. 75-100% of patients with serious/severe MH followed using Registry 2 3. Site has capability for either Registry 1 or 2 but does not use 4. Site does not have capability or less than 75% of patients with serious/severe MH were followed	X	X	X
% of patients w/ documented PCP and dental providers	N= All patients with serious/severe MH with documented PCP and dental providers D= Unduplicated number of patients with serious/severe MH being followed in the registry during the measurement time period	X	X	X
Process				
% of patients w/ serious/severe MH with BMI monitoring	N= All patients with serious/severe MH and monitoring of BMI D= Unduplicated number of with serious/severe MH being followed in the registry during the measurement time period	X	X	X
% of patients w/ serious/severe MH with blood glucose monitoring	N= All patients with serious/severe MH and monitoring of blood glucose D= Unduplicated number with serious/severe MH being followed in the registry during the measurement time period	X	X	X
% of patients w/ serious/severe MH with lipid monitoring	N= All patients with serious/severe MH and monitoring of lipids D= Unduplicated number with serious/severe MH being followed in the registry	X	X	X
% of patients w/ serious/severe MH with blood pressure monitoring	N= All patients with serious/severe MH and monitoring of blood pressure D= Unduplicated number of patients with serious/severe MH being followed in the registry during the measurement time period	X	X	X
% of patients w/ serious/severe MH with a PCP visit within last 12 months	N= All patients with serious/severe MH with documentation in the registry of dates of PCP visit within the last 12 months D= Unduplicated number of patients with serious/severe MH being followed in the registry during the measurement time period	X	X	X

Measure	Draft Specifications	Older Adult	Adult	Adolescent
Outcome				
% of patients identified as smokers who have had smoking cessation addressed	N= Total number of patients with serious/severe MH who have registry documentation of smoking cessation being addressed D= Unduplicated number of patients with serious/severe MH being followed in the registry who are identified as smokers during the measurement time period	X	X	X
% of patients with change in disease condition	N= All patients with serious/severe MH with baseline being the most recent applicable PCR measures (e.g., blood pressure) taken at admission or on entry into registry and change being the most recent measures taken 6 months or later D= Unduplicated number of patients with serious/severe MH on registry during the measurement time period	X	X	X
% of MH providers with high scores for Healthcare Access/Confidence/Skills	N= Unduplicated number of MH providers reporting average scores of 2 or less on the LifeWorks NW Healthcare Systems Evaluation, by subscale: • Service access • Confidence level • Confidence in specific assessment and treatment skills D= Unduplicated number of MH providers in the organization/clinic site	X	X	X
% of patients with high levels of satisfaction and activation	N= Unduplicated number of patients with serious/severe MH reporting a high level of satisfaction and activation using core questions to be developed* D= Unduplicated number of patients on serious/severe MH registry during the measurement time period *Core questions include satisfaction questions common to PCR measurement, adding patient activation questions from the PACIC or PAM. Desired analysis would report at team level and stratify team scores from patients receiving BHC services compared to team scores from patients not receiving BHC services	X	X	X

Appendix K: Training and Consulting Service Options

University of Washington Psychiatry and Behavioral Sciences Advancing Integrated Mental Health Solutions Center

The AIMS Center provides training, consultation, and technical assistance for integrated healthcare to more than 250 organizations and 3,500 clinicians for more than 6 years. The program is dedicated to translating evidence-based collaborative care programs from research to practice, building capacity to address mental health needs in underserved areas and for underserved populations, and developing a workforce skilled in evidence-based collaborative care. The AIMS Center houses the IMPACT Implementation Center, the preeminent model of evidence-based depression care, and developed the web-based registry called the Care Management Tracking System (CMTS) recommended in this report. The AIMS Center prepared a proposal for the implementation of the CMTS in Multnomah County and includes options for on-site trainings such as team-building coaching and CMTS implementation support and technical assistance (AIMS Center). More information can be found at AIMS Center - University of Washington - Psychiatry & Behavioral Sciences.

MCCP Healthcare Consulting

MCPP Healthcare Consulting works with healthcare, behavioral health and public health organizations in the western United States to help them build innovative and successful clinical, financial, and administrative systems (MCCP Healthcare Consulting). More information can be found at MCPP Healthcare Consulting.

Integrated Primary Care, Inc.

Alexander Blount, Ed.D. is the President and lead consultant of Integrated Primary Care, Inc. (IPCI). IPCI offers consulting for integrated healthcare program design and implementation and training for providers/staff, team building, productivity improvement, and development of collaborative clinical practices. IPCI also offers assessments of clinical, administrative, and financial processes that can be supportive of, or are barriers to, integrating care. These services are tailored to help practices make the transition to becoming Patient Centered Medical Homes (Blount). More information can be found at consulting for integrated primary care.

Department of Family Medicine and Community Health at University of Massachusetts Medical School

The Department of Family Medicine and Community Health at the University of Massachusetts Medical School offers a Certificate Program in Primary Care Behavioral Health for behavioral health professionals training to be successful practitioners in primary care settings. This training is particularly targeted to prepare behavioral health professionals for the PCMH model. Distance training to individuals or groups is offered by web-based conferencing. Participants can include primary care medical providers from their clinic, preparing the team for practice in a PCMH model (University of Massachusetts). More information can be found at Primary Care Behavioral Health - Education - Family Medicine and Community Health - UMass Medical School - Worcester.

TransforMED

TransforMED is a leading primary care transformation organization offering PCMH facilitation services. They offer a full range of training, consulting, and facilitation, as well as targeted services such as teamwork development and how to manage change within organizations (TransforMED). More information can be found at Medical Home Facilitation at TransforMED.

Appendix L: Benton County Peer Wellness Coach Training

Benton County Health Services Corvallis, Oregon

The goal of Wellness Coach Training is to provide participants a basic understanding of health issues and techniques that Wellness Coaches will use in their work.

As a member of a Person Centered Medical Home Care Team, Peer Wellness Coaches support people in creating wellness-oriented lifestyles. The Peer Wellness Coach helps people get information, identify self-management goals, and assists people in navigating the mental and physical health care systems, according to the person's needs and choices. The training will consist of presentations by people with subject matter expertise, in class activities, as well as out of class activities.

Peer Wellness Coach training is open to persons who have successfully completed the Peer Wellness Specialist Training. At the end of this 40-hour, 10-week training, people who have successfully completed the training will receive a certificate of completion. Successful completion will be based on:

1. Attendance at each of the assigned classes
2. Participation in the classes, and out of class exercises
3. Demonstrated understanding of key concepts
4. Instructor evaluation and recommendations.

We understand that these topics may be of interest to some people, who may not be interested in getting a certificate of completion. As space allows, persons interested participating in the classes, without receiving a certificate will need approval from the training coordinator.

There will be 10 sessions lasting 4 hours each. Some work outside of the sessions will be required. There will be a group project presentation at the end of the training.

Wellness Coach Training Curriculum

I. Introduction
   a. Welcome
   b. Overview of Training and participant outcomes
   c. What is the problem: Morbidity and Mortality Data: national, State, and local health concerns
   d. Role of the Peer Wellness Coach
   e. Characteristics of a team

II. What does A Peer wellness Coach Do
   a. Principles of Adult Learning
   b. What is wellness (in class exercise: Why is being a Peer Wellness Coach Important to me? What can I contribute to team based care? What will I need to learn more about?
   c. Recovery, Wellness and Medical Models
   d. Discussion of group project; pick partners.

III. Chronic Conditions
   a. Overview of Chronic Diseases and their Impact on health
      1. Heart Disease
      2. Pulmonary Disease
      3. Diabetes
      4. Out of class activity: Take home quiz

IV. Chronic Conditions
    1. Obesity
    2. Substance Use
    3. Tobacco use and its Impact
    4. Metabolic Syndrome

V. Principles of Person Centered Medical Home
    a. Principles of the Person Centered Medical Home model
    b. Team Based
        1. Who's who and what do they do
    c. Ethics

    Out of class activity: Take home quiz

VI. Elements of a healthy lifestyle
    a. Nutrition and supplements
    b. Exercise and movement
    c. Creativity
    d. Spirituality

VII. Elements of a healthy lifestyle (continued)
    a. Community Involvement
    b. Stress management
    c. Dental Care
    d. Financial health

VIII. Strategies for Peer Wellness Coach
    a. The components of a treatment plan: Self management goals
    b. Motivational Interviewing
    c. Cognitive Behavioral Restructuring
    d. Mindfulness
    e. Education and Training
    f. Using natural supports

IX. Work on Group Project

X. Group Project Presentations

Wrap-Up, Course Evaluation, Presentation of Certificates

Presentation Requirements (Be creative, you can write a paper, do a skit, PowerPoint, collage, write a song, whatever you would like!)

1. A description of the condition
2. Some facts about the condition
3. What are goals for improvement for the condition
4. What are some interventions and resources you might use as a peer wellness coach

Each participant will be asked to set a wellness goal for him/herself for the time they are in the class, and will be asked to write a weekly one-page journal entry describing how s/he is doing on his/her wellness goal.

Appendix M: Glossary of Mental/Behavioral Health Terms

Under Construction

Section III Bibliography

AHRQ. (2009, June 8). *AHRQ Healthcare Innovations Exchange.* Retrieved March 19, 2010, from AHRQ: http://www.innovations.ahrq.gov/content.aspx?id=2444

AIMS Center. (n.d.). *University of Washington Advancing Integrated Mental Health Solutions*. Retrieved April 26, 2010, from University of Washington : http://uwaims.org/index.html

AMH. (2006, September). *Peer Delivered Services.* Retrieved June 3, 2010, from Oregon Department of Human Services, Addictions and Mental Health Division: http://www.oregon.gov/DHS/mentalhealth/consumers-families/peer-delivered-services.pdf

Blount, A. (n.d.). *Consulting Services of Integrated Primary Care, Inc.* Retrieved April 13, 2010, from Integrated Primary Care, Inc.: http://www.integratedprimarycare.com/consulting%20for%20integrated%20primary%20care.htm

Druss, B. G., von Esenwein, S. A., Compton, M. T., Rask, K. J., Zhao, L., & Parker, R. M. (2010). A Randomized Trial of Medical Care Management for Community Mental Health Settings: The Primary Care Access, Referral, and Evaluation (PCARE) Study. *Am J Psychiatry*, 151-159.

IHI. (n.d.). *The Triple Aim*. Retrieved March 30, 2010, from Institute for Healthcare Improvement: http://www.ihi.org/IHI/Programs/StrategicInitiatives/TripleAim.htm

Jue, K. (2009, Summer). *NASMHPD Meeting Presentations Summer 2009.* Retrieved March 19, 2010, from NASMHPD: http://www.nasmhpd.org/general_files/meeting_presentations/Summer%202009%20Commish/KenJue_IN-SHAPE.pdf

MCCP Healthcare Consulting. (n.d.). *MCCP Healthcare Consulting*. Retrieved May 6, 2010, from MCCP Healthcare Consulting: http://www.mcpphealthcare.com/

Morrato EH, D. B. (2010 Jan). Metabolic testing rates in 3 state Medicaid programs after FDA warnings and ADA/APA recommendations for second-generation antipsychotic drugs. *Arch Gen Psychiatry*, 67(1):17-24.

The Pledge for Wellness. (2007, September). Retrieved February 17, 2010, from Center for Psychiatric Rehabilitation: http://www.bu.edu/cpr/resources/wellness-summit/index.html

TransforMED. (n.d.). *Medical Home Facilitation*. Retrieved April 13, 2010, from TransforMED: http://www.transformed.com/MedicalHomeFacilitation/index.cfm

University of Massachusetts. (n.d.). *Primary Care Behavioral Health Education*. Retrieved April 13, 2010, from University of Massachusetts Medical School Family Medicine and Community Health: http://umassmed.edu/fmch/pcbh/welcome.aspx